

# 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 home: \_\_\_\_\_ 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  
Parent  
Legal Guardian

Guarantor  
Healthcare Power of Attorney  
Other (please specify) \_\_\_\_\_



Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(Last) (First) (Middle)

**Name of Provider Being Seen:**

Craig Wright, MD

Julie Hannah, FNP-C

Mary Lauren Pfeiffer, 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: \_\_\_\_\_

**REASONS FOR YOUR APPOINTMENT:**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

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:

<b>General</b>	Weight Loss ___ Weight Gain ___ Fever ___ Night Sweats ___ Fatigue ___ None ___
<b>Eyes</b>	Blurry Vision ___ Loss of Vision ___ Eye Pain ___ Eye Redness ___ Dry Eyes ___ None ___
<b>ENT</b>	Sore Throat ___ Sinus Trouble ___ Hoarse Voice ___ Hearing Loss ___ Ringing in Ears ___ Ear Pain ___ Tooth Problems ___ None ___
<b>Cardiovascular</b>	Chest Pain ___ Rapid Heartbeat ___ Murmur ___ Leg Swelling ___ Leg Pain when Walking ___ None ___
<b>Respiratory</b>	Shortness of Breath ___ Cough ___ Sputum Production ___ Coughing up Blood ___ None ___
<b>Gastrointestinal</b>	Nausea ___ Vomiting ___ Diarrhea ___ Constipation ___ Abdominal Pain ___ Blood in Stool ___ Frequent Heartburn ___ Trouble Swallowing ___ None ___
<b>Genitourinary</b>	Burning with Urination ___ Incontinence ___ Blood in Urine ___ Excessive Urination at Night ___ Erectile Dysfunction ___ Vaginal Discharge ___ Breast Lump or Pain ___ None ___
<b>Musculoskeletal</b>	Joint Pain ___ Muscle Pain ___ Muscle Weakness ___ Back Pain ___ None ___ <i>If so, list where: _____</i>
<b>Endocrine</b>	Increased Thirst ___ Excessive Sweating ___ Heat Intolerance ___ Cold Intolerance ___ Poor appetite ___ Irregular Menstrual Periods ___ None ___
<b>Neurologic</b>	Headaches ___ Tremor ___ Tingling/Numbness ___ Dizziness ___ Speech Difficulty ___ None ___
<b>Psychiatric</b>	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>
<b>Hematologic/ Lymphatic</b>	Easy Bruising ___ Swollen Lymph Nodes ___ None ___
<b>Skin</b>	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: \_\_\_\_\_