Palms Primary Care

PATIENT REGISTRATION FORM

Today's Date: ___________________________

Name:____ Sex: ❑M ❑F

Local Address:____

City: __________________________________ State:____________ Zip:________________________

Home Phone:________________Work Phone:__________________ Cell Phone:__________________

Email: ____

Date of Birth: ___________________________ Age:________ SS#: ____________________________

Ethnicity:______________________________ Preferred Language:______________________________

Race: ❑American Indian or Alaska Native ❑Black or African American ❑Asian
❑Native Hawaiian or Other Pacific Islander ❑Unreported/Refused to Report ❑White

Emergency Contact: _______________________Phone: ______________Relationship:_____________

Marital Status: Single ___ Married ___ Divorced/Separated ___ Widowed ___

Employed: ❑Full Time ❑Part-time ❑Unemployed ❑Disabled ❑Retired ❑Military

Employer: ______________________________ Job Title: ____________________________________

Local Pharmacy Name: ____________________Address: ____________________________________

Preferred Lab Facility:_________________________

Insurance Card(s): Please present to receptionist to photocopy for file.

Primary Insurance: _______________________Secondary Insurance: __________________________

Whom may we thank for referring you to us?

❑ Friend/Family ❑ The Gabber local paper ❑ Postcard ❑ Letter ❑ Consult A Nurse ❑TBT
❑ Hospital______________ ❑ Physician referral _________ ❑ Insurance____________ ❑Valpak
Internet: ❑ Google Plus ❑ Facebook ❑ Vitals ❑ Healthgrades ❑ Yelp ❑ PalmsPrimaryCare.com

I hereby authorize Palms Primary Care to release all or part of my medical records to Medicare and/or any other companies, if requested, without any liability to Palms Internal Medicine. I hereby authorize Medicare and/or my insurance companies to pay directly to Palms Internal Medicine any payments, assignments or benefits due me.

____Date: ____________________
Patient Signature

Reason for Today's Visit?____

Which of the following conditions are you currently being treated or have been treated for in the past (please check)

Behavioral Health: yes/no
Provider's name___________________________________

Cardiovascular:
□Arrhythmia □Murmur □ Angina/heart stents □Clots in legs/arms □High cholesterol □High blood pressure □Heart attack □Congestive Heart Failure
Pulmonary:
□Asthma □Pneumonia □Lung Clots □COPD/Emphysema □Sleep Apnea
Gastrointestinal:
□Cirrhosis □ Hepatitis □Irritable Bowels □Crohn's disease □Heartburn (reflux)
□Gastric Ulcers □Diverticulitis □Rectal bleeding □Colonoscopy
Renal/GU:
□Prostate Enlargement □Kidney stones □Incontinence/loss of bladder control □Urinary Tract Infections
Musculoskeletal:
□Chronic Pain (where?)__________ □Fibromyalgia □Gout □Arthritis □Osteoporosis
Endocrine:
□Diabetes (□Type I or □Type II) □Thyroid problems (□High or □Low)
Neurological:
□Stroke □Dementia □Migraines □Multiple Sclerosis □Parkinson □Neuropathy □Seizures □TIA/ministroke
Allergy/Immunology/Dermatology:
□Allergies □eczema □frequent ear infections □psoriasis □frequent sinus infection
Other:
□Any Cancer (what kind?)______________________________
□Cataract □Glaucoma □Anemia or blood problems □Psychiatric care

CURRENT MEDICATIONS

Name, strength, frequency

1. ____________________ 7. ____________________
2. ____________________ 8. ____________________
3. ____________________ 9. ____________________
4. ____________________ 10. ____________________
5. ____________________ 11. ____________________
6. ____________________ 12. ____________________

ALLERGIES **Do you have allergies to drugs, food, latex, dye? YES NO**

Allergy - list medication, food, latex, dye, etc.	Reaction - rash, shortness of breath, hives, itching, etc

SURGICAL HISTORY

Surgery	Facility

FAMILY HISTORY

Living	Age	Health Status
Father		
Mother		
Sisters		
Brothers		
Deceased	**Age at Death**	**Cause of Death**
Father		
Mother		
Sisters		
Brothers		

Social History

Are you: Married Single Divorced Widowed

Number of Children? ______________________ Ages ____

Do you smoke? Yes ____ No ____ How much ______ How Long ______ Year Quit ____________

Do you drink alcohol? Yes ____ No _____ how much per week? _________________________________

Do you exercise? Yes ____ No _____What do you do? ___________________Frequency__________

Please circle if it applies to you:

Eyesight: Good - Fair - Poor - Glaucoma

Ears, Nose, Throat: Poor Hearing - Sore Throat - Sinus Problems

Gastrointestinal: Swallowing Problems - Indigestion - Bloody stools - Diarrhea

Genitourinary: Difficulty Urinating - Blood in Urine - Prostate Problems - Kidney problems

Musculoskeletal: Muscle Pain - Joint pain - Arthritis

Integumentary: Skin Rash - Skin Disorders

Neurological/Psychiatry: Fainting - Depression - Anxiety - Drug Dependence

Endocrine: Thyroid Disease - Diabetes

Hematologic/Lymphatic: Taking Blood Thinners - Taking Aspirin - Coumadin

Allergic/Immunologic: Sinusitis - Hayfever - Allergies

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

____ ____________________________

Signature of Patient or Personal Representative **Date**

____ ____________________________

Printed Name of Patient or Personal Representative **Relationship to Patient**

PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

Patient Name _________________________________ Date of Birth __________________

1. ____________**(Patient or Guardian Initials)**

Financial Agreement.

- I acknowledge, that as a courtesy, **Palms Primary Care** may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

2. ___________**(Patient or Guardian Initials)**

Third Party Collection. I acknowledge that **Palms Primary Care** may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. ___________**(Patient or Guardian Initials)**

Assignment of Benefits. I hereby assign to **Palms Primary Care** any insurance or other third-party benefits available for health care services provided to me. I understand **Palms Primary Care** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **Palms Primary Care,** I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. ______________**(Patient or Guardian Initials)**

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to **Palms Primary Care** by the Medicare or Medicaid program.

5. ______________**(Patient or Guardian Initials)**

Consent to Telephone Calls for Financial Communications. I agree that, in order for **Palms Primary Care**, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that **Palms Primary Care** or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or **Palms Primary Care** or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. ______________**(Patient or Guardian Initials)**

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X____Date_________________

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below):

Spouse
Parent
Legal Guardian

Guarantor
Healthcare Power of Attorney
Other (please specify)_____________________________________