PREMIER *medical group*

# INSTRUCTIONS

**Page 1** - *Patient Registration Form* - fill out entire page and sign at bottom of page.

**Page 2** - Complete *Records Release Form* as required for your upcoming office visit.

**Page 3** – Complete the *Health History Questionnaire* (per specialty).

**Bring all paperwork, filled out, to your scheduled appointment along with:**

- Medical insurance and prescription cards
- Any recent labs or radiology workups
- Picture ID
- List of medications

*If your insurance requires a referral, you must bring it with you at the time of service or you will be required to sign a waiver holding you responsible.*

## NO SHOW POLICY

A FEE MAY BE CHARGED TO ANY PATIENT WHO DOES NOT CANCEL THEIR OFFICE VISIT WITHIN 24 HOURS AND WILL BE CHARGED FOR ANY NO SHOW FOR AN OFFICE PROCEDURE.

## CO-PAYS ARE EXPECTED AT THE TIME OF SERVICE

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# PATIENT REGISTRATION FORM

**PATIENT ACCOUNT NUMBER:** _____

## PATIENT INFORMATION

| | |
|---|---|
| PATIENT NAME (LAST, FIRST, MIDDLE INITIAL) SEX ❑ MALE ❑ FEMALE | PRIMARY PHYSICIAN |
| PATIENT'S ADDRESS | EMERGENCY CONTACT AND TELEPHONE # |
| CITY STATE ZIP | STUDENT STATUS: If 18 years or older: (Circle one) Full Time Part Time Not a Student |
| TELEPHONE ( ) CELL PHONE ( ) DATE OF BIRTH ___/___/___ MO DAY YEAR | MARITAL STATUS: (Circle one) Single Married Separated Divorced Widowed |
| **RACE:** **ETHNICITY:** | **PRIMARY LANGUAGE:** / **EMAIL ADDRESS:** |

## INSURANCE INFORMATION

| | |
|---|---|
| PRIMARY INSURANCE COMPANY NAME COPAY _____ | SECONDARY INSURANCE COPAY _____ |
| INSURANCE ADDRESS | INSURANCE ADDRESS |
| CITY STATE ZIP | CITY STATE ZIP |
| INSURED'S ID NUMBER GROUP PLAN NUMBER | INSURED'S ID NUMBER GROUP PLAN NUMBER |
| PATIENT'S EMPLOYER NAME TELEPHONE ( ) | **PHARMACY NAME** **TELEPHONE** ( ) |
| EMPLOYER'S ADDRESS | **PHARMACY ADDRESS** |
| CITY STATE ZIP | CITY STATE ZIP |

## RESPONSIBLE PARTY INFORMATION

| | | |
|---|---|---|
| RESPONSIBLE PARTY'S NAME (LAST, FIRST, MIDDLE) | SEX ❑ MALE ❑ FEMALE | LEGAL REPRESENTATIVE ❑ YES ❑ NO |
| RESPONSIBLE PARTY'S ADDRESS | EMPLOYER'S NAME | |
| CITY STATE ZIP | EMPLOYER'S ADDRESS | |
| TELEPHONE ( ) | RELATIONSHIP TO PATIENT SPOUSE PARENT GUARDIAN OTHER _____ | |

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

**If your insurance requires a written referral from your physician and you do not obtain one prior to your visit or procedure, you will be responsible for payment for Services rendered.**

**COPAYMENTS ARE EXPECTED AT THE TIME SERVICES ARE RENDERED.**

If this account is assigned to an attorney of collection and/or suit, the practice shall be entitled to reasonable attorney's fees and costs of collection.
I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.
I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance and other health plans to the practice named on this form.
This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

I AGREE TO THE ASSIGNMENTS AND FINANCIAL RESPONSIBILITIES SHOWN ON THIS PAGE. **YOU SHOULD READ THESE TERMS CAREFULLY.** THANK YOU FOR YOUR COOPERATION.

**X** _____ DATE _____
SIGNED (Patient, or parent if under 18 years of age)

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## AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

_____

TELEPHONE: _____

I hereby authorize _____to disclose the following Protected Health Information (PHI) to _____.

PHYSICIAN PHONE: _____FAX: _____

The following information is to be disclosed: (please check off those that apply)

Physician notes _____ Dates _____
Lab results _____ Dates _____
X-Ray reports _____ Dates _____
Operative reports _____Dates _____
**COMPLETE RECORD _____**
Other: _____

The PHI to be used or disclosed for the following purposes:

I understand that the information in my record may include information relating to sexually transmitted diseases (STD), Acquired Immunodeficiency Syndrome (AIDS), or infection of the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol or drug abuse.

PREMIER MEDICAL GROUP will not determine my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide an authorization. I understand that I may inspect or obtain a copy of the information to be used or disclosed. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State laws.

Unless otherwise revoked, this authorization will expire on the following date, event or condition: (if I do not specify an expiration date, event or condition, this authorization will expire in one year from the date signed). DATE: _____

Signature of patient or patient representative

_____

Date

_____

*Revised 4/29/15*

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## MEDICAL INFORMATION

Reason for visit: _____.

Do you have or have you had any of the following**:**

| | | | |
|---|---|---|---|
| Diabetes _____ | Stroke____ | Seizure Disorder _____ | Hepatitis _____ |
| Heart Attack _____ | Heart Disease ____ | Mitral Valve Prolapse _____ | Anemia _____ |
| High Blood Pressure _____ | Sleep Apnea _____ | High Cholesterol _____ | Asthma _____ |
| Pacemaker ____ | Defibrillator ____ | Thyroid Disease _____ | COPD _____ |
| Heart Murmur _____ | Heart Valve Disease ____ | Joint Replacement _____ | Liver Disease ___ |
| Kidney Disease ____ | | | |

Other medical/psychiatric conditions: _____.

Past Surgical History (list **ALL** surgeries and the dates):

_____.
_____.
_____.

Are you under the care of any other physicians/specialists? Yes ___ No ___

If yes, list name and specialty: _____
_____.

Do you require information to be released to above physicians? Yes ____ No ____

Is there any family history of colon polyps, colon cancer or any other cancers? Yes ___ No ___

If yes, what type and who? _____.

Do you smoke? Yes___ No___ If yes, how long? _____

Do you drink alcohol? No ___ Occasionally ___ Regularly ___

Do you have a history of previous drug abuse? Yes ___ No___

Please list all prescription medications taken including over the counter products and the dosing instructions:

| | | |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Do you have any allergies to any medications?** Yes____ No _____

Name of drugs: _____

Type of Reaction: _____

Gastro-Intestinal: Have you ever experienced any of the following?

| | | | |
|---|---|---|---|
| Vomiting Blood ____ | Diarrhea ___ | Change in Bowel Habits ___ | Black Stools ___ |
| Rectal Bleeding ___ | Constipation ___ | Difficulty Swallowing ___ | Weight Loss ___ |

Have you had a previous colonoscopy/endoscopy? Yes ___ No ___

When _____ Where _____