

STERLING PRIMARY CARE
343 Franklin Road, Suite 203
Brentwood, TN 37027
Phone (615) 577-6520 Fax (615) 577-6521

PATIENT REGISTRATION FORM

PATIENT INFORMATION

(Please Print)

Dr. Mr. Mrs. Ms. Jr. Sr. Other _____
Patient's Name: (Last) _____ (First) _____ (Middle) _____
Also Known As Name: (Last) _____ (First) _____
Marital Status: Married Single Divorced Widowed Legally Separated Other
Social Security Number _____ - _____ - _____ Female Male Date of Birth ____/____/____
E-Mail Address _____ @ _____
Phone Numbers: Work _____ Day Evening Home _____ Day Evening
Cellular _____ Day Evening Pager _____ Day Evening
Address: _____
City, State, Zip (+4) _____
Employment Status: Employed Full-Time Student Part-Time Student Retired Self-Employed Unemployed
Employer _____ Occupation _____
Emergency Contact Name _____ Phone Number _____
Emergency Contact Relationship to Patient _____
Pharmacy Information _____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name: (Last) _____ (First) _____ (Middle) _____
Also Known As Name: (Last) _____ (First) _____
Social Security Number _____ - _____ - _____ Female Male Date of Birth ____/____/____
E-Mail Address _____ @ _____
Phone Numbers: Work _____ Day Evening Home _____ Day Evening
Address: _____
City, State, Zip (+4) _____
Employment Status: Employed Full-Time Student Part-Time Student Retired Self-Employed Unemployed
Employer _____ Employer Phone Number _____
Patient Relationship to Responsible Party _____

PRIMARY INSURANCE INFORMATION

(Provide your insurance card to the front desk at time of check-in)

Name of Insured _____ Patient Relationship _____ to Insured _____
Insured Employer Name _____
Insurance Company/Phone Number _____ (____) _____
Subscriber ID (Policy Number) _____ Group ID _____ Co-Pay Amount \$ _____
Effective Date ____/____/____ Termination Date ____/____/____ Female Male
Insured Date of Birth ____/____/____ Insured's Social Security Name _____ - _____ - _____
Insurance Company Address _____

SECONDARY INSURANCE INFORMATION

(Provide your insurance card to the front desk at time of check-in)

Name of Insured _____ Patient Relationship _____ to Insured _____
Insured Employer Name _____
Insurance Company/Phone Number _____ (____) _____
Subscriber ID (Policy Number) _____ Group ID _____ Co-Pay Amount \$ _____
Effective Date ____/____/____ Termination Date ____/____/____ Female Male
Insured Date of Birth ____/____/____ Insured's Social Security Name _____ - _____ - _____
Insurance Company Address _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Signature of Patient (or Responsible Party)

Date

STERLING PRIMARY CARE
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PATIENT CONSENT FORM

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all Treatment
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/test and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that **Sterling Primary Care Associates** may include consent at satellite office under common ownership.

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

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

Signature of Patient (or Responsible Party)

Date

STERLING PRIMARY CARE

PATIENT NAME _____ DATE OF BIRTH _____

PATIENT FINANCIAL AGREEMENT

1. _____ (Patient or Guardian Initials)

Financial Agreement.

- I acknowledge, that as a courtesy, **Sterling 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 **Sterling 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 **Sterling Primary Care** any insurance or other third-party benefits available for health care services provided to me. I understand **Sterling Primary Care** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **Sterling 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 **Sterling 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 **Sterling Primary Care**, or EBO Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that **Sterling 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 **Sterling 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 | Guarantor |
| Parent | Healthcare Power of Attorney |
| Legal Guardian | Other (please specify) _____ |



Date: _____

Patient Name: _____ Date of Birth: ____/____/____
(Last) (First) (Middle)

Name of Doctor Being Seen:

Preferred Pharmacy:

Name: _____

Address: _____

Phone: _____

Additional Physicians/Specialists You See Regularly:

Name: _____ Specialty: _____ Location: _____

Name: _____ Specialty: _____ Location: _____

Name: _____ Specialty: _____ Location: _____

Name: _____ Specialty: _____ Location: _____

Patient Name: _____ Date of Birth: ____/____/____
(Last) (First) (Middle)

REASONS FOR YOUR APPOINTMENT:

1. _____
2. _____
3. _____

PAST MEDICAL HISTORY: Please select your current medical conditions.

Hypertension (High Blood Pressure)	YES	NO
Diabetes (High Blood Sugar)	YES	NO
COPD (emphysema, chronic bronchitis)	YES	NO
High Cholesterol	YES	NO
Heart Disease	YES	NO
Anxiety	YES	NO
Depression	YES	NO
Thyroid Disorder	YES	NO

Please list your other medical conditions:

_____	_____
_____	_____
_____	_____

MEDICATIONS: List your current medications. Include aspirin, birth control pills, nutritional supplements, and over-the-counter medicines you use regularly.

Check here if you brought a medication list. Please give list to your nurse.

1.	_____	_____	_____
	Name of Medication	Dosage Amount	How Often Taken
2.	_____	_____	_____
	Name of Medication	Dosage Amount	How Often Taken
3.	_____	_____	_____
	Name of Medication	Dosage Amount	How Often Taken
4.	_____	_____	_____
	Name of Medication	Dosage Amount	How Often Taken
5.	_____	_____	_____
	Name of Medication	Dosage Amount	How Often Taken
6.	_____	_____	_____
	Name of Medication	Dosage Amount	How Often Taken
7.	_____	_____	_____
	Name of Medication	Dosage Amount	How Often Taken

*Note: Please check here if you have additional medicines. Ask nurse for additional paper if needed.

ALLERGIES: Medication/Food Type of Reaction

1. _____
2. _____
3. _____

If needed, list additional allergies here: _____

Patient Name: _____ Date of Birth: ____/____/____
(Last) (First) (Middle)

PAST SURGICAL HISTORY: List your past surgeries.

1. _____ Year _____
2. _____ Year _____
3. _____ Year _____
4. _____ Year _____

PRIOR HOSPITALIZATIONS: List specific hospitals and reason for hospitalization.

1. _____ Month/Year _____
2. _____ Month/Year _____
3. _____ Month/Year _____

FAMILY HISTORY:

List family members who have had the following:

Diabetes: _____

High Blood Pressure: _____

High Cholesterol: _____

Heart attacks: _____

Strokes: _____

Asthma/COPD: _____

HIV or AIDS: _____

Stomach/Colon Problems: _____

Psychiatric Disorders (i.e. anxiety, depression): _____

Bleeding Disorder or Anemia: _____

Cancer: _____

Relation Type (i.e. breast, prostate, etc.)

List additional conditions you consider significant: _____

OB/GYN HISTORY: Please complete if female.

Number of Pregnancies: _____

Number of Miscarriages, Abortions, Stillbirths: _____

Do you currently use contraception/birth control? YES NO

If yes, what type? _____

Do you see an OBGYN regularly? YES NO If yes, whom do you see? _____

PERSONAL HISTORY:

Occupation: _____

Education: *List highest level attained* _____

Marital Status: _____

Spouse's Occupation: _____

Children (include names and age):

Patient Name: _____ Date of Birth: ____/____/____
(Last) (First) (Middle)

PERSONAL HISTORY (continued):

Health Habits:

1. Alcohol use:

Do you drink alcohol? YES NO
How many drinks per week? _____
Do you drink alcohol daily? YES NO
What type, how much? _____

2. Smoking:

Are you a smoker? YES NO
If yes, how many packs per day? _____ If _____ a
former smoker, what year did you quit? _____

3. Illicit drug use (such as marijuana, cocaine, methamphetamines, etc.):

What type? _____
How often? _____

4. Exercise:

Do you exercise regularly? YES NO

5. Diet:

Are you satisfied with your diet? YES NO
How much water do you drink daily? _____
How many cups of coffee or tea per day? _____

6. Sleep:

Hours of sleep per day _____

PREVENTIVE CARE:

If applicable, please provide the approximate date of your last...

Obtained Where?

Pap Smear: _____	_____
Mammogram: _____	_____
Colonoscopy: _____	_____
Eye Exam: _____	_____
Bone Density (DEXA) Scan: _____	_____

Have you received the following immunizations?

List Date if known:

Influenza/Flu	YES	NO	_____
Pneumonia	YES	NO	_____
Tetanus	YES	NO	_____
Pertussis	YES	NO	_____
HPV/Gardasil	YES	NO	_____
Hepatitis A	YES	NO	_____
Hepatitis B	YES	NO	_____
Shingles	YES	NO	_____

Patient Signature: _____ Date: _____

Healthcare Provider Signature: _____ Date: _____

Patient Name: _____ **Date of Birth:** ____/____/____
 (Last) (First) (Middle)

REVIEW OF SYSTEMS: Please place a checkmark next to any symptom you are currently experiencing:

General	Weight Loss___Weight Gain___Fever___Night Sweats___Fatigue___ None___
Eyes	Blurry Vision___Loss of Vision___Eye Pain___Eye Redness___Dry Eyes___None___
ENT	Sore Throat___Sinus Trouble___Hoarse Voice___Hearing Loss___Ringing in Ears ___ Ear Pain ___Tooth Problems___None___
Cardiovascular	Chest Pain___Rapid Heartbeat___Murmur___Leg Swelling___Leg Pain when Walking ___ None___
Respiratory	Shortness of Breath___Cough___Sputum Production___Coughing up Blood___None ___
Gastrointestinal	Nausea___Vomiting___Diarrhea___Constipation___Abdominal Pain ___ Blood in Stool___Frequent Heartburn___Trouble Swallowing___None___
Genitourinary	Burning with Urination___Increased frequency___Urgency Incontinence___None ___ Blood in Urine___Erectile Dysfunction___Vaginal Discharge___Breast Lump or Pain ___
Musculoskeletal	Joint Pain___Muscle Pain___Muscle Weakness___Back Pain___None___ <i>If so, list where:</i> _____
Endocrine	Increased Thirst___Excessive Sweating___Heat Intolerance___Cold Intolerance ___ Poor appetite___Irregular Menstrual Periods___None ___
Neurologic	Headaches___Tremor___Tingling/Numbness___Dizziness___Speech Difficulty___None ___
Psychiatric	Anxiety___Depression___Panic Attacks___Alcohol/Drug Dependence ___ Suicidal Thoughts___Work/Home Life Unpleasant___None ___ <i>If you suffer from any of the above, do you desire psychiatric help: YES NO</i>
Hematologic/ Lymphatic	Easy Bruising___Swollen Lymph Nodes___None ___
Skin	Changes in Moles___Skin Problems___Rash___Itching___Hair Loss___None ___

Please list any additional symptoms you feel pertinent to your medical health:

Patient Signature: _____ **Date:** _____

Healthcare Provider Signature: _____ **Date:** _____