STERLING PRIMARY CARE - PATIENT REGISTRATION FORM

PATIENT INFORMATION (Please print)

Patient's Name: (Last) _____ (First) _____ (MI) _____

Address: _____

City, State, Zip: _____

Home: _____ Cell: _____ Work: _____

E-Mail Address: _____ DOB: _____

Sex: ☐ Female ☐ Male ☐ Transgender

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander
☐ Black/African American ☐ White ☐ Hispanic ☐ Other ☐ Declined

Language: ☐ English ☐ Spanish ☐ Indian: Hindi, etc. ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Social Security Number: _____ - _____- _____

Pharmacy Information: _____ Address: _____ Phone: _____

RESPONSIBLE PARTY INFORMATION (*If not self*) (Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐

Responsible party name: (Last) _____ (First) _____ (MI) _____

Date of birth: MM _____/DD _____/YYYY_____ Sex: ☐ Female ☐ Male

Social Security Number: _____-_____-_____ Phone number: _____

Address: _____

City, State: _____ ZIP: _____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last) _____ (First) _____

Phone number: _____ Do you have a living will? ☐ Yes ☐ No

Emergency contact relationship to patient: _____ ☐ Guardian

Address _____

City, State: _____ ZIP: _____

Home phone: _____ Work hone: _____ Ext. _____

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 Name: _____

Date of Birth: _____

Sterling Primary Care - Patient Consent for Financial Communications

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 there is a fee for returned checks.

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

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.

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.

Consent to Telephone Calls for Financial Communications. I agree that, in order for Sterling 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 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.

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

Patient/patient representative signature: _____ **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) _____

TRI STAR MEDICAL GROUP
Sterling Primary Care

Date: _____

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

Name of Provider Being Seen:

Craig Wright, MD ☐ Mary Lauren Pfieffer, FNP-BC ☐

Preferred Local Pharmacy:

Name: _____

Address: _____

Phone: _____

Please list name of your mail order pharmacy (if applicable): _____

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) (MI)

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 Disorder	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
8. _____
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) (MI)

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. _____ Year _____
2. _____ Year _____
3. _____ Year _____

FAMILY HISTORY:

List family members who have had the following:

Diabetes: _____
High Blood Pressure: _____
High Cholesterol: _____
Heart Disease: _____
Strokes: _____
Asthma/COPD: _____
Gastrointestinal Issues (i.e. IBS, reflux, etc.): _____
Psychiatric Disorders (i.e. anxiety, depression): _____
Cancer:

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

_____
_____
_____

List additional conditions you consider significant:

_____ _____

PERSONAL HISTORY:

Health Habits:

Tobacco Use:

Do you currently use tobacco products? YES NO
If yes, please circle: CIGARETTES SMOKELESS TOBACCO Other: _____
If a current smoker, how many packs per day? _____ Started at Age? _____
If a former smoker, what Age did you quit? _____ Started at Age? _____
What was your typical amount of smoking during this timeframe? Please circle:
SOCIAL ½ PACK/DAY 1 PACK/DAY MORE THAN 1 Pack/Day

Alcohol use:

Do you drink alcohol? YES NO
If yes, how often: DAILY WEEKLY SPECIAL OCCASIONS
If yes, what type(s) do you typically consume: _____

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

Do you currently use illicit drugs? YES NO
If yes, what type? _____

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

PERSONAL HISTORY (continued):

Occupation: _____ Employer: _____
Education (List highest level attained): _____
Marital Status: _____
Spouse's Occupation: _____
Children (include names and age):
_____ _____ _____ _____

Exercise:
Do you exercise regularly? YES NO If yes, what type(s): _____

Diet:
Are you satisfied with your diet? YES NO
How much water do you drink daily? _____
How many cups of coffee, tea, regular sodas per day? _____

Sleep:
Hours of sleep per day _____

OB/GYN HISTORY: Please complete if female.

Number of Total 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? _____

PREVENTIVE CARE:

If applicable, please provide the approximate date of your last… *Do you have a history of an abnormal result?*

Pap Smear: _____	YES	NO
Mammogram: _____	YES	NO
Colonoscopy: _____	YES	NO
Bone Density (DEXA) Scan: _____	YES	NO
Eye Exam: _____	YES	NO

Have you received the following immunizations?

			List Date if known:
Influenza/Flu	YES	NO	_____
Pneumonia	YES	NO	_____
Tetanus	YES	NO	_____
Pertussis (Tdap)	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) (MI)

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 ___ Incontinence ___ Blood in Urine ___ Excessive Urination at Night ___ Erectile Dysfunction ___ Vaginal Discharge ___ Breast Lump or Pain ___ None ___
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: _____