VALLEY FORGE URGENT CARE & FAMILY MEDICAL CENTER

Patient Registration Form for Detox Program

TODAY'S DATE: ______________________ CHART #: ______________________

PATIENT INFORMATION

FULL NAME: ____
LAST FIRST MI

SEX: M F MARITAL STATUS : S M D W

BIRTHDATE: _______ / _______ / _________

PERMANENT ADDRESS : ____
STREET APT #

____
CITY STATE ZIP

DL # ____________________ AGE _________

SOCIAL SECURTIY: _______ - _______ - _________

TEMPORARY ADDRESS : ____
STREET APT #

HOME PHONE #: (_______) - _______ - _________

____
CITY STATE ZIP

CELL PHONE #: (_______) - _______ - _________

E-MAIL ______________________ OCCUPATION ______________________

WORK PHONE #: (_______) - _______ - _________

EMPLOYER ____

EMPLOYER ADDRESS: ____
STREET SUITE CITY STATE ZIP

IN CASE OF EMERGENCY, PLEASE NOTIFY: ____

RELATION TO PATIENT: ______________________ EMERGENCY CONTACT PHONE #: ______________________

MEDICAL HISTORY

YOUR PRIMARY CARE PHYSICIAN: ______________________ PHONE #: (_______) - _______ - _________

CURRENT OR PAST MEDICAL CONDITIONS

	Y	N		Y	N		Y	N
Hypertension	☐	☐	GI disease	☐	☐	Nutritional deficiency	☐	☐
Asthma/respiratory	☐	☐	Pancreatic problems	☐	☐	HIV/AIDS	☐	☐
Head trauma	☐	☐	Diabetes	☐	☐	Epilepsy or seizure disorder	☐	☐
Liver problems	☐	☐	Abnormal Pap smear	☐	☐	Cardiovascular (heart attack, high cholesterol, angina)	☐	☐
STDs	☐	☐	Thyroid disease	☐	☐			

If Other, please describe: ____

Is there a family history of anything NOT listed here? ____

Have you ever had **surgery** or been **hospitalized**? (Please describe) ______________________

Have you or a family member ever been diagnosed with a **psychiatric** or **mental illness**? (Please describe)

____

Have you ever taken or been prescribed **antidepressants**? **( )** N **( )** Y

If so, for what reason? ____

Medication(s) and dates of use ______________________ Why stopped ______________________

Please list all current **prescription medications** and how often you take them (example: Dilantin 3x/day).

____

Please list any **allergies** you have (penicillin, bees, peanuts) : ______________________

Tobacco History

Cigarettes: Now? **( )** N **( )** Y In the past? **( )** N **( )** Y

Have you ever been **treated for substance misuse**? **( )** N (Please describe when, where and for how long)

____

How long have you been **using substances?** ____

SUBSTANCE USE HISTORY

	No	Yes/Past or Yes/Now	Route	How Much	How Often	Date/Time of Last Use	Quantity Last Used
Alcohol							
Caffeine (pills or beverages)							
Cocaine							
Crystal Meth-Amphetamine							
Heroin							
Inhalants							
LSD or Hallucinogens							
Marijuana							
Methadone							
Pain Killers							
PCP							
Stimulants (pills)							
Tranquilizers/Sleeping Pills							
Ecstasy							
Other							

Did you ever stop using any of the above because of dependence? **( )** N (Please list)

____

What was your longest period of abstinence? ____

SOCIAL / FAMILY HISTORY

Years married/ in long-term relationship ____________ Times Married ________ Times Divorced _______

Children? **( )** N **( )** Y Current ages (list) _____________ Residing with you? **( )** N **( )** Y If no, where? _______________

Where are you currently living? ____

Do you have family nearby? **( )** N (Please describe) ____

EDUCATION (check most recent degree):
( ) Graduate school ( ) College ( ) Professional or Vocational School ( ) High School Grade ______________

Are you currently employed? ( ) N Where (if "no, " where were you last employed?) ____

What type of work do/did you do? ____________________________ How long have/did you work (ed) there? _______________

Have you ever been arrested or convicted? ( ) N ( ) DWI ( ) Drug-related ( ) Domestic violence ( ) Other

Have you ever been abused? ( ) N ( ) Physically ( ) Sexually (including rape or attempted rape) ( ) Verbally ( ) Emotionally

Have you ever attended:
AA ( ) Current ( ) Past **NA** ( ) Current ( ) Past **CA** ( ) Current ( ) Past

ACOA ( ) Current ( ) Past **OA** ( ) Current ( ) Past

If you are not currently attending meetings, what factors led you to stop? ____

Have you ever been in counseling or therapy? ( ) N (Please describe) ____

PATIENT TREATMENT CONTRACT

Patient Name ____ **Date** _____________________________

As a participant in buprenorphine treatment for opioid misuse and dependence, I freely and voluntarily agree to accept this treatment contract as follows:

1. I agree to keep and be on time to all my scheduled appointments.
2. I agree to adhere to the payment policy outlined by this office.
3. I agree to conduct myself in a courteous manner in the doctor's office.
4. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal.
5. I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office.
6. I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my buprenorphine is filled, that the behavior will be reported to my doctor's office and could result in my treatment being terminated without any recourse for appeal.
7. I agree that my medication/prescription can only be given to me at my regular office visits. A missed visit may result in my not being able to get my medication/prescription until the next scheduled visit.
8. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of why it was lost.
9. I agree not to obtain medications from any doctors, pharmacies, or other sources without telling my treating physician.
10. I understand that mixing buprenorphine with other medications, especially benzodiazepines (for example, Valium®*, Klonopin®†, or Xanax®‡), can be dangerous. I also recognize that several deaths have occurred among persons mixing buprenorphine and benzodiazepines (especially if taken outside the care of a physician, using routes of administration other than sublingual or in higher than recommended therapeutic doses).
11. I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor.
12. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling as discussed and agreed upon with my doctor and specified in my treatment plan.
13. I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances (excepting nicotine).
14. I agree to provide random urine samples and have my doctor test my blood alcohol level.
15. I understand that violations of the above may be grounds for termination of treatment.

Patient Signature ____ Date:____________________________

ACKNOWLEDGEMENTS

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I agree to promptly pay for the services rendered for me or the patient named above. If I fail to meet my financial commitment to Valley Forge Urgent Care and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account. I acknowledge that I have received a copy of VFUC's Notice of Privacy Practices – according to HIPAA Policy.

Patient Signature ____ Date:____________________________