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:** _____
**ADDRESS:** _____
_____

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 m y record m ay include information relating to sexually transmitted diseases (STD), Acquired Immunodeficiency Syndrome (AIDS), or infection of the Hum an 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 m y 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 m ay 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 2/17/2020*


## *Premier Medical Group of the Hudson Valley, P.C.*

| | | | |
|---|---|---|---|
| ☐ | Atrium at MHRH- 1 Webster Avenue, Suite 301, Poughkeepsie, NY 126021 | Tel: 845.790.6100 | Fax: 845.345.9966 |
| ☐ | 400 Westage Business Center Drive, Suite 210, Fishkill, NY 12524 | Tel: 845.838.8480 | Fax: 845.838.8474 |
| ☐ | 243 North Road, Suite 103, Poughkeepsie, NY 12601 - Dr. Anita Pavels | Tel: 845.454.4600 | Fax: 845.454.4609 |
| ☐ | 243 North Road, Suite 204, Poughkeepsie, NY 12601 - Dr. David Cho | Tel: 845.451.7271 | Fax: 845.454.0702 |
| ☐ | 243 North Road, Suite 204, Poughkeepsie, NY 12601 - Dr. Elliot Levine | Tel: 845.451.7205 | Fax: 845.454.0702 |
| ☐ | 696 Dutchess Turnpike, Poughkeepsie, NY 12603 – Dr. Sunhee Woo | Tel: 845.454.8200 | Fax: 845.454.8202 |
| ☐ | 696 Dutchess Turnpike, Poughkeepsie, NY 12603 – Dr. David Wogalter | Tel: 845.454.4055 | Fax: 845.454.4506 |
| ☐ | 537 Blooming Grove Turnpike, New Windsor, NY, 12553 | Tel: 845.561.8500 | Fax: 845.561.8855 |
| ☐ | 21 Springside Avenue, Poughkeepsie, NY 12603 – Dr. Frank Pedevillano | Tel: 845.454.0244 | Fax: 845.454.0405 |
| ☐ | 21 Springside Avenue, Poughkeepsie, NY 12603 – Dr. Thomas Robinson | Tel: 845.485.2720 | Fax: 845.452.4578 |

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***PREMIER MEDICAL GROUP***
***PATIENT MEDICAL HISTORY FORM***

DATE:_____ DOB:_____

PHONE: DAY:_____EVENING:_____

PATIENT NAME:_____

ADDRESS:_____
(STREET) (CITY) (STATE) (ZIP)

BIRTHPLACE:_____ ETHNIC BACKGROUND:_____

EMERGENCY CONTACT'S NAME:_____PHONE#:_____

Name of Health Care Proxy/Durable Power of Attorney for Health Care:_____

Phone#:_____

***HOUSEHOLD MEMBERS***

| NAME | AGE | RELATIONSHIP |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

| NAME | AGE | RELATIONSHIP |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**SOCIAL HISTORY**

Occupation:_____Martial status:_____

***PERSONAL HEALTH HISTORY:*** List below any chronic illness (such as diabetes, high blood pressure, etc.) and in date order any hospitalizations and surgeries.

| NATURE OF PROBLEM | DATE |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

***MEDICATIONS:***

| NAME OF MEDICATION | DOSAGE | FREQUENCY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

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***PREMIER MEDICAL GROUP***
***PATIENT MEDICAL HISTORY FORM***

***ALLERGIES/SENSITIVITIES:*** Are you sensitive to any medication or substance? ___Yes ___No

| DRUG | REACTION |
|---|---|
| | |
| | |
| | |
| | |
| | |

***PERSONAL HABITS:***

**Tobacco Use/Exposure:**

Do you use any type of tobacco product? ___No___Yes? If yes, for how many years?_____

What tobacco product do you use? (Check all that apply)
___Cigarettes ___Pipes ___Cigars ___Chewing Tobacco

How often do you use tobacco products?_____
If you do or did smoke, how many packs per day?_____
If you are a former smoker, when did you quit?_____

**Substance Use:**

Do you consume alcohol? ___No ___Yes If yes, how often?_____how much?_____
Do you currently use any illegal drugs? ___No ___Yes,
If yes, what type of drugs do you use and when did you last use?_____
Did you use any illegal drugs in the past? ___No ___Yes If yes, how many years did you use?_____
What type of drugs did you use and when did you last take it?_____

**Other:**

Do you exercise regularly? ___No ___Yes, If so, how?_____
Have you every had a colonoscopy? ___No ___Yes, if Yes, when_____

**Safety:** Do you regularly use:

| | | |
|---|---|---|
| Seatbelt | ___No | ___Yes |
| Helmet (bicycle or motorcylce) | ___No | ___Yes |
| Are there smoke detectors in your home? | ___No | ___Yes |
| Do you have guns in your home? | ___No | ___Yes |
| Are you or have you been a victim of abuse? | ___No | ___Yes |
| Would you like help? | ___No | ___Yes |

***GENITO/REPRODUCTIVE***

**FEMALE**

Date of last pap smear_____
Age periods began?_____How many days do your periods last?_____
How often do they occur?_____When did your last period start?_____
If your period has stopped, give the year of your last period_____
Number of pregnancies_____Numberof births_____Number of miscarrages_____
Type of birth control, if used:_____
Do you feel you have a problem with any of the following: (Please specify briefly):
Menopausal symptoms:_____
Premenstrual symptoms:_____
Sexual function:_____

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***PREMIER MEDICAL GROUP***
***PATIENT MEDICAL HISTORY FORM***

**Male**

Do you perform testicular self exam? _____Yes _____No
Have you had a vasectomy? _____Yes _____No
Do you have a problem with any of the following:

| | | | | | |
|---|---|---|---|---|---|
| Infertility | ___No | ___Yes | Impotence/sexual function | ___Yes | ___No |
| Scrotum or testicles | ___No | ___Yes | Nightime urination | ___Yes | ___No |
| Decrease in stream | ___No | ___Yes | Change in pattern of urination | ___Yes | ___No |

(Optional) Do you consider yourself: _____Bisexual _____Homosexual

***FAMILY HEALTH HISTORY***

| | Living Age | Deceased Age and cause | | Living Age | Deceased Age and Cause |
|---|---|---|---|---|---|
| Father | | | Children 1 | | |
| Mother | | | 2 | | |
| Spouse | | | 3 | | |
| Brother/Sister 1 | | | Maternal Grandmother | | |
| 2 | | | Maternal Grandfather | | |
| 3 | | | Paternal Grandmother | | |
| 4 | | | Paternal Grandfather | | |

**Please write on the appropriate lines which family members have or have had the following medical problems. Please exclude yourself and your spouse, and be sure to list ilnesses affecting your parents grandparents, siblings and children.**

Heart Attack/bypass_____
Other heart disease_____
High blood pressure_____
Diabetes_____
Cancer and type_____
Thyroid Problem_____
Sickle Cell _____
Asthma _____
Psychiatric problem_____
Overuse of alcohol_____
Seizures_____
Migraines_____
Stroke_____
Kidney disease_____
Ulcer_____
Other _____

***ADVANCE DIRECTIVES***

Are you familiar with advance directives? _____Yes _____No
Have you prepared an advance directive (lving will, health care proxy)? _____Yes _____No
Have you given us a copy of your advance directive to put in your medical records _____Yes _____No
In order for your provider to follow your directive, we encourage you to send us a copy.