PREMIER *medical group*

INSTRUCTIONS

Page 1 - *Patient Registration Form* - fill out entire page and sign at bottom of page.

Page 2 - Complete *Records Release Form* as required for your upcoming office visit.

Page 3 – Complete the *Health History Questionnaire* (per specialty).

Bring all paperwork, filled out, to your scheduled appointment along with:

- Medical insurance and prescription cards
- Any recent labs or radiology workups
- Picture ID
- List of medications

If your insurance requires a referral, you must bring it with you at the time of service or you will be required to sign a waiver holding you responsible.

NO SHOW POLICY

A FEE MAY BE CHARGED TO ANY PATIENT WHO DOES NOT CANCEL THEIR OFFICE VISIT WITHIN 24 HOURS AND WILL BE CHARGED FOR ANY NO SHOW FOR AN OFFICE PROCEDURE.

CO-PAYS ARE EXPECTED AT THE TIME OF SERVICE

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PATIENT REGISTRATION FORM

PATIENT ACCOUNT NUMBER: _____

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, MIDDLE INITIAL) SEX ❑ MALE ❑ FEMALE	PRIMARY PHYSICIAN
PATIENT'S ADDRESS	EMERGENCY CONTACT AND TELEPHONE #
CITY STATE ZIP	STUDENT STATUS: If 18 years or older: (Circle one) Full Time Part Time Not a Student
TELEPHONE ( ) CELL PHONE ( ) DATE OF BIRTH ___/___/___ MO DAY YEAR	MARITAL STATUS: (Circle one) Single Married Separated Divorced Widowed
RACE: **ETHNICITY:**	**PRIMARY LANGUAGE:** / **EMAIL ADDRESS:**

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME COPAY _____	SECONDARY INSURANCE COPAY _____
INSURANCE ADDRESS	INSURANCE ADDRESS
CITY STATE ZIP	CITY STATE ZIP
INSURED'S ID NUMBER GROUP PLAN NUMBER	INSURED'S ID NUMBER GROUP PLAN NUMBER
PATIENT'S EMPLOYER NAME TELEPHONE ( )	**PHARMACY NAME** **TELEPHONE** ( )
EMPLOYER'S ADDRESS	**PHARMACY ADDRESS**
CITY STATE ZIP	CITY STATE ZIP

RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY'S NAME (LAST, FIRST, MIDDLE)	SEX ❑ MALE ❑ FEMALE	LEGAL REPRESENTATIVE ❑ YES ❑ NO
RESPONSIBLE PARTY'S ADDRESS	EMPLOYER'S NAME	
CITY STATE ZIP	EMPLOYER'S ADDRESS	
TELEPHONE ( )	RELATIONSHIP TO PATIENT SPOUSE PARENT GUARDIAN OTHER _____	

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

If your insurance requires a written referral from your physician and you do not obtain one prior to your visit or procedure, you will be responsible for payment for Services rendered.

COPAYMENTS ARE EXPECTED AT THE TIME SERVICES ARE RENDERED.

If this account is assigned to an attorney of collection and/or suit, the practice shall be entitled to reasonable attorney's fees and costs of collection.
I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.
I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance and other health plans to the practice named on this form.
This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

I AGREE TO THE ASSIGNMENTS AND FINANCIAL RESPONSIBILITIES SHOWN ON THIS PAGE. **YOU SHOULD READ THESE TERMS CAREFULLY.** THANK YOU FOR YOUR COOPERATION.

X _____ DATE _____
SIGNED (Patient, or parent if under 18 years of age)

PREMIER medical group

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

_____

TELEPHONE: _____

I hereby authorize _____to disclose the following Protected Health Information (PHI) to _____.

PHYSICIAN PHONE: _____FAX: _____

The following information is to be disclosed: (please check off those that apply)

Physician notes _____ Dates _____
Lab results _____ Dates _____
X-Ray reports _____ Dates _____
Operative reports _____Dates _____
COMPLETE RECORD _____
Other: _____

The PHI to be used or disclosed for the following purposes:

I understand that the information in my record may include information relating to sexually transmitted diseases (STD), Acquired Immunodeficiency Syndrome (AIDS), or infection of the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol or drug abuse.

PREMIER MEDICAL GROUP will not determine my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide an authorization. I understand that I may inspect or obtain a copy of the information to be used or disclosed. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State laws.

Unless otherwise revoked, this authorization will expire on the following date, event or condition: (if I do not specify an expiration date, event or condition, this authorization will expire in one year from the date signed). DATE: _____

Signature of patient or patient representative

_____

Date

_____

Revised 4/29/15

PREMIER *medical group*

Patient Name _____ Date of birth _____

Medical History

Primary Care Physician_____ Date of last visit _____
Pharmacy name and location _____
Former foot doctor_____
Previous foot care_____
Explain your foot/ankle problem_____

Please circle any symptoms in feet:

Burning Numbness Sharp Other_____

Circle pain level (10 being worst) 1 2 3 4 5 6 7 8 9 10

When did pain/discomfort begin? _____
What makes pain/discomfort better? _____
What makes pain/discomfort worse? _____
If condition has been treated, explain _____

Social History:

Height _____ Weight_____ Shoe size_____ Are you pregnant? _____ Nursing?_____
Do you have diabetes? _____ Are you insulin dependent? _____ Last A1C _____ Date of last A1C _____
Do you use tobacco? _____ How often? _____ Former smoker quit date _____
Do you use: Alcohol _____ Caffeine_____ Illegal drugs_____

List all medication names, doses & frequency (Attach list if possible)

_____
_____
_____

List all allergies (including environmental, adhesive, drug)_____
_____

List all surgeries and dates performed _____
_____

Family History Circle all that apply and whom it applies to.

Diabetes	mother/father	Heart disease	mother/father	Bleeding disorder	mother/father
Mental illness	mother/father	Stroke	mother/father	High blood press.	mother/father
Kidney disease	mother/father	Cancer	mother/father	Arthritis	mother/father

Other _____
_____ NONE OF THE ABOVE

** Please note your insurance company/government requires you to check YES or NO to each box **

Please check if you currently have or had a recurring history of the conditions listed below

Constitutional Symptoms:	Yes	No	Gastrointestinal:	Yes	No
Chills			Stomach Ulcers		
Sweats			Nausea		
Weight Loss			Vomiting		
Fevers			Diarrhea		
Other:			Constipation		
Head, Eyes, Ears, Nose, and Throat			Heartburn		
Wear: Contacts? Eyeglasses			Blood in Stool		
Glaucoma			Hepatitis		
Double Vision			Acid Reflux		
Dizziness			Irritable Bowel Syndrome		
Cataracts			**Endocrine:**		
Nose Bleeds			Often: Thirsty/Urination		
Ringing in Ears			Hypoglycemia		
Difficulty Swallowing			Kidney Disease		
Other:			Premenopausal symptoms		
Cardiovascular:			Thyroid Disorder: Hyper/Hypo PLEASE CIRCLE ONE		
Phlebitis			High Cholesterol		
High Blood Pressure			Gout		
Chest Pain/ Heart Attack/ Cardiovascular Sx			**Musculoskeletal:**		
Congestive Heart Failure			Tendonitis/Bursitis		
Heart Murmur			Arthritis		
Palpitations			Broken Bones: _____		
Mitral Valve Prolapse			Joint: Pain/Swelling		
Swelling in Legs/Ankles			Other:		
Leg Pain/Cramping			**Nervous System:**		
Other:			Migraines		
Hematological/Lymphatic (blood):			Seizures		
Prolonged: Healing/Bleeding			Strokes		
Anemia			Ataxia (loss of balance)		
Lump in Groin or behind knee			Numbness: tingling/ loss of sensation: Where:_____		
Lymphoma			Neuropathy (loss of sensation)		
Swollen Gland			Other:		
Bruise easily			**Skin Conditions:**		
HIV/AIDS			Rash		
Respiratory:			Sensitivity to Sun		
Shortness of Breath			Skin Ulcers		
Emphysema			Keloid (scarring)		
Cough			Contact Dermatitis		
Bronchitis			Growth on Skin		
Difficulty Breathing			Recurrent Infections		
Asthma			Cracking of the Skin		
Previous Pulmonary Disease			Eczema/Dermatitis/Psoriasis		
Pneumonia			**Genitourinary:**		
TB (tuberculosis) exposure/treatment			Urination: Painful/Bloody		
Other:			STD's:_____		
Psychiatric: History of…			Dialysis		
Nervousness			Other:		
Tension			**Other:**		
Depression			Cancer: Type_____		
Anxiety			Lyme Disease		

To the best of my knowledge, the questions on these forms have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient/Guardian Signature:_____ Date:_____