

VALLEY FORGE URGENT CARE & FAMILY MEDICAL CENTER

Patient Registration Form for Detox Program

TODAY'S DATE: _____ CHART #: _____

PATIENT INFORMATION

FULL NAME: _____ SEX: M F MARITAL STATUS: S M D W
LAST FIRST MI

PERMANENT ADDRESS: _____ BIRTHDATE: ____/____/____
STREET APT #
 DL # _____ AGE _____

TEMPORARY ADDRESS: _____ SOCIAL SECURITY: ____-____-____
STREET APT #
 HOME PHONE #: (____) - ____ - ____
CITY STATE ZIP
 CELL PHONE #: (____) - ____ - ____

E-MAIL _____ OCCUPATION _____
 EMPLOYER _____
 WORK PHONE #: (____) - ____ - ____

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	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Asthma/respiratory	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Head trauma	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Liver problems	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
STDs	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

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: _____