Patient Registration

CURRENT PATIENT INFORMATION -- PLEASE PRINT	Guarantor Information (to whom statements are sent)
Last Name: _____	Name: _____
First Name: _____	Address: _____
Middle Name: _____	_____
Address: _____	Relationship to patient: _____
City: _____ State: _____	Date of Birth: _____
Zip: _____	Social Security No.: _____
Home Phone: _____	Phone: _____
Work Phone: _____	**Emergency Contact Information**
Mobile Phone: _____	Name: _____
Sex: ____	Relationship: _____
Date of Birth: _____	Phone: _____
Social Security No.: _____	Mobile Phone: _____
Patient email: _____	
Required by government mandate [although you may refuse]:	**Employer information**
Language: _____	Employer: _____
Race: _____	Address: _____
Ethnicity: _____	Phone: _____
Marital Status: _____	

Other	Pharmacy Information:
Patient Referred by:	Name: _____
Primary Care Provider:	Crossroads: _____
Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email	Phone:

Primary Insurance Information	Secondary Insurance Information
Insurance Plan Name: _____	Insurance Plan Name: _____
Last Name:_____	Last Name:_____
First Name: _____	First Name: _____
Middle Name: _____	Middle Name: _____
Address: _____	Address: _____
City: _____ State: ____ Zip: _____	City: _____ State: ____ Zip: _____
Date of Birth: _____ Sex (please circle): **M** or **F**	Date of Birth: _____ Sex (please circle): **M** or **F**
Employer Name: _____	Employer Name: _____
Patient's relationship to policy holder: _____	Patient's relationship to policy holder: _____

To the best of my knowledge the above information is complete and accurate.

Signed_____ **Date:**_____

GENERAL CONSENT FOR TREATMENT

AUTHORIZATION FOR TREATMENT:

I voluntarily consent to the rendering of medical care, treatment and diagnosis, including such diagnostic, therapeutic or medical procedures to be performed by my attending physician, his or her designee, or assistants as is necessary in his or her judgment .

I understand that medical diagnosis and treatment may involve substantial risk. I understand that absent emergency or extraordinary circumstances, major therapeutic and diagnostic procedures will not be performed on me unless or until I have had the opportunity to discuss such procedures and the risks associated therewith to my satisfaction with my physician or other health care professional and I have consented to such procedure . I understand that the practice of medicine is not an exact science and I acknowledge that no guarantee has been made to me promising any specific result or outcome from any diagnostic or therapeutic treatment performed on me at the hospital .

Further, I understand and agree that medical, nursing, and other health care personnel in training may participate in my care and treatment as part of their education and training unless I request otherwise. I understand that I have the right to refuse or withhold my consent to any proposed diagnostic or therapeutic procedure . I have been afforded the opportunity to set forth below any limitation s to the general consent I have granted herein .

USE AND RELEASE OF INFORMATION:

I understand that Steward Medical Group will keep records that contain my medical, personal, and other information related to my diagnosis, care, and treatment in electronic, paper, and other forms. I understand that Steward Medical Group may release any information about me, my health, the health services provided to me, or payment for my health services, that may be necessary: (1) for my treatment (to other health care providers or facilities that need the information for my continued care); (2) for any purposes related to payment by me or a third party for services (to determine eligibility, to process insurance claims, for utilization and review, or for billing and collection purposes, as necessary to obtain payment); or (3) for the health care operations of Steward Medical Group or another health care provider that has had a relationship with me (quality assessment, training programs, planning, etc.). This information may include genetic test results or other information as needed for these purposes.

TELEMEDICINE:

I understand that Steward Medical Group may use telemedicine during the course of my care and treatment . Telemedicine uses audio and video equipment to permit a two- way, real- time, interactive communication between a patient and a physician or other practitioner who may be located at a distant site. The information gathered during a telemedicine encounter will be maintained in my medical record, and privacy and confidentiality of my medical information will be maintained at all times . The hospital will not record the actual audio or video transmission unless otherwise specified by my physician or practitioner . I understand that I have the right to withdraw my consent for telemedicine at any time without affecting my right to future care or treatment. I also understand that alternative methods of care may be available to me, and I may choose other options at any time.

ASSIGNMENTS OF BENEFITS:

I hereby assign to Steward Medical Group the right to all health insurance benefits otherwise payable to me, and I authorize Medicare and/or medical insurance benefits to be paid directly to Steward Medical Group. I agree to cooperate and provide information as needed to establish my eligibility for such benefits. A copy of this assignment and authorization may be used in place of the original.

FINANCIAL RESPONSIBILITY:

I understand that insurance may not pay the full amount of all my charges and I acknowledge that I am financial ly responsible and agree to pay my bill for non-covered services, as well as any deductibles, coinsurance or any amounts in excess of insurance benefits . If I am uninsured, I agree to assume full financial responsibility for payment of all charges.

SIGNATURE:

My signature below constitutes my acknowledgement that I have read and understand the above information, that any questions I have asked have been satisfactorily answered, and that I agree to this consent of treatment as described herein.

Patient's Signature: _____ Date: _____/_____/_____

Personal Representative: _____ Relationship to Patient: _____ Date: _____/_____/_____

Witness and/or Interpreter: _____ Date: _____/_____/_____

ACKNOWLEDGEMENT OF PRIVACY RIGHTS & PRACTICES AND CONSENT FOR COMMUNICATIONS

CONSENT TO USE OF TEXT MESSAGES

I consent to the receipt of text messages from Steward Medical Group and/or its agents on any phone number I provide. If I do not wish to continue receiving text messages, I can discontinue this service at any time.

Initials: _____ Cell Phone Number for Texting: (_____) _____- _____

CONSENT FOR PAYMENT & COLLECTION COMMUNICATIONS:

I agree that Steward Medical Group and its agents, including debt collectors, may contact me through the use of any dialing equipment (including a dialer, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice or message, even if I am charged for the call or message, for the purpose of servicing my account and collecting amounts due. I agree that such automated calls may be made to any telephone number (including numbers assigned to any paging, cellular, or mobile service, or any service) I have provided previously or may provide in the future in connection with my account, unless I have requested confidential communications from Steward Medical Group and its agents or a restriction on the disclosure of my healthcare information in accordance with the Notice of Privacy Practices and Steward Medical Group has agreed to such request. With this consent, I waive any claim I may have against Steward Medical Group and/or its agents, including debt collectors, for the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. I also agree that this provision applies to th e use of text messaging .

I understand there is a risk of a third-party accessing my health information when communicated over these media. I understand that I am not required to consent to these types of communications and a decision not to sign this consent authorization will not affect my health care in any way. If I prefer not to consent to these communication methods (opt out of receiving prerecorded telephone and text messages), I understand that Steward Medical Group will continue to use U.S. Mail or regular telephone messaging to communicate with me. I have read this consent and agree that Steward Medical Group may contact me as described above.

Patient's Signature: _____ Date: _____/_____/_____

NOTICE OF PRIVACY RIGHTS & PRACTICES – ACKNOWLEDGEMENT STATEMENT:

I acknowledge that I have received a copy of the Steward Notice of Privacy Practices. I understand that the Notice of Privacy Practices describes the ways in which Steward Medical Group may use and disclose my healthcare information for treatment, payment, and healthcare operations . I understand that I may contact the Privacy Officer identified in the Notice of Privacy Practices if I have questions or a complaint.

Patient's Signature: _____ Date: _____/_____/_____
(or signature of parent, representative/guardian if applicable)

Staff Use Only:
If unable to obtain acknowledgment, describe your attempt to obtain it and why you were unable to do so:

Reason: _____

Staff Signature: _____ Initials: _____ Date: _____/_____/_____

Patient Medical History Form

Patient Name_____ Date _____

Who referred you to our office?_____

Who is your Primary Care Doctor?_____

Surgical History (Please list all surgical procedures you have had in the past)

Surgery	Year	Surgeon

Family Medical History (please check pertinenet medical history for the listed family members

GF=Grandfather, GM=Grandmother

	Mother	Father	Brother	Sister	Maternal GM	Maternal GF	Paternal GM	Paternal GF
Heart Disease								
Cancer								
Diabetes								
Clotting Disorders								
Obesity								
Other (list)								

Patient Medical History Form

Patient Name_____

Drug Allergies (please list all drug allergies to include reaction)

Current Medications (please list all current medications and supplements with dosages or provide a list)

Medication	Dosage

Patient Medical History Form

Patient Name_____

Social History

Occupation_____ Marital Status_____

□ Live alone □ Live with Others

Tobacco: □ Nerver Smoked □ Former smoker □ Current every day smoker □ Current Someday smoker

□ Smoked within last year □ Quit date_____

Alcohol: □ None □ Occasional □ Moderate □ Heavy

Recreational Drugs_____ □ None □ Current □ Former

Caffeine: □ None □ Occasional □ Moderate □ Heavy

Special Diet?_____

Exercise: □ None □ Occasional □ Moderate □ Heavy

Dieting History (List all diet and exercise attempts within the last 5 years)

□ Physician Supervised Weight Loss Program
□ HCG Diet
□ Prescription Medications
□ Over the counter medications
□ Weight Watchers
□ Jenny Craig
□ Nutri System
□ Exercise/Personal trainer

The Epworth Sleepiness Scale

How likely are you to fall asleep in the following situations, in contrast to just feeling tired. Use the following scale to choose the most appropriate number for each situation.

Scale

0=Would never doze
1=slight chance of dozing
2=moderate chance of dozing
3=high chance of dozing

Score results

1-6 Congratulations you are getting enough sleep
7-8 Your score is average
9 and up-Very sleepy and should seek medical advice

Situation	
Sitting and reading	
Watching television	
Sitting inactive in a public place	
As a paasenger in a car for an hour without a break	
Sitting and talking to someone	
Sitting quitely after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	
Add together for **Total Score**	

Patient Medical History Form

Patient Name_____

Medical History (Please check all that apply)

General

Functional Status: □ Independent □ Partially dpeendent □ Totally dependent

Neurologic

□ Seizure □ Stroke □ Migraines

Cardiac

□ High Blood pressure □ History of heart attack □ Cardiac stents □ Cardiac Surgery

Vascular

□Venous stasis □ Vein thrombosis □ Coumadin □ IVC filter

Pulmonary

□ Asthma □ COPD □ Oxygen Dependent □ Pulmonary embolism □ Sleep apnea □ CPAP/BPAP

Gastrointestinal

□ Reflux □ Hiatal hernia □ Stomach ulcers □ Fatty liver disease

Endocrine

□ Diabetes Mellitus □ High Cholesterol □ Hypothyroid

Musculoskeletal

□ Osteoarthritic □ Rheumatoid arthritis □ Back Injury □ Ambulation is limited most of the time

Genitourinary

□ Renal Insufficiency □ Dialysis

Hematologic/Immune/Oncology

□ Anemia □ Routine steroid use or other Immunosuppressant □ Cancer_____

Psychological

□ Bipolar □ Eating Disorder □ Substance abuse □ Suicide attempt

Review Symptoms(Please check symptoms your are currently experiencing)

General	**Neurologic**	**Cardiac**	**Pulmonary**
□ Fatigue	□ Headaches	□ Chest Pain	□ Shortness of breath
□Weight gain/loss	□Memory loss	□Palpitations	□Chronic cough
□Hard of hearing	□Numbness	□Leg Swelling	□Wheezing
	□Weakness		

Ear/Nose/Throat	**Gastrointestinal**	**Genitourinary**
□ Hard of hearing	□ Heartburn	□ Urinary Incontinence
□Difficulty swallowing	□Abdominal Pain	□Difficult urination
Musculoskeletal	□Nausea/Vomitting	□Urinary frequency
□ Joint Pain	□Diarrhea	**Psychiatric**
□Impaired mobility	□ Constipation	□ Depression
		□ Panic attacks/anxiety

REQUEST FOR CONFIDENTIAL COMMUNICATION

I, _____, Date of Birth ___/___/___ request an alternative means of communication of my health information as designated below.

I understand that requests for communication by alternative means (location or person) in applicable only to information held by Steward Medical Group (SMG). This includes confidential communication related to my billing information requested from the SMG Business Office.

Please describe your proposed alternative means below, for receiving communication from SMG:

Alternate Means of Contact (*please specify if there is anyone with which we may share your protected health information*):

Name:_____ Date of Birth: ___/___/___

Relationship to You: _____ Phone# ( ) _____-_____

Name:_____ Date of Birth: ___/___/___

Relationship to You: _____ Phone# ( ) _____-_____

Alternate Mailing Address: _____

Alternate Phone Number: ( ) _____-_____

This request applies to the following information:

☐ Today's Date of Service Only

☐ From: ___/___/___ To: ___/___/___

☐ From: ___/___/___ Until Further Notice

_____ ___/___/__
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE
(If Personal Representative, state relationship to patient: _____)

_____ ___/___/__
SIGNATURE OF WITNESS DATE

FOR SMG USE ONLY

☐ Request Approved ☐Request Denied

If denied, reason (check one):

☐Request is not reasonable to accommodate ☐ Alternate address or contact not provided

☐Failure to provide information on how payment will be made (if applicable)

☐Other (please explain): _____