STERLING PRIMARY CARE
2400 Patterson Street, Suite 500
Nashville, TN 37203
Phone (615) 327-7400 Fax (615) 327-4818

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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Nashville, TN 37203
Phone (615) 327-7400 Fax (615) 327-4818

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
Parent
Legal Guardian

Guarantor
Healthcare Power of Attorney
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 are 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________ *If so, list where:* ____
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 _______ *If you suffer from any of the above, do you desire psychiatric help: YES NO*
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:** ______________