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<br>☐ Identify as Female<br>☐ Gender Nonconforming/Nonbinary<br>☐ Other (Please Specify)_____<br>☐ Choose not to disclose | ☐ Straight/Heterosexual<br>☐ Lesbian/Gay/Homosexual<br>☐ Bisexual<br>☐ Something else, please describe<br>_____<br>☐ Don't Know ☐ Choose not to disclose | ☐ She/Her/Hers<br>☐ He/Him/His<br>☐ They/Them/Theirs<br>☐ Other:_____ |

| PATIENTS ADDRESS | EMERGENCY CONTACT AND TELEPHONE # |
|---|---|
| CITY STATE ZIP | STUDENT STATUS: If 18 years or older:(Circle One)<br>Full Time Part Time Not a Student |
| TELEPHONE ( ) CELL PHONE ( ) DATE OF BIRTH ___/___/_____ MO DAY YEAR | MARITAL STATUS: (Circle One)<br>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<br>☐ MALE ☐ FEMALE | LEGAL REPRESENTATIVE<br>☐ YES ☐ NO |
|---|---|---|
| RESPONSIBLE PARTY'S ADDRESS | EMPLOYERS NAME | |
| CITY STATE ZIP | EMPLOYERS ADDRESS | |
| TELEPHONE<br>( ) | RELATIONSHIP TO PATIENT<br>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 #**: _____

PREMIER *medical group*

# 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*

# RHEUMATOLOGY PATIENT HISTORY FORM

**PATIENT NAME:** _____ **TODAY'S DATE:** _____

**DATE OF BIRTH:** _____ **BIRTHPLACE:** _____

**MARITAL STATUS:** ☐ NEVER MARRIED ☐ MARRIED ☐ PARTNER / SIGNIFICANT OTHER
☐ WIDOWED ☐ DIVORCED ☐ SEPARATED

**NAME OF YOUR PRIMARY CARE PHYSICIAN:** _____

**REFERRED BY:**

☐ SELF ☐ DOCTOR NAME: _____ OTHER HEALTHCARE PROVIDER: _____

**DESCRIBE BRIEFLY YOUR PRESENT SYMPTOMS:** _____

_____

_____

**WHEN DID YOUR SYMPTOMS START? (MONTH, DAY, YEAR)?** _____

**WHAT DIAGNOSIS HAVE YOU BEEN GIVEN, IF ANY?** _____

_____

**PLEASE LIST THE NAMES OF OTHER PRACTITIONERS YOU HAVE SEEN FOR THIS PROBLEM:**

_____

_____

## ***PAST MEDICAL & SURGICAL HISTORY***

**PLEASE LIST ANY MEDICAL PROBLEMS YOU HAVE OR HAD IN THE PAST:**

_____

_____

_____

**PLEASE LIST ANY SURGERIES YOU HAVE HAD, YEAR, HOSPITAL, AND REASON FOR SURGERY:**

_____

_____



INITIALS: _____

**ANY PREVIOUS FRACTURES?** ☐ NO ☐ YES - PLEASE DESCRIBE: _____

_____

**ANY OTHER SERIOUS INJURIES?** ☐ NO ☐ YES - PLEASE DESCRIBE: _____

_____

## ***MEDICATIONS & ALLERGIES***

**PLEASE LIST ALL CURRENT MEDICATIONS, DOSE AND HOW OFTEN YOU ARE TAKING THEM:**

_____

_____

_____

_____

_____

**PLEASE LIST ANY DRUG ALLERGIES YOU HAVE: NAME OF MEDICATION AND THE REACTION:**

_____

_____

## ***INFECTION, TRAVEL & IMMUNIZATION HISTORY***

**HAVE YOU EVER HAD ANY OF THE FOLLOWING? IF YES, PLEASE LIST DATE:**

☐ TUBERCULOSIS: _____ ☐ HEPATITIS B: _____ ☐ HEPATITIS C: _____

☐ HIV: _____ ☐ LYME: _____ ☐ COVID: _____

☐ SHINGLES: _____ ☐ OTHER: _____

**HAVE YOU EVER TRAVELLED TO ANY OTHER COUNTRIES OUTSIDE OF USA AND CANADA?**

☐ NO ☐ YES, PLEASE LIST: _____

**HAVE YOU RECEIVED ANY OF THE FOLLOWING VACCINATIONS? IF YES, PLEASE LIST DATES (MONTH/YEAR):**

☐ INFLUENZA: _____ ☐ SHINGREX (SHINGLES VACCINE): _____

☐ COVID: _____ ☐ COVID BOOSTER: _____

☐ PNEUMOVAX (PNEUMONIA VACCINE): _____



INITIALS: _____

## ***FAMILY HISTORY***

**DOES ANY FAMILY MEMBER RELATED TO YOU BY BLOOD HAVE ANY OF THE FOLLOWING CONDITIONS? IF YES, PLEASE LIST RELATIVE/RELATIONSHIP (I.E. MATERNAL/PATERNAL):**

- ☐ RHEUMATOID ARTHRITIS: _____
- ☐ LUPUS OR SLE: _____
- ☐ ANKYLOSING SPONDYLITIS: _____
- ☐ PSORIATIC ARTHRITIS: _____
- ☐ PSORIASIS: _____
- ☐ ARTHRITIS: _____
- ☐ GOUT: _____
- ☐ OSTEOARTHRITIS: _____

**DOES ANY FAMILY MEMBER RELATED TO YOU BY BLOOD HAVE THE FOLLOWING AND/OR OTHER ILLNESS? IF YES, PLEASE LIST RELATIVE/RELATIONSHIP.**

- ☐ CANCER: _____
- ☐ LEUKEMIA OR LYMPHOMA: _____
- ☐ COLITIS: _____
- ☐ HEMOCHROMATOSIS: _____
- ☐ CELIAC DISEASE: _____
- ☐ DIABETES: _____
- ☐ MULTIPLE SCLEROSIS: _____
- ☐ HEART DISEASE: _____
- ☐ HYPERTENSION: _____
- ☐ STROKE: _____

| | **IF LIVING** | | **IF DECEASED** | |
|---|---|---|---|---|
| | **AGE** | **HEALTH** | **AGE AT DEATH** | **CAUSE** |
| **FATHER** | | | | |
| **MOTHER** | | | | |

**NUMBER OF SIBLINGS:** _____ **NUMBER LIVING:** _____

**NUMBER OF CHILDREN:** _____ **NUMBER LIVING:** _____

**LIST AGES OF EACH CHILD IF APPLICABLE:** _____

**HEALTH OF CHILDREN:** _____



INITIALS: _____

## ***PERSONAL HISTORY***

**WHAT IS YOUR HIGHEST EDUCATION LEVEL?**

☐ HIGH SCHOOL ☐ SOME COLLEGE ☐ COLLEGE GRADUATE

☐ ADVANCED DEGREE ☐ OTHER: _____

**WHAT IS YOUR CURRENT OR PAST OCCUPATION?**

_____

**ARE YOU CURRENTLY WORKING?**

☐ EMPLOYED AS: _____ ☐ SELF-EMPLOYED AS: _____

☐ HOME MAKER ☐ RETIRED ☐ STUDENT

☐ MEDICAL LEAVE ☐ LOOKING FOR WORK ☐ DISABILITY

☐ OTHER: _____

**WITH WHOM DO YOU CURRENTLY LIVE? PLEASE LIST RELATIONSHIP AND AGE OF EACH PERSON:**

_____

_____

**DO YOU HAVE ANY PETS?**

☐ YES, PLEASE LIST:_____ ☐ NO

**DO YOU SMOKE OR VAPE?**

☐ NO

☐ YES - STARTED AGE: _____ HOW MANY CIGARETTES/DAY: _____

☐ FORMER SMOKER OR VAPING – FROM AGE: _____ TO AGE: _____ HOW MANY CIGARETTES/DAY: _____

**DO YOU DRINK ALCOHOL?**

☐ NO ☐ YES – USUAL DRINK: _____ HOW MUCH: _____

**HAS ANYONE EVER TOLD YOU TO CUT BACK ON YOUR DRINKING?**

☐ YES ☐ NO



INITIALS: _____

**DO YOU USE RECREATIONAL DRUGS?**

☐ NO ☐ YES - PLEASE LIST:_____

**ARE YOU APPLYING FOR OR RECEIVING DISABLITY?**

☐ NO ☐ YES, APPLYING FOR DISABILITY ☐ YES, RECEIVING DISABILITY

**DO YOU HAVE ANY MEDICALLY RELATED LAWSUIT PENDING?**

☐ YES ☐ NO

**PATIENT GLOBAL ASSESSMENT OF DISEASE ACTIVITY:** CONSIDERING ALL THE WAYS YOR ARTHRITIS OR CONDITION AFFECTS YOU, RATE HOW WELL YOU ARE DOING ON THE FOLLOWING SCALE:

| | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Very well | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | Very poor |

***WE ARE INTERESTED IN LEARNING HOW YOUR ILLNESS AFFECTS YOUR ABILITY TO FUNCTION IN DAILY LIFE. PLACE AN "X "IN THE BOX WHICH BEST DESCRIBES YOUR USUAL ABILITIES <u>OVER THE PAST WEEK</u>. ARE YOU ABLE TO:***

| **TOTAL SCORE: _____**<br>**TOTAL SCORE/10: _____** | **WITHOUT ANY DIFFICULTY (0)** | **WITH SOME DIFFICULTY (1)** | **WITH MUCH DIFFICULTY (2)** | **UNABLE (3)** |
|---|---|---|---|---|
| GET ON AND OFF THE TOILET? | ☐ | ☐ | ☐ | ☐ |
| OPEN CAR DOORS? | ☐ | ☐ | ☐ | ☐ |
| STAND UP FROM A STRAIGHT CHAIR? | ☐ | ☐ | ☐ | ☐ |
| WALK OUTDOORS ON FLAT GROUND? | ☐ | ☐ | ☐ | ☐ |
| WAIT IN LINE FOR 15 MINUTES? | ☐ | ☐ | ☐ | ☐ |
| REACH AND GET DOWN A 5-POUND OBJECT (EX. BAG OF SUGAR) FROM JUST ABOVE YOUR HEAD? | ☐ | ☐ | ☐ | ☐ |
| GO UP 2 OR MORE FLIGHTS OF STAIRS? | ☐ | ☐ | ☐ | ☐ |
| DO OUTSIDE WORK (SUCH AS YARD WORK)? | ☐ | ☐ | ☐ | ☐ |
| LIFT HEAVY OBJECTS? | ☐ | ☐ | ☐ | ☐ |
| MOVE HEAVY OBJECTS? | ☐ | ☐ | ☐ | ☐ |



INITIALS: _____

# SYSTEMS REVIEW

Date of last eye exam: _____ Date of last chest x-ray: _____

Date of last bone density test: _____

Result of last TB (PPD) test: ☐ Never done ☐ Negative ☐ Positive Date test performed: _____

**GENERAL**

- ☐ Recent weight gain; how much _____
- ☐ Recent weight loss; how much _____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever
- ☐ Night sweats

**MUSCLE/JOINTS/BONES**

- ☐ Morning stiffness
  Lasting how long _____ Minutes
  _____ Hours
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Joint swelling

List joints affected in the last 6 months:

_____

_____

_____

_____

**EARS**

- ☐ Ringing in ears
- ☐ Loss of hearing

**EYES**

- ☐ Pain
- ☐ Redness
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Dryness
- ☐ Feels like something in eye

**MOUTH**

- ☐ Sore tongue
- ☐ Bleeding gums
- ☐ Sores in mouth
- ☐ Loss of taste
- ☐ Dryness
- ☐ Recent increase in tooth cavities

**NOSE**

- ☐ Nosebleeds
- ☐ Loss of Smell

**THROAT**

- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty in swallowing
- ☐ Pain in jaw while chewing

**NECK**

- ☐ Swollen glands
- ☐ Tender glands

**HEART AND LUNGS**

- ☐ Pain in chest
- ☐ Irregular heart beat
- ☐ Sudden change in heart beat
- ☐ Shortness of breath
- ☐ Difficulty in breathing at night
- ☐ Swollen legs of feet
- ☐ Cough
- ☐ Coughing of blood
- ☐ Wheezing

**STOMACH AND INTESTINES**

- ☐ Nausea
- ☐ Heartburn
- ☐ Stomach pain relieved by food
- ☐ Vomiting of blood/"coffee grounds"
- ☐ Yellow jaundice
- ☐ Increasing constipation
- ☐ Persistent diarrhea
- ☐ Blood in stools
- ☐ Black stools

**KIDNEY/URINE/BLADDER**

- ☐ Difficult urination
- ☐ Pain or burning on urination
- ☐ Blood in urine
- ☐ Cloudy, "smoky" urine
- ☐ Pus in urine
- ☐ Discharge from penis/vagina
- ☐ Frequent urination
- ☐ Getting up at night to pass urine
- ☐ Vaginal dryness
- ☐ Rash/ulcers
- ☐ Sexual difficulties
- ☐ Prostate trouble

**BLOOD**

- ☐ Anemia
- ☐ Bleeding tendency

**SKIN**

- ☐ Easy bruising
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Sun sensitive
- ☐ Skin tightness
- ☐ Nodules/bumps
- ☐ Hair loss
- ☐ Color changes of hands or feet in the cold (Raynaud's)

**NERVOUS SYSTEM**

- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting or loss of consciousness
- ☐ Numbness or tingling in hands/feet
- ☐ Memory loss
- ☐ Muscle weakness

**PSYCHIATRIC**

- ☐ Depression
- ☐ Excessive worries
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep

***For women only:***

Age when periods began: _____

Number of pregnancies: _____

Number of miscarriages: _____

Have you reached menopause?

☐ NO ☐ YES

If yes, what age?_____

Date of last Pap smear: _____

Date of last mammogram: _____

If you are still having periods:

Are they regular? ☐ YES ☐ NO

How many days apart? _____



INITIALS: _____