PREMIER MEDICAL GROUP

PATIENT REGISTRATION FORM

PLEASE PRINT **ACCOUNT #** _____

Name: _____ **Date of Birth:** _____
Last First M.I Maiden Name

Address: _____ **City:** _____ State: _____ Zip _____ SSN: _____

Home Phone (_____) _____ **Cell Phone** (_____) _____ **Work Phone** (_____) _____

Preferred Contact Number: ☐ Home ☐ Cell ☐ Work **E-MAIL:** _____

Race _____ **Gender** _____ **Primary Language** _____ Student: ☐ Full Time ☐ Part Time ☐ Veteran

Check Appropriate Box(es): ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

MEDICAL INSURANCE INFORMATION

Name of Medical Insurance _____ Group # _____ ID # _____

Insurance Billing Address _____

INSURED CARDHOLDER/RESPONSIBLE PARTY (IF NOT THE PATIENT)

Name: _____ Date of Birth: _____ Relation to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) _____

Employer _____ Work Phone (____) _____ SSN# _____

FINANCIAL POLICIES

Patient Insurance Responsibility: I understand that as a patient, I am responsible for fully understanding my health insurance policy, including: co-pay, deductible, benefits, and co-insurance related costs. I understand that any applicable co-pay or deductible amount will be due upon check-in. We strive to be as accurate as possible when calculating your responsibility but, with so many variations in policies and fee schedules, we are not always exact.

_____ INITIALS

Financial Policy: I understand that I am financially responsible for any co-pays, deductibles, coinsurance and charges which are not covered by my insurance. I understand that verification of coverage is not a guarantee of payment of benefits. My insurance company determines benefit payments.

_____ INITIALS

Forms: I understand there will be an additional $50 charge for forms deemed appropriate (FMLA, Disability, etc.) that need to be filled out by a Provider.

_____ INITIALS

No-Show Fee: I understand that I may be subject to a $25 charge for missing a scheduled appointment or cancelling within less than 24 hours of scheduled appointment.

_____ INITIALS

_____ **Non-Sufficient Funds:** I understand there will be a $25 charge for any check returned due to non-sufficient funds.

INITIALS

Collection Policy: I understand that I may be turned over to collections for further processing if a payment has not been made on my account within 90 days. NO ADDITIONAL APPOINTMENTS WILL BE MADE ON DELINQUENT ACCOUNTS UNTIL THEY ARE CURRENT. In the event that my account is transferred to a licensed collection agency; I agree to pay the fees of the collection agency equal to a maximum of 50% of our outstanding balance at the time the account is placed with the collection agency; interest of 10% per year will be accrued on the principal balance. Should legal action be necessary to collect the account, I agree to pay attorney fees and court costs incurred for collection.

_____ INITIALS

Specimen Handling: Any specimens collected in-house will be sent to a contracted lab based on the health insurance provided by you at time of service. Specimens may be split and sent to different facilities as needed. Specimens are collected and tested to determine diagnosis and treatment, while it is considered medically necessary we cannot guarantee that your health plan will cover the service. While we make every effort to use the proper medical coding, coverage is ultimately determined by your health plan.

_____ INITIALS

RESPONSIBLE PARTY SIGNATURE: _____ **DATE:** _____

If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient

REV 2/12/2020

PREMIER MEDICAL GROUP

PAGE FAMILY PRACTICE

PRIVACY PRACTICES AND INSTRUCTIONS FOR DISCUSSING PERSONAL HEALTH INFORMATION

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Preferred Phone Number: _____ E-Mail: _____

Emergency Contact: _____ Phone Number: _____

Notice of Privacy Practice and Patient Rights:

☐ I acknowledge receipt of Page Family Practice's Notice of Privacy Practices and Patient Rights

I give Page Family Practice permission to discuss my personal health information with the following individuals:

Name:	Relation to Patient:
_____	_____
_____	_____

The above mentioned individual(s) is/are granted access to the below selected categories of my Health Record:

☐ **ENTIRE Record** ☐ **All Test Results** ☐ **Appointments** ☐ **Medications** ☐ **Billing**

☐ **Other** _____

I give Page Family Practice permission to communicate messages regarding appointments, referrals, and test results as follows:

☐ You may leave messages on my voicemail

☐ You may leave messages with _____

☐ Other (please specify): _____

☐ I give permission for medical records to be mailed to my home if requested by phone or fax.

NEXTMD PATIENT PORTAL CARE MANAGER ACCESS

I give Page Family Practice/Premier Medical Group to grant *PATIENT PORTAL CARE MANAGER* access to:

_____

The above mentioned individual is granted access to the below selected categories of my Electronic Health Record on the NextMD Patient Portal:

☐ Messages ☐ Appointments ☐ Documents ☐ IMH (Instant Medical Health Record)

☐ Statements ☐ Medications ☐ Online Forms ☐ PHR (Public Health Record)

By signing I am allowing these methods of communication for one year. Any changes to this information will be ade in writing to Page Family Practice.

_____

Patients Name (Please Print) **Patient or Legal Guardian Signature** **Date**

Page Family Practice Intake Form – Please complete all sections to help us make the best health care decisions for you and your family

Last Name _____ First Name _____ MI _____ DOB _____

Medications

List all medications you take, prescription and nonprescription, and their dosage:

☐ No medications

Medication	Dose
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

Medication/Food Allergies

Allergies

Are you allergic to penicillin or any other drugs? ☐Yes ☐No

Please list: _____ Reaction _____

Food	Reaction	Food	Reaction	Food	Reaction
☐ Chocolate		☐ Peanuts		☐ Strawberries	
☐ Corn		☐ Red dye		☐ Wheat	
☐ Eggs		☐ Rice		☐ Other:	
☐ Iodine or shellfish		☐ Soy		☐ Other:	

Please indicate if you have ever experienced any of the following conditions. Please include the date of experience.

☐ Alcohol dependence	___/___/___	☐ Diabetes Type I	___/___/___	☐ Hepatitis	___/___/___
☐ Allergies	___/___/___	☐ Diabetes Type II	___/___/___	☐ Kidney stones	___/___/___
☐ Anemia	___/___/___	☐ Diarrhea	___/___/___	☐ Other kidney disease	___/___/___
☐ Angina	___/___/___	☐ Disc degeneration	___/___/___	_____	
☐ Anxiety	___/___/___	☐ Duodenal ulcer	___/___/___	☐ Liver disease	___/___/___
☐ Arthritis	___/___/___	☐ Emphysema	___/___/___	☐ Low blood pressure	___/___/___
☐ Asthma	___/___/___	☐ Esophageal reflux	___/___/___	☐ Migraines	___/___/___
☐ Blood clots	___/___/___	☐ Gallbladder stones	___/___/___	☐ Mixed hyperlipidemia	___/___/___
☐ Broken bones	___/___/___	☐ Goiter	___/___/___	☐ Obesity	___/___/___
☐ Cancer	___/___/___	☐ Gout	___/___/___	☐ Osteoarthritis	___/___/___
Type: _____		☐ Headache	___/___/___	☐ Osteoporosis	___/___/___
☐ Chronic blood thinner use	___/___/___	☐ Heart attack	___/___/___	☐ Palpatations	___/___/___
☐ Chronic bronchitis	___/___/___	☐ Heart disease	___/___/___	☐ Palpatations	___/___/___
☐ Chronic fatigue syndrome	___/___/___	☐ Other heart disease	___/___/___	☐ Rheumatoid Arthritis	___/___/___
☐ Chronic hepatitis	___/___/___	_____		☐ Sciatica	___/___/___
☐ Chronic kidney disease	___/___/___	☐ Heart failure	___/___/___	☐ Seizures/epilepsy	___/___/___
☐ Chronic neck pain	___/___/___	☐ Hepatitis	___/___/___	☐ Sleep apnea	___/___/___
☐ Chronic sinusitis	___/___/___	☐ High blood pressure	___/___/___	☐ Stomach ulcer	___/___/___
☐ Circulatory disease	___/___/___	☐ High cholesterol	___/___/___	☐ Stroke (CVA)	___/___/___
☐ Colitis	___/___/___	☐ Irregular heart rhythm	___/___/___	☐ Thyroid disease	___/___/___
☐ Congestive heart failure	___/___/___	☐ Hypertension	___/___/___	☐ Tinnitus	___/___/___
☐ COPD	___/___/___	☐ Hyperthyroidism	___/___/___	☐ Tuberculosis	___/___/___
☐ Crohn's disease	___/___/___	☐ Insomnia	___/___/___	☐ Other:	___/___/___
☐ Depression	___/___/___	☐ Irritable bowel syndrome	___/___/___	_____	

Surgical History

	Date		Date		Date
☐ Angioplasty		☐ Cholecystectomy		☐ Liver biopsy	
☐ Angioplasty w/ stent		☐ Colectomy		☐ Open Reduction Internal Fixation	
☐ Appendectomy		☐ Colostomy		☐ Pacemaker	
☐ Arthroscopy knee		☐ Gastric bypass		☐ Small bowel resection	
☐ Back surgery		☐ Hernia repair		☐ Thyroidectomy	
☐ Coronary Artery Bypass Graft		☐ Hip replacement		☐ Tonsillectomy	
☐ Carpal tunnel release		☐ Knee replacement			
☐ Cataract extraction		☐ LASIK			
☐ Other:					

☐ Augmentation mammoplasty		☐ Mastectomy	
☐ Bilateral tubal ligation		☐ Myomectomy	
☐ Breast biopsy		☐ Reduction mammoplasty	
☐ Cesarean section		☐ TAH/BSO (Total Abdominal Hysterectomy) / (Bilateral Salpingo-Oophorectomy)	
☐ D and C (Dilation and curettage)			
☐ Hysterectomy		☐ Vaginal hysterectomy	
☐ Other:			

Family History

Please check if any family member has had any of the following conditions **Adopted**

	Mother	Father	Sibling(s)	Grandparents	Children	Cause of Death
☐ ADD/ADHD						
☐ Alcoholism						
☐ Allergies						
☐ Alzheimer's disease						
☐ Asthma						
☐ Blood disease						
☐ Heart disease						
☐ Heart disease before age 50						
☐ Cancer						
Type:						
☐ Depression						
☐ Developmental delay						
☐ Diabetes						
☐ Eczema						
☐ Hearing deficiency						
☐ High cholesterol						
☐ Hypertension						
☐ Inflammatory Bowel Disease						
☐ Kidney disease						
☐ Learning disability						
☐ Mental illness						
☐ Migraines						
☐ Obesity						
☐ Osteoporosis						
☐ Peripheral Vascular Disease						
☐ Seizures/epilepsy						
☐ Stroke (CVA)						
☐ Other:						
☐ Other:						

Social History

Do you use tobacco? ☐ Yes ☐ No ☐ Former Type of tobacco used? _____ / _____

Packs per day? _____ Years smoked? _____ Year Quit? _____

Other Tobacco units per day (cans, cigars, etc)? _____

Units per day? _____ Years used? _____ Year Quit? _____

Do you drink caffeine? ☐ Yes ☐ No Type? _____ Amount Daily? _____

Do you drink alcohol? ☐Yes ☐No ☐Former Year Quit? _____

Type? _____ How much per week? _____

Amount? _____ Last Drink? _____

Do you exercise regularly? ☐ YES ☐ NO If no, why? _____

What type of exercise? _____

Hand Dominance Left Handed Right Handed or Both _____

Do you give permission to receive blood transfusion if medically necessary? _____

Do you have a preferred pharmacy? ☐ Yes ☐ No

Pharmacy: _____ Phone Number: _____

Address: _____

Pharmacy: _____ Phone Number: _____

Address: _____

Health Maintenance

			Date of last
Lipid Panel	☐ Yes	☐ No	___/___/____
Stool cards for hidden blood	☐ Yes	☐ No	___/___/____
History and Physical	☐ Yes	☐ No	___/___/____
Colonoscopy	☐ Yes	☐ No	___/___/____
Sigmoidoscopy	☐ Yes	☐ No	___/___/____
Influenza Vaccine	☐ Yes	☐ No	___/___/____
Pneumococcal Vaccine	☐ Yes	☐ No	___/___/____
Tetanus Vaccine	☐ Yes	☐ No	___/___/____
DEXA Scan	☐ Yes	☐ No	___/___/____
Gyn Exam	☐ Yes	☐ No	___/___/____
PAP	☐ Yes	☐ No	___/___/____
Mammogram	☐ Yes	☐ No	___/___/____
Breast Exam	☐ Yes	☐ No	___/___/____

Disease Management

			Date of last
Abdominal Ultrasound	☐ Yes	☐ No	___/___/____
Cardiac Stress Test	☐ Yes	☐ No	___/___/____
Chest X-Ray	☐ Yes	☐ No	___/___/____
Echocardiogram	☐ Yes	☐ No	___/___/____
EKG	☐ Yes	☐ No	___/___/____
Eye Exam	☐ Yes	☐ No	___/___/____
Foot Exam	☐ Yes	☐ No	___/___/____
Pulmonary Function Tests	☐ Yes	☐ No	___/___/____

Patient Signature _____ Date: _____ Provider Signature _____ Date: _____