Pendleton Family Care, LLC
1412 North Race St.
Glasgow, KY 42141
270.629.6333 (office)
270.629.6334 (fax)
www.pendletonfamilycare.com

Dear Valued Patient,

Welcome to our practice! We are so glad you have elected to visit us!

Pendleton Family Care, LLC is dedicated to providing our patients with the best care available. Enclosed you will find our new patient informational packet, office policies, and other pertinent information.

Before your scheduled appointment, please carefully read and complete the enclosed "New Patient Registration Packet," along with all other pertinent information listed below within this letter. Be sure to bring these forms with you to your scheduled appointment. ***We ask that you arrive 15 minutes prior to your scheduled appointment time to allow for our staff to register you in our system and complete any additional documents that may be necessary.***

At the time of your appointment, you will need the following:

- Your insurance card(s), drivers license, and social security card. (Initial visit)
- Any lab tests, medical records, X-Rays pertinent to why you are being seen by our provider. (Initial visit)
- A complete list of any or all prescriptions, over the counter, and herbal medications that you are currently taking. (Each visit, we will make you a medication card for your convenience if requested)
- Payment for any applicable copayment, deductible, and/or coinsurance responsibility. We gladly accept VISA, MasterCard, Discover, and American Express credit cards. We also accept check and cash payments. (Payments are due at each visit)

If you cannot keep your appointment for any reason, please contact our office as soon as possible so that we may reschedule your appointment.

Again, we thank you for choosing Pendleton Family Care, LLC, for your medical care. Please feel free to contact us anytime with your questions or concerns, our contact information is located on the above right corner of this page.

Sincerely,
The Staff at Pendleton Family Care, LLC

Pendleton Family Care, LLC
1412 North Race St.
Glasgow, KY 42141
270.629.6333 (office)
270.629.6334 (fax)
www.pendletonfamilycare.com

New Patient Registration Packet

Please advise our staff if you or anyone in your family has any special accommodation needs, we will be happy to make proper arrangements.

Patient Information:

Name: _____ Social Security Number: _____-_____-____ Date of Birth:_____ Sex: _____

Marital Status: (circle) Single Married Divorced Separated Widow(er)
Ethnicity: (circle) Caucasian African American Hispanic Other: _____ Language: (circle) English Spanish Other:_____
Religion: (circle) Atheist Baptist Christian Jehovah's Witness Methodist Mormon Non-Religious
Pentecostal United Church of Christ Other: _____
Mailing Address: _____City/State/Zip: _____
Billing Address: _____ City/State/Zip: _____

Employer: _____Occupation:_____

Home: (___) _____Cell: (___) _____Work:(___) _____What is preferred number at which to reach you? _____
For cell phones, do you have text capability? (circle) Yes No If yes, may we send you text messages? (circle) Yes No
How did you hear about our practice? _____

For Pendleton Family Care Patient Portal Use (online access to request appointments, make medication requests, refills, receives lab results, contact staff for general non emergent message(s) etc. Terms and conditions for use are posted on our practice website or available by request.
Email Address: _____

Concurrent Care:

Previous Primary Care Provider: _____ Primary Dental Provider: _____ Primary Vision Provider: _____

List any other providers/specialists whose care you are under:
_____ Reason _____ Phone Number _____
_____ Reason _____ Phone Number _____
_____ Reason _____ Phone Number _____

Emergency Contact Information:

(Used only if unable to reach you. Please note that no health information will be shared)

Name:_____ Phone:(___)_____ Relationship to Patient:_____

Parent/Legal Guardian Information:

(If patient is a minor, (under 18) or over 18 and unable to make decision for him/herself)

Name of Parent/Guardian 1: _____
Street Address: _____City, State, Zip:_____
Mailing Address: _____City, State, Zip:_____
Relation to patient: _____
Best Phone # to reach you: (____) _____

Name of Parent/Guardian 2: _____
Street Address: _____City, State, Zip:_____
Mailing Address: _____City, State, Zip:____
Relation to patient: _____
Best Phone # to reach you: (____) _____

(Please provide a copy or relevant court documents if you claim sole legal custody of a minor or are the legal guardian for patient over 18.)

Insurance Information:

Primary Insurance Name: _____ **Secondary** Insurance Name: _____

Pendleton Family Care, LLC
1412 North Race St.
Glasgow, KY 42141
270.629.6333 (office)
270.629.6334 (fax)
www.pendletonfamilycare.com

Group Number: _____ ID Number: _____ Group Number: _____ ID Number: _____

Name of Subscriber: _____ Name of Subscriber: _____
Subscribers address: _____ Subscribers address: _____
(If different from patients) *(If different from patients)*
Subscribers Date of Birth: _____ Subscribers Date of Birth: _____
Relationship to Patient: _____Relationship to Patient: _____

Advance Directive is a legal document with instructions you give regarding your future care if you are unable to make decisions about your care.
1) *Durable Power of Attorney for your Health Care (DPOAH)* – you name another individual to make healthcare decisions for you when you are unable to. Your provider determines that you can no longer make decisions for yourself and activates the DPOAH.
2) *Living Will* – You instruct your health care provider to give no life-sustaining treatment if you are near death or are permanently unconscious with no hope for recovery to your previous baseline health line status.

Do you have an Advance Directive? (circle)	Yes No	If yes, **please provide us a copy**.
Do you only have a Living Will? (circle)	Yes No	If yes, **please provide us a copy**.
Do you only have a DPOAH for your health care?(circle)	Yes No	If yes, **please provide us a copy**.
Do you have a DPOAH for your finances? (circle)	Yes No	If yes, **please provide us a copy**.

Permission for Health Care Providers to Discuss my Health care with family members/friends:
(Please note: If you do not want Pendleton Family Care, LLC to discuss your health care with anyone you may leave this section blank.)

I allow my treating healthcare provides to discuss my health care with the individual(s) names below. These individuals play some role in my care, either by assisting me directly or by offering support to me and my other family members.
I understand that this form does not give the individual named below any authority to make health care decisions for me. It also does NOT allow them to access my medical record. This document is not a health care power of attorney. *The sole purpose of this form is to protect my privacy by ensuring that my health care will be discussed with ONLY the individuals I have chosen.*

I understand that I am not required to designate any such individuals.
This document will stay in effect unless we receive in writing that privileges are to be revoked by the patient in which we are treating.

_____ _____ **(___)**_____
Printed Name of Individual Authorized to Receive Information — Relationship — Phone Number

_____ _____ **(___)**_____
Printed Name of Individual Authorized to Receive Information — Relationship — Phone Number

_____ _____
Printed Name of Patient/Legal Guardian — Date of Birth

_____ _____
Signature of Patient/Legal Guardian — Today's Date

Pendleton Family Care, LLC
1412 North Race St.
Glasgow, KY 42141
270.629.6333 (office)
270.629.6334 (fax)
www.pendletonfamilycare.com

Fax Authorization Request for Medical Records to be sent:

(Please note if you do not wish for Pendleton Family Care, LLC to request a copy of your medical records for the past year from your previous primary care provider you may leave this page blank)

Please list the Medical Provider/Hospital in which you would like us to request a copy of your medical records:

_____

I agree that this authorization to release records will be as valid on a faxed copy or photocopy as it is on the signed original.

Please release the following records to Pendleton Family Care, LLC:

_____ All medical Records and Medical Summary/Progress Notes
_____ Labs and Diagnostic Imaging Reports (X-Rays, Dexa, Mammo, U/S, CT, MRI, PET)
_____ Consult/Operative Notes
_____ Complete Hospital Records (ER Records, Discharge Summaries, Inpatient Stay Records, All Diagnostic Results)

_____ _____
Printed Name of Patient/Legal Guardian Patient Date of Birth

_____ _____
Signature of Patient/ Legal Guardian Date

Exceptional Records: (Release of these records requires a separate signature in order to approve release)

____ Psychiatric Records ____ HIV Status

_____ _____
Printed Name of Patient/Legal Guardian Patient Date of Birth

_____ _____
Signature of Patient/Legal Guardian Date

Pendleton Family Care, LLC
1412 North Race St.
Glasgow, KY 42141
270.629.6333 (office)
270.629.6334 (fax)
www.pendletonfamilycare.com

Family History:

Check Box if relative has:	Mother	Father	Sister	Brother	Child	Grandparent (Paternal)	Grandparent (Maternal)
Alcohol or Substance Abuse							
Allergies							
Anemia							
Anxiety							
Arthritis							
Asthma							
Bronchitis							
Cancer							
COPD							
Depression							
Diabetes							
Eczema							
Emphysema							
Glaucoma							
Heart Attack							
Heart Disease							
Hepatitis							
High Blood Pressure							
High Cholesterol							
Bowel Disease(s)							
Kidney Stones							
Migraines							
Obesity							
Osteoporosis							
Pneumonia							
Seizure Disorder							
Stroke							
Suicide							
Thyroid Disorder							
Vascular Disease							
Other							

Pendleton Family Care, LLC
1412 North Race St.
Glasgow, KY 42141
270.629.6333 (office)
270.629.6334 (fax)
www.pendletonfamilycare.com

Past Medical History:

Health Maintenance: **(Both Men and Women)**

Last Visual Exam: _____
Last Dental Exam: _____
Last Hearing Exam:_____
Last Mammogram: _____
Last Self Breast Exam: _____
Last PAP: _____
Last Testicular Exam: _____
Last Self Testicular Exam:_____
Last Colonoscopy:_____
Last Rectal Exam:_____
Last Dexa Scan: _____

Alcohol/Caffeine/Tobacco Use:

Weekly Amt of Alcohol:_____
Daily Amt of Caffeine:_____
Daily Amt Tobacco:
Cigars:_____
Cigarettes:_____
Smokeless Tobacco:____
Interested in Quitting? Yes|No

Surgical History:

Date: Surgery:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Drug, Food, and Other Allergies:

_____
_____
_____
_____
_____

Current Medications:

Check box if None ☐
List:
Name: Dose: How Often:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Vitamins/Supplements:

Name: Dose: How Often:

_____
_____
_____
_____
_____

Immunizations:

Please circle if you have had the following Immunizations and list date

Pneumonia (Pneumovax) Shot: _____
Tetanus Shot: _____
Smallpox Vaccine: _____
Meningococcal Vaccine: _____
Hepatitis A Series: _____
Hepatitis B Series: _____
Flu Shot (Influenza): _____
TB Skin Test (PPD): _____
HPV Vaccine _____
Chicken Pox Vaccine (or disease)_____
Zoster Vaccine (Shingles): _____

Current Medical History:

_____
_____
_____
_____
_____

Pendleton Family Care, LLC
1412 North Race St.
Glasgow, KY 42141
270.629.6333 (office)
270.629.6334 (fax)
www.pendletonfamilycare.com

Electronic Medical Records System:

We maintain many medical records through a computer database. This system is structured to maintain the privacy of your records in accordance with applicable laws, while allowing access to your records by your other health care providers who utilize the system. Once we entered medical records on the system, if you seek care from another provider who utilizes the same system, the other healthcare provider may access medical records relating to your treatment here as appropriate to provide you with ongoing care. However, if they do not use the same medical software as us here at Pendleton Family Care, LLC you may sign consent to allow us to send any information to the consulting provider(s) they may need to help us care for you.

Insurance Authorization and Assignments of Benefits:

While we participate with many national healthcare/insurance plans, if we do not participate with your insurance carried, you will be billed as a self-pay patient and be responsible for the entire balance for all services rendered. If we participate with your insurance, you will be responsible for any co-payments and/or deductibles at the time the services are rendered. We accept debit, credit, cash and check; however, we must charge a $50 fee for any returned check. In an effort to help ensure accurate insurance billing, we ask that you present your insurance card and a photo ID at each visit. Acceptable forms of payment are cash, check, debit and all major credit cards.

Acknowledgement:

I authorize and assign insurance benefit payment directly to the practice for any medical services I receive. I understand and agree that I am ultimately responsible for the charges on my account for any professional services rendered. I will be responsible for payment in full of all balances not paid by my insurance company.

Consent to Contact

I, _____, acknowledge and agree that Pendleton Family Care, LLC and any affiliates or vendor thereof, including collection or billing companies, may contact me by telephone or text message to any telephonic number I have provided to you, and any other telephone number associated with my account, including wireless or mobile telephone numbers. I further agree that you may use any method of contact to these numbers, such as an Automated Telephone Dialing System (ATDS) or prerecorded message. I also agree that I will notify Pendleton Family Care, LLC, if I have given up ownership or control of any such telephone number.

Collections

While copays, deductibles and co-insurance are due at the time of service there are times that after insurance processes your claims there will still be an amount due from you. We will bill you for any remaining balance due. If you fail to pay your balance promptly and your account is placed with an outside collections agency you will be responsible for any cost incurred to collect any balance due with our office.

Joint Notice of Privacy Practices-Health Insurance Portability and Accountability Act (HIPPA:

I have received/was offered a copy of the Joint Notice of Privacy Practices. The Joint Notice describes how my health information may be used or disclosed and explains my rights as a patient. I understand that I should read this document carefully and that it may be changed at any time. I may obtain a copy of the Joint Notice by calling the practices. This practice uses an electronic medical record that maybe be shared with other provider specialties and/or hospitals. I consent to evaluation and treatment by any provider affiliated with Pendleton Family Care. I herby authorized release

_____ _____

Printed Name of Patient/Legal Guardian Patient Date of Birth

_____ _____

Signature of Patient/ Legal Guardian Date