

Eastside Medical Group
Patient Registration Form

PATIENT INFORMATION

(Please Print)

Dr. Mr. Mrs. Ms. Jr./Sr.

Patient's Name (Last) _____ (First) _____ (MI) _____ Previous Name _____

Address _____

City, State _____ ZIP _____

Home Phone _____ Cell No. _____ Work Phone _____ Ext. _____

E-Mail Address: _____

Date of Birth MM ____/DD ____/YYYY _____ Sex F - Female M - Male Transgender

Social Security Number ____ - ____ - ____

Race/Ethnicity Asian Black or African American Caucasian Hispanic or Latino
 American Indian/Alaska Native Native Hawaiian/Other Pacific Islander Declined

Language English Spanish Other _____

Marital Status Married Single Divorced Widowed Legally Separated Partner

Primary Care Provider (PCP) _____ Referring Provider _____

Pharmacy _____ Pharmacy Phone _____

Employer Name _____ Employer Phone _____

Employment Status 1 - Full-Time 2 - Part-Time 3 - Not Employed 4 - Self-Employed 5 - Retired 6 - Active
Military

Emergency Contact Last Name _____ First Name _____

Phone Number _____ Relationship to Patient _____

Do you have a living will? Yes No

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Self

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Date of Birth MM ____/DD ____/YYYY _____ Sex F - Female M - Male

Social Security Number ____ - ____ - ____ Telephone _____

E-Mail Address _____

(If different from patient) Address _____ City, State _____ ZIP _____

Employer _____ Employer Phone Number _____

INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Primary Insurance _____ Insured _____ DOB _____

Secondary Insurance _____ Insured _____ DOB _____

How did you hear about us?

- Website Internet Search Internet Advertisement Family/Friends Facebook Magazine/Newspaper Ad
 Another healthcare provider: _____ Physician Directory Hospital MD Referral - Medline

EASTSIDE MEDICAL GROUP
Patient HIPAA Acknowledgment and Consent Form

Patient Name: _____

Date of Birth: _____

_____(Patient initials) **Notice of Privacy Practices.** I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____(Patient initials) **Release of Information.** I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family Members

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			

Financial acknowledgement for Private Pay Patients or Patients without Insurance

Patients who do not have insurance coverage are expected to pay charges in full at the time services are rendered. I agree that I am financially responsible for all charges incurred during the time of service.

Signature of Patient or Personal Representative **Date**

Assignment and Authorization of Benefits for Patients with Insurance

I hereby assign all medical and/or surgical benefits, to which I am entitled, including Medicare, private insurance, and other plans to the practice. I understand that I am financially responsible for all charges, co-payments, co-insurance and deductibles. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical record. I authorize insurance claims filed and benefits assigned.

Signature of Patient or Personal Representative **Date**

Medicare Patient's Only Lifetime Authorization

I certify that the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration of its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payments of authorized benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

I assign the benefits payable for services to _____. Patient Initial: _____

I request this authorization also apply to all other insurance. Patient Initial: _____

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

_____ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is _____.

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is _____.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Revocation

I hereby revoke my request for future communications via email and/or text.

I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.

I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.

NOTE: *This revocation only applies to communications from this Practice.*

Patient Name: _____

Patient/Patient Representative Signature: _____

Date: _____ Time: _____

Consent for Photographing or Other Recording for Security and/or Health Care Operations

_____ (Patient Initials) I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

_____ (Patient initials) I wish to designate the following family member / friend to pick up an order on my behalf:

Name: _____ Date: _____

Name: _____ Date: _____

_____ (Patient initials) I do not want to designate anyone to pick-up my prescription order.

Patient Signature _____ Date _____

Eastside Medical Group:

DATE: _____

Name: _____ Date of Birth: _____ Age: _____

Male / Female (circle one)

Pregnant Yes / No (circle one)

Reason you are here: _____

SOCIAL HISTORY

Marital Status: Single Married Partner Divorced Widow/Widower
Children _____ Occupation/Job _____ Religion _____

HABITS

Do you dip or chew tobacco? Yes No If yes, how much per day? _____

Smoking:

Never smoked Former smoker Date Quit _____ Current smoker / How Long? _____ Packs per day? _____

Do you drink alcoholic beverages? If yes, how many per week? _____

Do you drink beverages that contain caffeine: (coffee, tea, soda) _____ cups per day

Do you use recreational drugs? If yes, what and how often? _____

CURRENT MEDICATIONS:

Include herbal and over-the-counter drugs. List and name dose. Using additional sheet if needed.

(If you brought a medication list or brought your medications DO NOT FILL OUT)

1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

MEDICATION ALLERGIES:

No medication allergies

Are you allergic to latex? Yes No

PAST MEDICAL HISTORY

Please check below if you have, or have had any of the following medical conditions

No Past medical problems

- Acid reflux
- Adverse reaction to anesthesia
- Alzheimer's significant memory loss
- Anemia
- Angina or chest pain
- Arthritis
- Asthma
- Atrial fibrillation or erratic heartbeat
- Bleeding problems
- Blood transfusion
- Blood clot in leg(s) or lung(s)
- Bruise easily
- Cancer Type: _____
- Thyroid Disease
- Other not listed, explain:

- Congestive heart failure
- Dental disease
- Depression
- Diabetes
- Emphysema
- Epilepsy/Seizures
- Fibromyalgia
- Gallbladder disease
- Gout
- Heart disease
- Hemophilia / Excessive bleeding
- Hepatitis
- High blood pressure / Hypertension
- High cholesterol
- Tuberculosis

- HIV or Aids
- Infections: _____
- Kidney/Bladder disease
- Leg pain
- Lung disease
- Osteoporosis
- Peripheral vascular disease
- Pneumonia
- Psychiatric disorder
- Rheumatoid arthritis
- Sickle cell
- Sleep apnea / CPAP machine
- Stroke

FAMILY HISTORY

Please check below if Mother, Father, Siblings have had any of the following: **No family medical history to report**

	Who		Who
<input type="checkbox"/> Adverse reaction to anesthesia	_____	<input type="checkbox"/> Blood clots/Pulmonary embolism	_____
<input type="checkbox"/> Bleeding disorders	_____	<input type="checkbox"/> Cancer Type & Age	_____
<input type="checkbox"/> Depression	_____	<input type="checkbox"/> Osteoporosis	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Rheumatoid Arthritis	_____
<input type="checkbox"/> Heart Disease (age at first event)	_____	<input type="checkbox"/> Stroke (age at first event)	_____
<input type="checkbox"/> Hypertension	_____		

SURGICAL HISTORY

Please check below if you have had any of these surgeries

No Previous Surgeries

	Year		Year		Year
<input type="checkbox"/> Aneurysm – Abdominal	_____	<input type="checkbox"/> Colon surgery	_____	<input type="checkbox"/> Open heart surgery	_____
<input type="checkbox"/> Angioplasty / stents	_____	<input type="checkbox"/> Fistula R or L	_____	<input type="checkbox"/> Pacemaker/Defibrillator	_____
<input type="checkbox"/> Appendectomy	_____	<input type="checkbox"/> Gallbladder	_____	<input type="checkbox"/> Prostate surgery	_____
<input type="checkbox"/> Artery bypass of arm/ leg	_____	<input type="checkbox"/> Gastric bypass surgery	_____	<input type="checkbox"/> Spine surgery	_____
<input type="checkbox"/> Breast surgery	_____	<input type="checkbox"/> Heart stents	_____	<input type="checkbox"/> Tonsils	_____
<input type="checkbox"/> Caesarean section	_____	<input type="checkbox"/> Hernia surgery where	_____	<input type="checkbox"/> Total hip / knee	_____
<input type="checkbox"/> Carotid surgery	_____	<input type="checkbox"/> Hysterectomy	_____	<input type="checkbox"/> Other not listed, explain: _____	
<input type="checkbox"/> Cataract surgery	_____	<input type="checkbox"/> Nasal surgery	_____		

HOSPITALIZATIONS

No Past Hospitalizations

Date: (Mo/Yr)	Reason
_____	_____
_____	_____
_____	_____

GYN HISTORY

<input type="checkbox"/> LMB	_____	<input type="checkbox"/> Last PAP Smear (date)	_____
<input type="checkbox"/> Last Mammogram (date)	_____	<input type="checkbox"/> Last Dexascan (date)	_____
<input type="checkbox"/> Hx of Abnormal PAP smear		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> STD	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Birth Control	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	

To Be Filled Out By Nurse

Review of symptoms negative

HEIGHT: _____ WEIGHT: _____ TEMP: _____ PULSE: _____ O2 SAT: _____

BP RIGHT ARM: _____ BP LEFT ARM: _____

FLU SHOT: _____ Date: _____

Diagnosis _____