STERLING PRIMARY CARE

4200 Stammer Place
Nashville, TN 37215
Phone (615) 320-4100 Fax (615) 320-4346

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**

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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)_____

TRI STAR MEDICAL GROUP
Sterling Primary Care

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:** _____