PREMIER *medical group*

PATIENT REGISTRATION FORM PACKET

INSTRUCTIONS:

- Please complete all pages included in this packet.

- Bring the completed paperwork to your scheduled appointment. Do not fax or email it to the office. Additionally, bring the following items with you:
  - All medical insurance cards
  - Photo ID
  - List of medications
  - Any recent lab results and radiology reports

- If your insurance company requires a referral, it is your responsibility to bring the referral with you on the day of your appointment.

- Please note that **all co-pays are due at the time of service**.

- We do not accept Worker's Compensation insurance.

NO-SHOW FEE POLICY

If you do not provide at least 48 hours' notice for the cancellation of your scheduled appointment, a no-show fee may be billed to your account.

PREMIER *medical group*

PATIENT ACCOUNT NUMBER

PATIENT REGISTRATION FORM

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)	PRIMARY PHYSICIAN

Gender Identity (Check One)	Sexual Orientation (Check One)	Pronouns
☐ Identify as Male ☐ Identify as Female ☐ Gender Nonconforming/Nonbinary ☐ Other (Please Specify)_____ ☐ Choose not to disclose	☐ Straight/Heterosexual ☐ Lesbian/Gay/Homosexual ☐ Bisexual ☐ Something else, please describe _____ ☐ Don't Know ☐ Choose not to disclose	☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs ☐ Other:_____

PATIENTS 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** ( )
EMPLOYERS 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	EMPLOYERS NAME	
CITY STATE ZIP	EMPLOYERS 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*

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.

Print Name: _____ **Signature**: _____

Address: _____

Date: _____

RECORDS RELEASE AUTHORIZATION

This record release authorization allows us to obtain/release your records to and from your primary physician and other physicians you are under the care of.

Date: _____ **Physician/Hospital:** _____

Address: _____

Phone #: _____

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PATIENT TREATMENT/ FINANCIAL WAIVER

I_____realize that if I do not provide the proper referral or insurance information to cover the services that I am requesting from Premier Medical Group, I will be responsible for the payment of this visit and all associated charges for me or my dependent(s).

Signed: _____ **Date:** _____

Witnessed: _____

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided with a copy of the Notice of Privacy Practices and the Patient Rights and Responsibilities Brochure for Premier Medical Group.

Print Name: _____ **Date:** _____

Signature: _____

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

I hereby authorize the use or disclosure of my health information and records to the following people (please list yourself, and family members, friends, or physicians who did not refer you). In filling out this form, I understand that whoever I have listed will have the right to my medical records/information:

_____

_____

FOR OFFICE USE ONLY: *If patient/representative requested a copy of the notice, provide date copy was given: _____. If no acknowledgement could be obtained, state the reason(s) why and the efforts taken to try to obtain the acknowledgment:* _____

PREMIER *medical group*

NO-SHOW POLICY

We understand that there may be times when you need to cancel an appointment. If this occurs, please contact us at least 48 hours before your scheduled appointment time. You can reach us by calling the office or through the patient portal. Timely rescheduling of your appointment allows us to offer that time to another patient in need of care.

If you do not attend your appointment or if you cancel or reschedule within 48 hours of your scheduled time, it will be classified as a no-show. No-show appointments may incur a fee ranging from $50 to $150, as detailed below:

- Holter Monitor- $25.00
- Office Visits - $50.00
- Ultrasound or Xray - $50.00
- Cardiac Testing - $50.00
- Imaging or In-office Procedures - $100.00
- Nuclear Stress Test- $150.00
- Out of Office Procedures - $150.00

This fee is the patient's responsibility and must be paid in full before your next appointment. If the no-show fee could prevent you from receiving necessary care, please reach out to us.

We understand that unexpected situations may occur. In cases of emergencies or extenuating circumstances, we may choose to waive the no-show fee. Such waivers will be evaluated on a case-by-case basis at the discretion of the practice management.

NO-SHOW POLICY ACKNOWLEDGEMENT

I acknowledge that I was provided with a copy of the No-Show Policy from Premier Medical Group.

Print Name: _____

Signature: _____ **Date**: _____

*If the 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

PREMIER *medical group*

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.