PREMIER MEDICAL GROUP

PATIENT REGISTRATION FORM

Full Legal Name: _____ DOB: ____ / ____ / ____ Gender: _____ SSN: _____ - _____ - _____

Address: _____ Apt: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____ Preferred contact number: ☐ Home ☐ Cell

Email address: _____ Primary Language Spoken: _____

Emergency Contact: _____ Relation: _____ Phone: (____) _____ - _____

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

Ethnicity: ☐ Hispanic/Latino ☐ Non Hispanic/Latino ☐ Unknown ☐ Declined

FINANCIAL POLICIES

Patient Insurance Responsibility: I understand that as a patient, I am responsible for fully understanding my health insurance policy, including: co-pay, deductible, benefits, and co-insurance related costs. I understand that any applicable co-pay or deductible amount will be due upon check-in. We strive to be as accurate as possible when calculating your responsibility but, with so many variations in policies and fee schedules, we are not always exact.
_____ **INITIALS**

Financial Policy: I understand that I am financially responsible for any co-pays, deductibles, coinsurance and charges which are not covered by my insurance. I understand that verification of coverage is not a guarantee of payment of benefits. My insurance company determines benefit payments.
_____ **INITIALS**

Forms: I understand there will be an additional $50 charge for forms deemed appropriate (FMLA, Disability, etc.) that need to be filled out by a Provider without an appointment.
_____ **INITIALS**

Non-Sufficient Funds: I understand there will be a $25 charge for any check returned due to non-sufficient funds.
_____ **INITIALS**

Collection Policy: I understand that I may be turned over to collections for further processing if a payment has not been made on my account within 90 days. NO ADDITIONAL APPOINTMENTS WILL BE MADE ON DELINQUENT ACCOUNTS UNTIL THEY ARE CURRENT. In the event that my account is transferred to a licensed collection agency; I agree to pay the fees of the collection agency equal to a maximum of 50% of our outstanding balance at the time the account is placed with the collection agency; interest of 10% per year will be accrued on the principal balance. Should legal action be necessary to collect the account, I agree to pay attorney fees and court costs incurred for collection.
_____ **INITIALS**

Specimen Handling: Any specimens collected in-house will be sent to a contracted lab based on the health insurance provided by you at time of service. Specimens may be split and sent to different facilities as needed. Specimens are collected and tested to determine diagnosis and treatment, while it is considered medically necessary we cannot guarantee that your health plan will cover the service. While we make every effort to use the proper medical coding, coverage is ultimately determined by your health plan.
_____ **INITIALS**

I acknowledge that this office does not verify my insurance and cannot tell me if a provider is in network. I am responsible for determining my own benefits and coverage for all services. I am responsible for all medical charges that are not covered by insurance. By signing below I authorize appropriate examination and treatment for problems identified on this and subsequent visits. A copy of our Notice of Privacy Practices is available for you at the front desk if you would like one. By signing below I acknowledge it has been made available to me.

RESPONSIBLE PARTY SIGNATURE: _____ **DATE:** _____

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Telephone (480) 838-3100
Fax (480) 838-3902

Medical Information Release Form

Name _____ Date of Birth _____ / _____ / _____

Release of Information

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

Name _____ **Relationship** _____

Name _____ **Relationship** _____

Name _____ **Relationship** _____

Name _____ **Relationship** _____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Signed _____ Date _____ / _____ / _____

Health Information Exchange

Your healthcare provider participates in a non-profit, non-governmental health information exchange (HIE) called Health Current. It will not cost you anything and can help your doctor, healthcare providers, and health plans better coordinate your care, by allowing your providers to securely access your health records.

The following types of health information may be available:

- Hospital records
- Medical history
- Medications
- Allergies
- Lab test results
- Radiology reports
- Clinic and doctor visit information
- Health plan enrollment and eligibility
- Other information helpful for your treatment

By signing below, I acknowledge I have received, read, and understand the Notice of Health Information Practices regarding my provider's participation in the statewide Health Information Exchange (HIE), **OR** that I have previously received this information and decline another copy.

Full name _____ DOB _____

Signature _____ Today's date _____

MEDICAL HISTORY INTAKE FORM

Please complete all sections to assist us in providing you and your family with the best healthcare.

Last Name **First Name** **MI** **DOB**

MEDICATIONS

List all medications you take, prescription and non-prescription and their dosage: ☐ **NO MEDICATIONS**

Medication	**Dose**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

MEDICATION/FOOD ALLERGIES

Allergies

Are you allergic to penicillin or any other drugs? ☐ Yes ☐ No

Please list: _____ **Reaction:** _____

Food	**Reaction**	**Food**	**Reaction**	**Food**	**Reaction**
☐ Chocolate		☐ Peanuts		☐ Strawberries	
☐ Corn		☐ Red Dye		☐ Wheat	
☐ Eggs		☐ Rice		☐ Other:	
☐ Iodine or Shellfish		☐ Soy		☐ Other:	

Please indicate if you have ever experienced any of the following conditions. Please include the date of experience.

☐ Alcohol Dependence	__/__/__	☐ Diabetes Type I	__/__/__	☐ Hepatitis	__/__/__
☐ Allergies	__/__/__	☐ Diabetes Type II	__/__/__	☐ Kidney Stones	__/__/__
☐ Anemia	__/__/__	☐ Diarrhea	__/__/__	☐ Other Kidney Disease	__/__/__
☐ Angina	__/__/__	☐ Disc Degeneration	__/__/__	_____	
☐ Anxiety	__/__/__	☐ Duodenal Ulcer	__/__/__	☐ Liver Disease	__/__/__
☐ Arthritis	__/__/__	☐ Emphysema	__/__/__	☐ Low Blood Pressure	__/__/__
☐ Asthma	__/__/__	☐ Esophageal Reflux	__/__/__	☐ Migraines	__/__/__
☐ Blood Clots	__/__/__	☐ Gallbladder Stones	__/__/__	☐ Mixed Hyperlipidemia	__/__/__
☐ Broken Bones	__/__/__	☐ Goiter	__/__/__	☐ Obesity	__/__/__
☐ Cancer	__/__/__	☐ Gout	__/__/__	☐ Osteoarthritis	__/__/__
Type: _____		☐ Headache	__/__/__	☐ Osteoporosis	__/__/__
☐ Chronic Blood Thinner Use	__/__/__	☐ Heart Attack	__/__/__	☐ Palpitations	__/__/__
☐ Chronic Bronchitis	__/__/__	☐ Heart Disease	__/__/__	☐ Rheumatoid Arthritis	__/__/__
☐ Chronic Fatigue Syndrome	__/__/__	☐ Other Heart Disease	__/__/__	☐ Sciatica	__/__/__
☐ Chronic Hepatitis	__/__/__	_____	_____	☐ Seizures/Epilepsy	__/__/__
☐ Chronic Kidney Disease	__/__/__	☐ Heart Failure	__/__/__	☐ Sleep Apnea	__/__/__
☐ Chronic Neck Pain	__/__/__	☐ Hepatitis	__/__/__	☐ Stomach Ulcer	__/__/__
☐ Chronic Sinusitis	__/__/__	☐ High Blood Pressure	__/__/__	☐ Stroke (CVA)	__/__/__
☐ Circulatory Disease	__/__/__	☐ High Cholesterol	__/__/__	☐ Thyroid Disease	__/__/__
☐ Colitis	__/__/__	☐ Irregular Heart Rhythm	__/__/__	☐ Tinnitus	__/__/__
☐ Congestive Heart Failure	__/__/__	☐ Hypertension	__/__/__	☐ Tuberculosis	__/__/__
☐ COPD	__/__/__	☐ Hyperthyroidism	__/__/__	☐ Other:_____	__/__/__
☐ Crohn's Disease	__/__/__	☐ Insomnia	__/__/__	☐ COVID-19	__/__/__
☐ Depression	__/__/__	☐ Irritable Bowl Syndrome	__/__/__		

SURGICAL HISTORY

☐ Angioplasty	__/__/__	☐ Cholecystectomy	__/__/__	☐ Liver Biopsy	__/__/__
☐ Angioplasty w/stent	__/__/__	☐ Colectomy	__/__/__	☐ Open Reduction Internal Fixation	__/__/__
☐ Appendectomy	__/__/__	☐ Colostomy	__/__/__	☐ Pacemaker	__/__/__
☐ Arthroscopy Knee	__/__/__	☐ Gastric Bypass	__/__/__	☐ Small Bowel Resection	__/__/__
☐ Back Surgery	__/__/__	☐ Hernia Repair	__/__/__	☐ Thyroidectomy	__/__/__
☐ Coronary Artery Bypass Graft	__/__/__	☐ Hip Replacement	__/__/__	☐ Tonsillectomy	__/__/__
☐ Carpal Tunnel Release	__/__/__	☐ Knee Replacement	__/__/__		
☐ Cataract Extraction	__/__/__	☐ LASIK	__/__/__		
☐ Other: _____	__/__/__				

☐ Augmentation Mammoplasty	__/__/__	☐ Masectomy	__/__/__
☐ Bilateral Tubal Ligation	__/__/__	☐ Myomectomy	__/__/__
☐ Breast Biopsy	__/__/__	☐ Reduction Mammoplasty	__/__/__
☐ Cesarean Section	__/__/__	☐ TAH/BSO (Total Abdominal Hysterectomy)/ (Bilateral Salpingo-Oophorectomy)	__/__/__
☐ D and C (Dilation and Curettage)	__/__/__	☐ Vaginal Hysterectomy	__/__/__
☐ Hysterectomy	__/__/__		
☐ Other:_____	__/__/__		

FAMILY HISTORY

Please check if any family member has had any of the following conditions: ☐ **Adopted**

	Mother	Father	Sibling(s)	Grandparents	Children	Cause of Death
☐ ADD/ADHD						
☐ Alcoholism						
☐ Allergies						
☐ Alzheimer's Disease						
☐ Asthma						
☐ Blood Disease						
☐ Heart Disease						
☐ Heart Disease before age 50						
☐ Cancer						
Type:						
☐ Depression						
☐ Developmental Delay						
☐ Diabetes						
☐ Eczema						
☐ Hearing Deficiency						
☐ High Cholesterol						
☐ Hypertension						
☐ Inflammatory Bowel Disease						
☐ Kidney Disease						
☐ Learning Disability						
☐ Mental Illness						
☐ Migraines						
☐ Obesity						
☐ Osteoporosis						
☐ Peripheral Vascular Disease						
☐ Seizures/Epilepsy						
☐ Stroke (CVA)						
☐ Other:						
☐ Other:						

SOCIAL HISTORY

Do you use tobacco? □ Yes □ No □ Former Type of tobacco used? _____

Packs per day? _____ Years smoked? _____ Year quit? _____

Other Tobacco (cans, cigars, etc)? _____ Units per day? _____ Years Used? _____

Do you drink caffeine? □ Yes □ No Type? _____ Amount Daily? _____

Do you drink alcohol? □ Yes □ No □ Former Year Quit? _____

Type? _____ How much per week? _____

Amount? _____ Last Drink? _____

Do you exercise regularly? □ Yes □ No If no, why? _____

What type of exercise? _____

Hand Dominance □ Left Handed □ Right Handed □ Both

Do you give permission to receive blood transfusion if medically necessary? _____

Do you have a preferred pharmacy? □ Yes □ No

Pharmacy: _____ Phone Number: _____

Address: _____

Pharmacy: _____ Phone Number: _____

Address: _____

Health Maintenance		**Date of Last**
Lipid Panel	□ Yes □ No	____/____/____
Stool cards/IFOBT	□ Yes □ No	____/____/____
History and Physical	□ Yes □ No	____/____/____
Colonoscopy	□ Yes □ No	____/____/____
Sigmoidoscopy	□ Yes □ No	____/____/____
Influenza Vaccine	□ Yes □ No	____/____/____
Pneumococcal Vaccine	□ Yes □ No	____/____/____
Tetanus Vaccine	□ Yes □ No	____/____/____
DEXA Scan	□ Yes □ No	____/____/____
Gyn Exam	□ Yes □ No	____/____/____
PAP	□ Yes □ No	____/____/____
Mammogram	□ Yes □ No	____/____/___
Breast Exam	□ Yes □ No	____/____/____

Disease Management		**Date of Last**
Abdominal Ultrasound	□ Yes □No	____/____/___
Cardiac Stress Test	□ Yes □No	____/____/___
Chest X-Ray	□ Yes □No	____/____/___
Echocardiogram	□ Yes □No	____/____/___
EKG	□ Yes □No	____/____/___
Eye Exam	□ Yes □No	____/____/___
Foot Exam	□ Yes □No	____/____/___
Pulmonary Function Tests	□ Yes □No	____/____/___

Patient Signature Date Provider Signature Date