Southside Family Practice

230 Beiser Blvd., Suite 200
Dover, Delaware 19904
Phone: 302-735-1880
Fax: 302-735-1884

28 Deak Drive
Smyrna, Delaware 19977
Phone: 302-659-3800
Fax: 302-659-3850

Brian Horn, D.O. · Allison Ford, PA-C · Julia Warrington, DNP · Anjali Das, PA-C

NEW PATIENT REGISTRATION (Please print clearly)

PATIENT INFORMATION			
Legal Last Name:	First Name:		M.I.:
Preferred name (if different):		Date of Birth:	
Sex assigned at birth:	Gender identity (if different):	Pronouns:	
Marital status:	Preferred language:	Interpreter needed? ☐ Yes ☐ No	
Street Address:			Apt / Unit:
City:	State:		Zip:
Mobile Phone:	Home / Alternate Phone:		
Email Address (required for the patient portal):			
Preferred contact method: ☐ Mobile ☐ Home ☐ Email ☐ Portal		OK to text reminders? ☐ Yes ☐ No	
Employer:	Occupation:		
Race (optional):	Ethnicity (optional):		
Prior SSFP patient? ☐ Yes ☐ No	How did you hear about us:		
Establishing care with: ☐ Dr. Horn ☐ A. Ford, PA-C ☐ J. Warrington, DNP ☐ A. Das, PA-C ☐ No preference			

RESPONSIBLE PARTY / GUARANTOR — complete only if the patient is a minor or has a legal representative		
Name:	Relationship to Patient:	Date of Birth:
Address (if different from above):		Phone:
City / State / Zip:	Email:	
Legal authority: ☐ Parent ☐ Legal guardian ☐ Power of attorney ☐ Healthcare proxy ☐ Other: _____		

EMERGENCY CONTACT		
Name:	Relationship:	Phone:

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INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
Plan Name:	Plan Name:
Member ID #:	Member ID #:
Group #:	Group #:
Effective Date:	Effective Date:
Member Services Phone (back of card):	Member Services Phone (back of card):
Subscriber's Name:	Subscriber's Name:
Subscriber's Date of Birth:	Subscriber's Date of Birth:
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other	Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other
Is this visit related to an accident or injury? ☐ No ☐ Auto ☐ Work ☐ Other	Date of injury:

If your insurance requires you to choose a Primary Care Physician (PCP), please make sure it is one of our Providers *PRIOR* to your appointment. If we are not listed as your PCP at the time of your visit, your appointment may need to be rescheduled.

Please bring your insurance card and photo ID to every visit, and be ready to pay your copay — it is due at the time services are rendered.

I authorize Southside Family Practice, P.A. to release any medical information necessary to process my claims, and I assign payment of insurance benefits directly to the practice. I authorize release of this information to my insurance companies, including by fax.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES NOT PAID BY INSURANCE.

Signature of Patient / Responsible Party Date

OFFICE USE ONLY			
☐ Insurance card scanned ☐ Photo ID scanned	☐ Eligibility verified	Date:	Initials:

Patient name: _____ DOB: _____

PATIENT HEALTH HISTORY (Please print clearly)

Patient Name:	Date of Birth:	Date:
Reason for Visit:	Height:	Weight:

ALLERGIES & REACTIONS

Allergy (drug, food or environmental)	Reaction

☐ **No known allergies**

CURRENT MEDICATIONS — include prescriptions, OTC, herbal remedies and supplements

Medication	Dose	How often

☐ **No current medications**

PERSONAL MEDICAL HISTORY

Chronic problem you are being treated for	Managing physician

☐ **No known problems**

HOSPITAL VISITS & SURGERIES

Procedure	Date	Procedure	Date

☐ **None**

FAMILY MEDICAL HISTORY

Condition	Relationship (father / mother / brother / sister)

☐ **Adopted / family history unknown**

PATIENT HEALTH HISTORY (continued)

Preventative Screenings	Yes — date of last test (mm/dd/yy)	Never had it
Mammogram		☐
Pap Smear		☐
DEXA Scan		☐
Colonoscopy		☐
PSA		☐
Last Eye Exam		☐
Last Dental Exam		☐
Immunisations up to date?	☐ Flu ☐ Tdap ☐ COVID-19 ☐ Shingles ☐ Pneumonia	Unsure

Social History	Present	Past	Never	Type & Amount
Do you or did you drink **alcohol**?	☐	☐	☐	
Do you or did you ever use **tobacco** products?	☐	☐	☐	
Do you or did you ever use **electronic cigarettes (vape)**?	☐	☐	☐	
Do you drink **caffeinated** products?	☐	☐	☐	
Do you or did you ever use **illicit drugs**?	☐	☐	☐	
Do you get regular **exercise**? (outside of your daily routine)	☐	☐	☐	
Do you feel safe at home?	☐ Yes ☐ No			
Do you have an advance directive?	☐ Yes ☐ No If yes: ☐ Healthcare proxy ☐ Living will ☐ DNR			☐ Copy given to office

MOOD — over the last 2 weeks, how often have you been bothered by the following?				
	Not at all	**Several days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed or hopeless	☐	☐	☐	☐
Feeling nervous, anxious or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐

REPRODUCTIVE HISTORY (if applicable)	
First day of your last menstrual period:	
If menopausal, date of your last period:	☐ Not applicable

PREFERRED PHARMACY	
Pharmacy name & location:	Phone:
Mail-order pharmacy (if you use one):	Phone:

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Use and Disclosure Authorization
Southside Family Practice, P.A.

Last Name | First Name | Middle Initial | Date of Birth

Please list the individual(s) who may receive information about your medical condition, diagnosis or appointments, and who may accompany you to appointments.

Name	Relationship	Phone Number

Please list the individual(s) who are authorized to discuss billing and account issues:

Name	Relationship	Phone Number

Communication preferences

May we leave appointment reminders and non-urgent messages on your voicemail? ☐ Yes ☐ No

May we leave detailed test results on your voicemail? ☐ Yes ☐ No

May we contact you at your place of employment? ☐ Yes ☐ No

May we mail correspondence to your home address? ☐ Yes ☐ No

Missed appointments, returned checks and self-pay charges are covered by our Financial Policy, which is included in this packet and which you will sign separately. Please read it before signing below.

My signature below acknowledges that I have received or been offered a copy of Southside Family Practice's Privacy Notice, and that I have read, completed and understood the above information. I agree to notify the practice in writing if any of this information changes.

Signature of Patient (Parent/Guardian if Minor) Date

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Authorization for Use or Disclosure of Protected Health Information

Previous Provider — please give us the practice name, address, phone and fax so we can request your records.

Practice / Provider Name:	Phone:
Address:	Fax:
Records requested: ☐ Complete record ☐ Last 5 years ☐ Last 2 years ☐ Other: _____	

Person Authorized to Receive Information:

Information listed will be disclosed to:

Southside Family Practice, P.A.
230 Beiser Blvd., Suite 200
Dover, DE 19904 · Fax: 302-735-1884

Purpose of Disclosure

Information listed above will be disclosed for the following purpose:

TRANSFER OF MEDICAL CARE

Expiration Date of Authorization:

This authorization is effective through ____ / ____ / _____ unless revoked or terminated earlier by the patient (or the patient's personal representative). If left blank, this authorization expires one year from the date signed.

Right to Terminate or Revoke Authorization:

You may revoke or terminate this authorization at any time by submitting a written revocation to Southside Family Practice. Revoking it does not affect information already released.

Rights of the Individual:

☐ You may inspect or request a copy of information used or disclosed under this Authorization.

☐ You may refuse to sign this authorization.

Name of Patient (Please Print) **Date of Birth**

Signature of Patient/Guardian **Date**

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IQ Health

Welcome to your secure patient portal

Dear Patient,

Southside Family Practice offers a secure online patient portal called IQ Health. Through the portal you can:

- View your test results
- Request an appointment
- Request medication refills
- Update your demographic and insurance information
- Send and receive secure messages with the office
- Keep track of your health history

To set up your account you will receive a one-time secure email invitation from IQHealth.com. Please check your inbox and your spam folder — the invitation usually arrives within 1–2 business days, and the link expires after 30 days. Click the link and follow the prompts to activate your account. If you need help, call the office at (302) 735-1880.

Using the portal is optional. If you choose not to participate, you can still reach us by telephone and mail.

Sincerely,

Southside Family Practice, P.A.

☐ **Yes — please send me a portal invitation.** ☐ **No thank you.**	
Name (please print):	Date of Birth:
Email address for the invitation:	

This must be an email address only you can access — the invitation gives access to your medical record.

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FINANCIAL POLICY

Thank you for choosing us as your medical provider. We are committed to providing you with a consistently high standard of care and are happy to discuss our policies at any time. Your clear understanding of our financial policy is an important part of our professional relationship. Please take the time to **review, understand and sign below** prior to receiving treatment from our office.

You are expected to present your current insurance card(s) and photo ID at every visit. Any minor patient must be accompanied by an adult over 18 who has assumed financial responsibility for the patient. That adult must also be listed on the "Use and Disclosure" form on file with the office.

It is your responsibility to advise us of any change in your demographic and insurance information — address, telephone number, email address, employer and insurance.

Your insurance is a contract between you and the insurance company. We are not a party to that contract. It is very important that you understand the provisions of your policy. We will file an insurance claim as a courtesy to our patients, however this does not release you from your financial responsibility.

If you have more than one insurance plan, it is your responsibility to tell us the order in which we should file your claims and to coordinate benefits with your insurance company.

We will collect your co-payment, deductible, balances or charges for non-covered services at the time of your visit. We will not be responsible for any disputes between you and your insurance company regarding co-pays, deductibles or covered charges, other than to supply factual information.

We cannot guarantee payment of all claims. If your insurance pays only a portion of the bill or rejects your claim, you will be responsible for the timely payment of your account. For those who request it, we can provide an estimate of the cost of a service to be performed, if such information is available to us.

If you do not have insurance, or we do not participate with your insurance company, you will be expected to pay in full at the time of the visit. The self-pay charge is a minimum of $85.

We accept cash, checks and major credit cards. It is our policy to charge a $45 fee for returned checks.

We follow the fee schedule set forth by the Board of Professional Regulation for charging for reproduction of medical records.

We charge a $25 fee for completion of forms (for example FMLA or disability paperwork) that are not completed during your office visit.

When you schedule an appointment, that time is reserved specifically for you. Please give us at least 24 hours' notice if you are unable to keep it. **Appointments cancelled with less than 24 hours' notice, and missed appointments, are charged a $25 fee for established patients and a $50 fee for new patients.** If three appointments are missed, you may be discharged from the practice for non-compliance.

We reserve the right to take lawful action, including referring your account to a collection agency and reporting to one or more credit bureaus, for non-payment.

Thank you for taking the time to review our financial policy. If you have any questions, please speak with the practice manager.

Patient/Authorized Representative Printed Name: _____

Signature: _____

Date: _____