PATIENT REGISTRATION FORM

**Today's Date: ______________________ *Clinic Name:* ______________________

PATIENT INFORMATION: (Please use full legal name, no nicknames)

*Last Name: ______________________ *First Name: ______________________ Middle Initial: __________

*Address: ____

City: ______________________ State: ______________ Zip: ______________

Home Phone #: (______) ______-__________ *Social Security #: ______________________

*Date of Birth: __________ Age: ________ *Sex: ______ Marital Status: __________ Drivers Lic#: __________

*Employer Name and Address: ____

______________________________ Work Phone #: (______) ______-__________

E-mail Address: ______________________________ Cell Phone #: (______) ______-__________

Emergency Contact Name: ______________________________ Emerg Phone #: (______) ______-__________

Please tell us how you heard about us: ______________________ *Referred by* ______________________

GUARANTOR INFORMATION: (List person or insured name responsible for bill - use full legal name, no nicknames)

*Relationship of Guarantor to Patient: Self _____ Spouse _____ Parent _____ Other __________

*Last Name: ______________________ *First Name: ______________________ Middle Initial: __________

*Address: ____

City: ______________________ State: ______________ Zip: ______________

Home Phone #: (______) ______-__________ *Social Security #: ______________________

*Date of Birth: __________ Age: __________ *Sex: Female ______ Male ______

*Employer Name and Address: ____

______________________________ Work Phone #: (______) ______-__________

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS

PRIMARY INSURANCE:

Plan Name : ______________________ *Insured's Name: ______________________

Insured's Social Security #: ______________________ *Insured's Date of Birth: ______________________

*Policy / ID #: ______________________ *Group #: ______________ Eff Date: ______________

Claims Address & Phone: ____

SECONDARY INSURANCE:

Plan Name : ______________________ *Insured's Name: ______________________

*Insured's Social Security #: ______________________ *Insured's Date of Birth: ______________________

*Policy / ID #: ______________________ *Group #: ______________ * Eff Date: ______________

Claims Address & Phone: ____

*REQUIRED FIELDS-PLEASE COMPLETE FOR BILLING. *ATTACH COPY OF INSURANCE CARDS.

Please read and sign back of form.

PATIENT REGISTRATION FORM
DISCLOSURES & CONSENTS

Patient Name: ____ Date of Birth: ______________
First Name M.I. Last Name

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to MedicalEdge Healthcare Group or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that MedicalEdge is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to MedicalEdge Healthcare Group or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have received and read a copy of the MedicalEdge Healthcare Group Patient Information Privacy Policy. I hereby authorize MedicalEdge Healthcare Group or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a MedicalEdge Healthcare Group representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying MedicalEdge Healthcare Group to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing, and treatment as directed by my MedicalEdge physician or his or her designee.

PATIENT SIGNATURE: ______________________________ DATE: ______________

GUARANTOR SIGNATURE: ______________________________ DATE: ______________
(If different from patient)

GUARANTOR NAME (Please Print): ______________________________

Clinic: ____________________

FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: ____________________ Date of Birth: __________ Date of Visit: __________

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any Medical service or visit, Preventative exam or physical, Lab testing, X-ray, EKG, and any other Screening service or Diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility and not the responsibility of the Physician or Clinic to know if my insurance will pay for my Medical service or visit, Preventative exam or physical, Lab testing, X-ray, EKG, or any other Screening service or Diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility to know if my insurance has any Deductible, Co-payment, Co-insurance, Out-of-Network amount, Usual and Customary Limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.

I understand and agree it is my responsibility to know if my PCP choice has been processed by my Insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.

Signature: ______________________________ **Date:** ____________________

(please sign here — Patient or Responsible Party)

Responsible Party Name: ______________________________

(please print name of Responsibility Party if different from Patient)

Patient Privacy Directive

In our efforts to comply with the Health Insurance Portability and Accountability Act (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.

Please circle your response to the following:

May we leave messages concerning your **appointments** with a co-worker, receptionist or secretary that regularly answer your calls? Yes No N/A

May we leave **messages** on a voice mail at work? Yes No N/A

May we leave **messages** on a voice mail at home? Yes No N/A

May we discuss your **appointments/treatment** with your spouse? Yes No N/A

If you are over the age of 18, still living at home, may we discuss your **appointments/treatment** with your parent(s) or guardian? Yes No N/A

If you are over the age of 18, may we discuss your **appointments and/or treatment** with your children? Yes No N/A

You must inform us, **in writing**, of any changes in your directives. This record takes effect on the date below and will be kept in your file .

I have received a copy of the "Notice of Privacy Practices"

Signature: ______________________ Date: ______________

Printed Name: ______________________ Date of Birth: ____________

Physician Office Representative______________________

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

This practice reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the "Notice of Privacy Practices"

____
Name of Patient (Print)

____
Signature of Patient   Date of Signature

____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

____
Relationship of Patient Representative to Patient

Request for Confidential Communication of Your Protected Health Information

Please circle your response to the following:

May we leave messages concerning your **appointments** with a co-worker, receptionist or secretary that regularly answer your calls? Yes No N/A

May we leave **messages** on a voice mail at work? Yes No N/A

May we discuss your **appointments/treatment** with your spouse? Yes No N/A

If you are over the age of 18, still living at home, may we discuss your **appointments/treatment** with your parent(s) or guardian? Yes No N/A

If you are over the age of 18, may we discuss your **appointments and/or treatment** with your children? Yes No N/A

You must inform us **in writing** if you wish to change the manner in which this office communicates to you.

Thank you.

Please place in the patient's medical record.

12/06

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of [name of practice]. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies who support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Research
Provider may disclose your medical information to people preparing to conduct a research project (for example, to help them look for patients with specific medical needs) so long as the medical information they review is not removed from the premises of this practice. Provider may also disclose the medical information of decedents for a research project, so long as the information is necessary for the research.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment Reminders. Your health information may be used by our staff to send you appointment reminders. If you would like this office to communicate your health information to you in a confidential manner, please indicate your wishes on the '*Acknowledgement of Receipt of HIPAA Notice of Privacy Practices*' form.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information;

- The right to receive confidential communications concerning your medical condition and treatment;
- The right to inspect and copy your protected health information;
- The right to amend or submit corrections to your protected health information;
- The right to receive an accounting of how and to whom your protected health information has been disclosed; &
- The right to receive a printed copy of this notice.

Practice Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this "Notice of Privacy Practices".

We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting this practice. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter or placing a call outlining your concerns to:

HIPAA Privacy Officer
MedicalEdge Healthcare Group
9229 LBJ Freeway
Dallas, TX 75243
(972) 792-3803

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You may also submit complaints to the Secretary of Health and Human Services.

You will not be penalized or otherwise retaliated against for filing a complaint.

New Patient Medical History

Name: ____________________

Date of Birth: ____________________ **Sex:** Female Male

What is the main problem for which you are being seen?

MEDICAL HISTORY: Please check all of your current or past medical problems

- [ ] Allergies
- [ ] Asthma
- [ ] Emphysema / COPD
- [ ] Diabetes
- [ ] High Blood Pressure
- [ ] Cancer
- [ ] High cholesterol
- [ ] Thyroid problems
- [ ] Heart problems
- [ ] Seizures
- [ ] ____________
- [ ] ____________
- [ ] ____________
- [ ] ____________
- [ ] ____________

FAMILY HISTORY: Please check all of the following that run in your family

- [ ] Allergies
- [ ] Asthma
- [ ] Cancer
- [ ] Emphysema / COPD
- [ ] Diabetes
- [ ] High Blood Pressure
- [ ] High cholesterol
- [ ] Thyroid problems (low / high)
- [ ] Heart problems
- [ ] Seizures
- [ ] ____________
- [ ] ____________
- [ ] ____________
- [ ] ____________
- [ ] ____________

SURGERIES: Please list any surgeries you may have had

ALLERGIES: Please list any allergies to medications you may have

- [ ] **No known allergies**

SOCIAL HISTORY:

Do you smoke cigarettes? ☐ no ☐ yes If so, how many per day? ______________
Did you smoke in the past? ☐ no ☐ yes
Do you drink alcohol? ☐ no ☐ yes How many drinks per day / week / month ________.
Did you drink in the past? ☐ no ☐ yes
Do you use illicit drugs of any kind? ☐ no ☐ yes If so, what kind and how often ______________
Have you *ever* used drugs? ☐ no ☐ yes

PREVENTIVE MEDICINE TESTING

Please mark all the following tests that you have had performed and the dates they were done.

Test	Date		
☐ EKG	______	☐ Normal	☐ Abnormal
☐ Stress test	______	☐ Normal	☐ Abnormal
☐ Echocardiogram	______	☐ Normal	☐ Abnormal
☐ Colonoscopy	______	☐ Normal	☐ Abnormal
☐ TB Test	______	☐ Normal	☐ Abnormal
☐ Pneumonia vaccine	______		
☐ Flu shot	______		
☐ Tetanus shot	______		

FEMALES

Test	Date		
☐ Pap Smear	______	☐ Normal	☐ Abnormal
☐ Mammogram	______	☐ Normal	☐ Abnormal
☐ Bone Density Test	______	☐ Normal	☐ Abnormal

MALES

Test	Date		
☐ PSA	______	☐ Normal	☐ Abnormal
☐ Prostate / Rectal Exam	______	☐ Normal	☐ Abnormal

If you are diabetic, when was your last eye exam? ______________

MEDICATIONS

Please list all of your medications, including dose and frequency.
Use the back of the page if necessary.

REVIEW OF SYSTEMS Please mark any symptoms you have now, or have had in the last six months.

General:
- [ ] Weight gain
- [ ] Weight loss
- [ ] Loss of appetite
- [ ] Fever
- [ ] Chills
- [ ] Fatigue

Skin:
- [ ] New area of concern
- [ ] Bruising
- [ ] Rash
- [ ] Itching

Head:
- [ ] Blurred Vision
- [ ] Vision Change
- [ ] Headache
- [ ] Hearing Loss
- [ ] Ear Pain
- [ ] Ringing in the Ears
- [ ] Vertigo
- [ ] Nasal Congesion
- [ ] Runny Nose
- [ ] Sore Throat

Neck:
- [ ] Swelling
- [ ] Pain
- [ ] Glands Swollen

Respiratory:
- [ ] Cough
- [ ] Sputum Production
- [ ] Coughing up Blood
- [ ] Shortness of Breath
- [ ] Snoring
- [ ] Wheezing

Heart:
- [ ] Chest Pain
- [ ] Fainting
- [ ] Short of Breath on Exertion
- [ ] Swelling in legs / feet
- [ ] Irregular Heart Beat
- [ ] High Blood pressure
- [ ] Short of Breath lying down
- [ ] Palpiations

GI:
- [ ] Abdominal Pain
- [ ] Bloody Stool
- [ ] Change in bowel habits
- [ ] Constipation
- [ ] Diarrhea
- [ ] Difficulty swallowing
- [ ] Gas
- [ ] Heartburn
- [ ] Dark black stools
- [ ] Nausea
- [ ] Vomiting

MS:
- [ ] Back pain
- [ ] Joint pain
- [ ] Joint redness
- [ ] Joint stiffness
- [ ] Joint swelling
- [ ] Muscle cramps
- [ ] Muscle aching
- [ ] Muscle weakness

Neuro:
- [ ] Dizziness
- [ ] Weakness
- [ ] Headaches
- [ ] Numbness
- [ ] Tingling
- [ ] Passing Out
- [ ] Tremor
- [ ] Unsteadiness

Psych:
- [ ] Anxiety
- [ ] Depression
- [ ] Insomnia
- [ ] Difficulty Concentrating

Endocrine:
- [ ] Cold Intolerance
- [ ] Heat Intolerance
- [ ] Excess Urination
- [ ] Thyroid Problems
- [ ] Excess Thirst
- [ ] Change in sex drive

Heme:
- [ ] Easy Bruising
- [ ] Prolonged Bleeding
- [ ] Enlarged Lymph Nodes

Women:
- [ ] Breast Lumps
- [ ] Nipple Discharge
- [ ] Breast Tenderness
- [ ] Heavy Periods
- [ ] Absent Periods
- [ ] Irregular Periods
- [ ] Pain with intercourse
- [ ] Vaginal Discharge
- [ ] Buring with urination
- [ ] Urinary hesitancy
- [ ] Urinary frequency
- [ ] Blood in urine

Men:
- [ ] Buring with urination
- [ ] Urinary hesitancy
- [ ] Urinary frequency
- [ ] Blood in urine
- [ ] Getting up at night to urinate
- [ ] Problems with erections
- [ ] Premature ejaculation
- [ ] Lump on testicle
- [ ] Pain in testicle
- [ ] Discharge from penis

Signature: ______________________ **Date:** ______________