

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 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 a 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___ <i>If so, list where:</i> _____ |
| 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 ___ <i>If you suffer from any of the above, do you desire psychiatric help: YES NO</i> |
| 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:** _____