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
- **3125 Rt. 9W, Suite 201**, 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

PAYMENTS OF BENEFITS AUTHORIZATION

I hereby authorize payment of all services rendered to me, to be paid directly to Premier Medical Group providing that my insurance company will forward payment directly to them. I understand that regardless of my insurance, I am financially responsible for payment of services rendered to me. I also authorize the release of any information that is needed by my insurance company to process such claims.

Name _____
Signature _____ Date _____

RECORDS RELEASE AUTHORIZATION

This record release authorization allows us to obtain and/or release your records to and from your primary physician and other physicians you are under the care of.
Date _____
Physician/Hospital _____
Address _____
Phone number ( ) _____

ADVANCED DIRECTIVES

Do you have an advanced directive in place? _____Yes _____No
If yes, do you have: ___Living Will ___Power of Attorney ___Healthcare Proxy ___DNR
Custodian of document: _____ Relationship: _____
Please be advised, if you do have any advanced directive, our office is required to obtain a copy for your records.

NO SHOW POLICY

I acknowledge that I was provided a copy of the No Show policy letter from Premier Medical Group.

Print Name: _____
Signature: _____ Date:_____
*If person signing is not the patient, please print your name and relationship to patient:
Name:_____
Relationship:_____

PREMIER *medical group*

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.