PREMIER *medical group*
Cardiology Division

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 4/11/19

HEALTH QUESTIONNAIRE

Formedic

REASON FOR VISIT

FAMILY HISTORY *IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING - PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE*

1) Epilepsy	6) Thyroid	11) Osteoporosis	16) High cholesterol
2) Migraine	7) Hayfever	12) Arthritis	17) Alcoholism
3) Mental illness	8) Asthma	13) Heart disease	18) Hepatitis
4) Glaucoma	9) Anemia	14) Stroke	19) Cancer
5) Diabetes	10) Bleeds easily	15) High blood pressure	20)

HOSPITAL ADMISSIONS *not including pregnancies*

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

LIST ALL MEDICATIONS YOU ARE NOW TAKING - INCLUDE THOSE YOU BUY WITHOUT A PRESCRIPTION

ALLERGIES

SUPPLEMENTS

VACCINE	YEAR OF LAST	TEST / EXAM	YEAR OF LAST
Tetanus / Td		Rectal/stool	
Influenza (flu)		Cholesterol	
Pneumonia		Eye exam	
Hepatitis		TB test	
		Hepatitis	

MEDICAL HISTORY *MARK (C) FOR CURRENT PROBLEMS. CHECK (✓) AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES.*

- ☐ Decreased hearing
- ☐ Ringing in ear
- ☐ Ear infections - *frequent*
- ☐ Dizzy spells ☐ Fainting spells
- ☐ Failing vision ☐ Eye pain
- ☐ Double or blurred vision
- ☐ Nose bleeds - *recurrent*
- ☐ Sinus trouble
- ☐ Sore throats - *frequent*
- ☐ Hoarseness - *prolonged*
- ☐ Hayfever / Allergies
- ☐ Pneumonia / Pleurisy
- ☐ Bronchitis / Chronic cough
- ☐ Asthma / Wheezing
- ☐ Shortness of breath:
  - ☐ on exertion ☐ lying flat
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Heart murmur ☐ Swollen ankles
- ☐ Irregular pulse ☐ Palpitations
- ☐ Leg pain - *when walking*
- ☐ Varicose veins / Phlebitis
- ☐ Cold numb feet
- ☐ Loss of appetite - *recent*
- ☐ Difficulty swallowing
- ☐ Heartburn ☐ Peptic ulcer
- ☐ Nausea/Vomiting ☐ Abdominal pain
- ☐ Abdominal pain
- ☐ Gallbladder trouble
- ☐ Jaundice / Hepatitis
- ☐ Diarrhea ☐ Constipation
- ☐ Diverticulosis ☐ Crohn's / Colitis
- ☐ Inflammatory Bowel Syndrome
- ☐ Bloody or tarry stools
- ☐ Hemorrhoids ☐ Hernia
- Urination - Overactive Bladder
  - ☐ Overnight more than twice
  - ☐ More than 8 times / 24 hrs.
  - ☐ Urgency to urinate ☐ with leakage
- ☐ Decrease in force/flow ☐ Painful
- ☐ Stress incontinence — urine leakage with exercise / movement
- ☐ Blood in urine ☐ Kidney stones
- ☐ Urine infections - *frequent*
- ☐ Weight loss / gain ☐ Height loss
- ☐ Appetite
- ☐ Anemia ☐ Bruise easily
- ☐ Blood transfusions
- ☐ Cancer ☐ Easily fatigued
- ☐ Decreased energy / endurance
- ☐ Diabetes ☐ Thyroid disease
- ☐ Seizures ☐ Stroke
- ☐ Tremor / hands shaking
- ☐ Numbness / tingling sensations
- ☐ Headaches — *frequent*
- ☐ Arthritis / Rheumatism
- ☐ Back pain - *recurrent*
- ☐ Bone fracture / joint injury
- ☐ Osteoporosis
- ☐ Foot pain ☐ Gout
- ☐ Rashes ☐ Hives
- ☐ Psoriasis ☐ Eczema
- ☐ Concentration prob ☐ Sleep problems
- ☐ Depression ☐ Nervousness
- ☐ Agitation ☐ Memory loss
- ☐ Moodiness ☐ Suicidal thoughts
- ☐ Phobias ☐ Mental illness
- ☐ Feelings of worthlessness
- ☐ Rheumatic Fever ☐ Scarlet Fever
- ☐ Chickenpox ☐ Polio ☐ Mumps
- ☐ Measles ☐ German measles
- ☐ Tuberculosis ☐ Herpes
- ☐ AIDS / HIV ☐ STD
- ☐ Sexual problems / enjoyment
- ☐ Decreased life enjoyment
- ☐ Decreased work performance
- ☐ Alcohol _____ oz. per week
- ☐ Coffee / Tea _____ cups per day
- ☐ Smoking - cig/day___ # years year quit ___
- ☐ Exercise _____
- ☐ Street drugs _____
- ☐ Unwanted facial hair

Hair loss: ☐ progressive ☐ recent

MALES - ☐ Prostate problems

FEMALES - *Please complete*

Menstrual flow:

☐ Reg. ☐ Irreg. ☐ Pain / Cramps

Days of flow___ Length of cycle___

Date — 1st day of last period _____

☐ Pain / Bleeding during or after sex

Number of:

Pregnancies ___ Abortions _____

Miscarriages ___ Live births _____

Birth control method _____

B.C. pill (name)_____

☐ Flushing / Menopause

Date of last Pap test_____

☐ Normal ☐ Abnormal

Date of last mammogram_____

☐ Normal ☐ Abnormal

NOTES

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