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 48 HOURS AND WILL BE CHARGED FOR ANY NO SHOW FOR AN OFFICE PROCEDURE.

CO-PAYS ARE EXPECTED AT THE TIME OF SERVICE

Premier Medical Group of the Hudson Valley, P.C.
Urology · Gastroenterology · Internal Medicine · Cardiology · Rheumatology · Dermatology · Endocrinology · Gynecology · Podiatry · Neurology
Poughkeepsie | Fishkill | Kingston | Newburgh | New Windsor | Hopewell Junction | Wappingers Falls
Tel: 1-888-632-6099 | *Web:* www.premiermedicalhv.com

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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)

PREMIER medical group

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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Neurology Patient History Form

Name: _____ DOB_____

Reason for today's visit: _____

Describe the following:

Who referred you here today? _____

How long have you had this problem? _____

How severe is this problem? __Mild __Moderate __Severe

How often are you having this problem? _____

What caused the problem? _____

Do you know of anything that may have contributed to this problem? _____

Does anything else occur with this problem? _____

Additional Comments: _____

Illness or Operation	**Year**	**Allergies**

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Do you smoke? ☐ Yes ☐ No ☐ If yes, how long?_____

Do you drink alcohol? ☐ No ☐ Occasionally ☐ Regularly

Do you have a current/past history of drug abuse? ☐ No ☐ Yes Type/Frequency_____

Last Tetanus: _____

Have you ever had the following?								
Cancer.....	Yes	No	Convulsions.....	Yes	No	Hypertensions.....	Yes	No
Arthritis/Gout.....	Yes	No	Diabetes.....	Yes	No	Heart Trouble.....	Yes	No
Acute Infections.....	Yes	No	Stroke.....	Yes	No	Bleeding Tendency...	Yes	No
			Venereal Disease.....	Yes	No	Hereditary Defects..	Yes	No

	Age	**Diseases**	**If Deceased, Cause of Death**
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers	_____	_____	_____
	_____	_____	_____
Sisters	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____

HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING IN THE PAST THREE MONTHS?
CIRCLE YES ANSWERS ONLY!

CONSTITUTIONAL **DATE**

Good general health..... No.....Yes
Recent weight change..... No.....Yes
Fever..... No.....Yes
Headaches..... No.....Yes

EYES

Eye disease/injury..... No.....Yes
Wear glasses/contacts..... No.....Yes
Blurred or double vision.....No.....Yes
Glaucoma..... No.....Yes

ENT

Hearing loss..... No.....Yes
Ringing in ears..... No.....Yes
Earaches or drainage.....No.....Yes
Sinus problems..... No.....Yes
Nose bleeds..... No.....Yes
Bad breath/taste.....No.....Yes
Sore throat/voice change.....No.....Yes
Swollen neck glands.....No.....Yes

CARDIOVASCULAR

Heart trouble..... No.....Yes
Chest pains..... No.....Yes
Sudden heartbeat change.....No.....Yes
Swelling of feet/ankles/hands.....No.....Yes

RESPIRATORY

Frequent coughing..... No.....Yes
Spitting up blood..... No.....Yes
Shortness of breath.....No.....Yes
Asthma or wheezing..... No.....Yes

GASTROINTESTINAL

Loss of appetite..... No.....Yes
Change in bowel movements..... No.....Yes
Nausea or vomiting.....No.....Yes
Frequent diarrhea..... No.....Yes
Painful bowel movement/constipation.. No..Yes
Blood in stool.....No.....Yes
Stomach pain.....No.....Yes

GENITOURINARY

Frequent urination..... No.....Yes
Burning/painful urination..... No.....Yes
Blood in urine.....No.....Yes
Change in force/strain when urinating... No...Yes
Incontinence/dribbling..... No.....Yes
Kidney stones.....No.....Yes
Male - testicle pain.....No.....Yes
Female - pain with periods.....No.....Yes
Female - #pregnancies_____ #Miscarriages_____

MUSCOSKELETON **DATE**

Joint pain..... No.....Yes
Joint stiffness..... No.....Yes
Weakness/swelling..... No.....Yes
Muscle pain/cramps..... No.....Yes

SKIN

Rash or itching..... No.....Yes
Change in skin color..... No.....Yes
Change in hair or nails.....No.....Yes
Varicose veins..... No.....Yes
Breast pain..... No.....Yes
Breast lump.....No.....Yes
Breast discharge.....No.....Yes

NEUROLOGICAL

Frequent/recurrent headaches..... No.....Yes
Lightheaded/dizziness..... No.....Yes
Convulsions/seizures.....No.....Yes
Tremors..... No.....Yes
Paralysis..... No.....Yes
Stroke..... No.....Yes

PSYCHIATRIC

Memory loss..... No.....Yes
Nervousness..... No.....Yes
Depression.....No.....Yes
Sleep problems..... No.....Yes

ENDOCRINE

Glandular/hormone problem.....No.....Yes
Thyroid disease..... No.....Yes
Excessive thirst/urination.....No.....Yes
Heat/cold intolerance..... No.....Yes
Dry skin..... No.....Yes
Change in hat/glove size..... No.....Yes

Patient Signature_____

Provider Signature_____