

ALBERT FRANCHI, M.D.
Patient Registration Information

PATIENT INFORMATION

First Name	M.I.	Last Name	Date Of Birth	Age	Sex M () F ()
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Street Address	Apt.	City	State	Zipcode	Phone Numbers Home: () - Cell: () -
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Email : _____

Marital Status
Single () Married () Divorced () Widowed ()

How did you learn about our practice?

- WBZ 1030 AM Radio**
 98.5 FM The Sports Hub
 Google / Internet
 Physician Referral
 Facebook
 Previous Patient
 Family / Friend Referral
 OTHER _____

EMERGENCY CONTACT

First Name	M.I.	Last Name	Relationship to Patient	Sex M () F ()
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Street Address	City	State	Zipcode	Phone Numbers Home: () - Cell: () -
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PRIMARY INSURANCE INFORMATION

Insurance Name	Address	City	State	Zipcode
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ID/Certificate Number	Group ID/Number	Employer/Company
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Policy Holder (Subscriber) Name	Subscriber Birth Date	Subscriber Sex M () F ()
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SECONDARY INSURANCE INFORMATION

Insurance Name	Address	City	State	Zipcode
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ID/Certificate Number	Group ID/Number	Employer/Company
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Policy Holder (Subscriber) Name	Subscriber Birth Date	Subscriber Sex M () F ()
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REFERRED TO THIS PRACTICE BY

Primary Care Physician	Phone Number () -
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I hereby give lifetime authorization for payment of insurance benefits to be made directly to ALBERT FRANCHI, M.D., and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. **Your initial office consultation with the doctor will be billed directly to your insurance carrier. Prolotherapy is not a covered service under Medicare or insurance plans, and physicians are therefore not allowed to bill insurance companies for the Prolotherapy injections. Patients must pay for Prolotherapy injections directly.** In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I understand that no guarantees have been made to me regarding the outcome of this care. I agree a photocopy of this agreement shall be valid as the original.

Date: _____ Signature: _____

Last Name _____ First Name _____ Middle _____

Chief Complaint : _____ **LEFT / RIGHT / BILATERAL**

How & Where it happened? _____ **Date of Onset:** _____

Have you had X-rays? _____ an MRI? _____ If yes, when and where were they done? _____

Have you had a problem like this before? Yes (When?) _____ No

PAST MEDICAL HISTORY : HAVE YOU EVER HAD?

	Yes	No	Don't Know		Yes	No	Don't Know
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (location)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COPD				Kidney failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

LIST ANY PREVIOUS SURGERIES

Date _____ Surgical Procedure _____ Hospital _____

FAMILY HISTORY Indicate which family member next to the illness M=Mother F=Father S=Sibling C=Child

	M	F	S	C
Arthritis				
Anxiety /Depression				
Cancer				
Diabetes				
Heart Disease				

	M	F	S	C
Hemophilia				
High Blood Pressure				
Kidney Disease				

	M	F	S	C
Liver Disease				
Other:				

SOCIAL HISTORY

Are you ? Single Partner Married Separated Divorced Widowed How many people live with you? _____

Currently working / volunteering ? Yes No Retired Student Disabled Occupation: _____

Do you use Tobacco Products? NO YES _____ Packs per day Alcohol Use ? None Socially Daily Frequently

REVIEW OF SYSTEMS:					
CIRCLE ANY CONDITION BELOW THAT YOU HAVE OR CHECK				NONE	Describe
M/S			Back Pain	<input type="checkbox"/>	
		Fracture	Which bone?		
GI	Heartburn	Nausea	Vomiting	<input type="checkbox"/>	
ENDO	Frequent Thirst	Frequent Urination	Always Hot or Cold	<input type="checkbox"/>	
CONST	Weight Loss	Frequent Fever	Loss of appetite	<input type="checkbox"/>	
EYE	Blurred Vision	Double Vision	Vision loss	<input type="checkbox"/>	
ENT	Hearing Loss	Hoarseness	Trouble swallowing	<input type="checkbox"/>	
C-VAS					
C	Chest Pain	Palpitations		<input type="checkbox"/>	
RESP	Chronic Cough	Shortness of Breath		<input type="checkbox"/>	
GU	Painful Urination	Blood in Urine		<input type="checkbox"/>	
SKIN	Frequent Rashes	Skin Ulcers	Psoriasis	<input type="checkbox"/>	
NEUR					
O	Headaches	Dizziness		<input type="checkbox"/>	
PSYCH	Drug / Alcohol Problem	Depression		<input type="checkbox"/>	
HEME	Easy Bleeding	HIV / AIDS		<input type="checkbox"/>	

MEDICATIONS

I DO NOT TAKE ANY MEDICATIONS

MEDICATIONS LIST ALL YOUR MEDICATIONS BELOW INCLUDING VITAMIN OR HERBAL SUPPLEMENTS.

- | | | | | |
|------------------------|---------------------|----------------------|---------------------|-----------------------|
| 1. Atenolol _____ | 6. Coumadin _____ | 11. Insulin _____ | 16. Naproxen _____ | 21. Simvastatin _____ |
| 2. Allopurinol _____ | 7. Flexeril _____ | 12. Levoxyll _____ | 17. Paxil _____ | 22. Synthroid _____ |
| 3. Aspirin 81 mg _____ | 8. Fosamax _____ | 13. Lipitor _____ | 18. Percocet _____ | 23. Vicodin _____ |
| 4. Celexa _____ | 9. Glucophage _____ | 14. Lisinopril _____ | 19. Prilosec _____ | 24. Xanax _____ |
| 5. Crestor _____ | 10. HCTZ _____ | 15. Metformin _____ | 20. Procardia _____ | |

Other : _____

DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS? PLEASE LIST **I DO NOT HAVE ANY ALLERGIES**

Name /Address of Preferred Pharmacy: _____

MEDICATION / NARCOTICS POLICY

You must take your medication only as prescribed. Supplementation, early refilling of your prescription, requesting prescriptions from any other physician or practice, prescriptions taken from family or friends, overuse or abuse of medications subjects you to immediate dismissal from the practice. If you are to have a prescription refilled from our office, you may need to make an appointment during standard business hours. Prescriptions will not be filled outside of normal business hours

 This is to certify that I, the undersigned(1) Consent to the administration upon the patient named above, such medications and treatments as may be considered necessary or advisable, (2) Authorize the release of any information from this record as required by my attorney, an insurance company or other reimbursing agency, (3) am responsible for obtaining any referrals and / or pre-authorizations that may be required by my insurance company (4)Authorize payment directly to Albert Franchi, M.D any benefits otherwise payable to me for services rendered (5) have read and understand the MEDICATION/ NARCOTICS POLICY. I understand that I am financially responsible for any charges not covered by this authorization.

SIGNATURE	RELATIONSHIP	DATE	WITNESS	PHYSICIAN'S INITIALS / DATE
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Patient Office Visit Attestation

1. In the past 10 days have you had

- | | |
|---|---|
| <input type="checkbox"/> Fever or Chills | <input type="checkbox"/> Cough |
| <input type="checkbox"/> New onset headache | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> New loss of taste or smell | <input type="checkbox"/> Unexplained muscle aches |
|
<input type="checkbox"/> NONE OF THESE | |

2. Do you have severe shortness of breath or difficulty breathing ?

- Yes No

3. Have you been diagnosed with Coronavirus (COVID-19) within the past 10 days ?

- Yes No

4. In the past 14 days, have you been within 6 feet for more than 15 minutes of someone with suspected or confirmed coronavirus (COVID-19)?

- Yes No

Patient Name (Printed) / Signature

Date