TRISTAR STERLING PRIMARY CARE PATIENT REGISTRATION FORM (eCW)

PATIENT INFORMATION (Please print)

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

Preferred Full Name (if different from above): _____

Address: _____

City, State, Zip: _____

Home Phone Number (landline):_____Cell:_____Work: _____

E-Mail Address:_____Date of Birth: _____

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer ☐ Choose not to disclose ☐ Additional Gender category not listed _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White ☐ Hispanic ☐ Chose not to disclose ☐ Other not listed _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to disclose

Preferred Language: ☐ English ☐ Spanish ☐ ASL ☐ Japanese ☐ Mandarin ☐ Korean ☐ French ☐ Indian: Hindi, Tamil, Gujarati etc ☐ Swahili ☐ Russian ☐ Arabic ☐ Vietnamese ☐ Haitian Creole ☐ Bosnian/Croatian/Serbian/Serbo-Croatian ☐ Albanian ☐ Burmese ☐ Tagalog ☐ Farsi-Iranian/Persian ☐ Portuguese ☐ Cambodian ☐ Other not listed_____

Patient Social Security Number:___-_____-_____

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

Responsible Party 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 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:** _____