PATIENT REGISTRATION FORM

DATE _____ PATIENT # _____

PATIENT INFORMATION

(Required data)

Please provide your Driver's License card to the Receptionist to copy.

What is the name of the Physician you are seeing? _____

SOCIAL SECURITY #_____

FIRST NAME _____ MIDDLE _____

LAST NAME _____

PATIENT PRIMARY LANGUAGE _____

HOME ADDRESS _____

APT. ____ CITY/STATE _____ ZIP _____

GENDER _____ DATE OF BIRTH _____

EMAIL _____

HOME PHONE _____

WORK PHONE _____

CELL PHONE _____

- ○ SINGLE
- ○ SEPARATED
- ○ EMPLOYED
- ○ BLACK
- ○ ASIAN
- ○ AMERICAN INDIAN/NATIVE ALASKAN
- ○ MARRIED
- ○ WIDOWED
- ○ RETIRED
- ○ CAUCASIAN
- ○ PACIFIC ISLANDER
- ○ DIVORCED
- ○ DOMESTIC PARTNER
- ○ F/T STUDENT
- ○ HISPANIC
- ○ ASIAN PACIFIC AMER.
- ○ OTHER RACE

EMPLOYER _____

EMPLOYER ADDRESS _____

STE. _____ CITY/STATE _____ ZIP _____

EMPLOYER PHONE _____

HOW DID YOU HERE ABOUT US?

- ○ EMERGENCY
- ○ ESTABLISHED PATIENT
- ○ FRIEND/FAMILY
- ○ HOSPITAL
- ○ INSURANCE COMPANY
- ○ INTERNET
- ○ MAGAZINE
- ○ NEWSPAPER
- ○ RADIO
- ○ PROVIDER BOOK
- ○ RESEARCH PATIENT
- ○ REFERRING PROVIDER
- ○ OFFICE STAFF
- ○ TELEPHONE
- ○ TELEVISION
- ○ WALK-IN
- ○ YELLOW PAGES
- ○ OTHER RACE

PHARMACY INFORMATION

PHARMACY NAME _____ PHARMACY PHONE _____

PHARMACY ADDRESS _____ CITY/STATE _____ ZIP _____

I have an Advanced Directive or Health Care Directive ○ YES ○ NO

EMERGENCY CONTACT

RELATIONSHIP TO PATIENT _____ GENDER _____ HOME PHONE _____

FIRST NAME _____ LAST NAME _____ WORK PHONE _____

I authorize Quick Claimers to discuss with the above-named Emergency Contact the following issues related to my care: ○ MEDICAL ○ FINANCIAL PATIENT INITIALS _____

MEDICAL INFORMATION RELEASE FORM

PATIENT _____

DATE OF BIRTH _____ PHONE NUMBER _____

I, _____ The patient/guardian/healthcare power of attorney,

Authorize Quick Claimers to:

- ○ Receive medical and other information from: _____
- ○ Release medical and other information to: _____

Individual Name or Practice (required):

_____

PHONE (required) _____ FAX _____

SPECIFY EMAIL OR STREET ADDRESS _____

CITY (required) _____ STATE _____ ZIP _____

TREATMENT DATES TO BE DISCLOSED: ○ ENTIRE ○ YEAR TO DATE ○ OTHER _____

PURPOSE OF THE DISCLOSURE: ○ INSURANCE ○ LEGAL ○ CONTINUING CARE ○ PERSONAL

○ OTHER (SPECIFY) _____

SPECIFIC DESCRIPTION OF THE INFORMATION TO BE DISCLOSED

○ HISTORY AND PHYSICALS ○ PROGRESS NOTES ○ HOSPITAL ○ CORRESPONDENCE

○ LABS AND X-RAYS ○ INSURANCE ○ MISCELLANEOUS ○ ALL

SPECIFIC INFORMATION TO NOT BE DISCLOSED _____

I understand that the purpose of this authorization is for the use and/or disclosure of my protected health information (PHI) and that it may contain information that is protected under state laws and federal regulations. I understand that when the above information is disclosed it may be subject to re-disclosure and will no longer be protected by Privacy Protection Rules. I understand that I have the right to revoke this authorization at any time and that my revocation must be submitted to *Quick Claimers*. I understand that my revocation is not effective to the the extent that the persons or organizations in which I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to receive treatment, payment enrollment, or eligibility for benefits. I understand that I will be given a copy of this authorization upon my signature.

I hearby authorize *Quick Claimers* to disclose/release medical records and other information obtained in the course of my diagnosis and/or treatment. I agree to pay copy charges if applicable.

I hearby release *Quick Claimers* from any liability which may result from this disclosure of confidential medical information or which may arise of the result of the use of the information contained in the information released. Unless withdrawn, this consent will expire 90 days from the date signed.

This information may include Medical/Surgical, Psychiatric, Substance Abuse and HIV/AIDS information.

PATIENT'S SIGNATURE _____ DATE _____

PATIENT'S REPRESENTATIVE SIGNATURE
AND AUTHORITY TO SIGN _____ DATE _____

WITNESS _____ DATE _____

PATIENT REGISTRATION FORM

DATE _____ PATIENT # _____

CONSENT FOR MEDICAL TREATMENT

I, the undersigned, the patient (or the patient's duly authorized representative) do hereby voluntarily consent to and authorize medical care encompassing all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the physician, his assistants or designees. I am aware that the practice of medicine and surgery is not an exact science and acknowledge that no guarentees have been made to me as to the results of treatment or examinations performed. This form has been fully explained to me and I certify that I understand and accept its contents. All the above will be discussed with me, by the attending physician prior to any proposed testing or any type of surgical procedures to be scheduled.

SIGNATURE (Patient or Parent if Minor) _____ DATE _____

FINANCIAL POLICY

INSURANCE INFORMATION

Your health insurance is a contract between you and your insurer. Any charges not paid by your insurer for any reason are your responsibility. It is your responsibility to understand your insurance benefits, including plan limitations, the difference between screening or preventative care benefits versus diagnostic procedure benefits and need for referrals or pre-certifications. We will make every effort to verify your benefits, identify your financial liabilities and obtain any necessary pre-certifications prior to your appoinment on your behalf; however, this is not a guarantee of payment.

OPEN BALANCES

It is our policy to collect payment in full at the time of service. If you need to make special payment arrangements, it is your responsibility to initiate this effort with our offices. As a last resort, patients who fail to adhere to our financial policies may be sent to collections, occur additional costs and be terminated from our practice. Identified balances on account may be refunded only during the final week of the month.

MISCELLANEOUS FEES

We will charge $30 for returned checks for any reason. Failure to remedy the returned check may result in legal action. Missed or cancelled appointments with less than 24 hours notice for the office visits and 48 hours for procedures will result in a fee of $25 (office) and $100 (procedure). Our fee for completing forms is $25.

PATIENT'S REASSIGNMENT AND RELEASE STATEMENT

By signing below, I understand and accept the financial policies of Quick Claimers, and its subsidiary locations. I authorize payment of any insurance coverage and benefits to Quick Claimers and authorize them to release any medical information necessary to process claims. I give Quick Claimers permission to apply payments received to balances among its locations, including application to oldest balances first. I understand that I am financially responsible for the services I receive from Quick Claimers and its subsidiaries. Should I neglect to meet my financial responsibility, I understand that I may be charged additional fees incurred in the collection process, including from third party collection agencies.

SIGNATURE (Patient or Parent if Minor) _____ DATE _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

Hereby authorize payment directly to the Physician of the surgical and/or Medical Beneifts, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

SIGNATURE
(Patient or Parent if Minor) _____

DATE _____

AUTHORIZATION TO RELEASE INFORMATION:

Hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims.

SIGNATURE
(Patient or Parent if Minor) _____

DATE _____

MEDICAL AND FAMILY HISTORY FORM

TODAY'S DATE _____

NAME _____ DATE OF BIRTH _____

CHIEF COMPLAINT _____

REFERRING PHYSICIAN NAME _____

MEDICATIONS - Please list all of your current prescription and non-prescirption medications.
(ex. vitamins and supplements)

MEDICATION NAME:	DOSAGE:

ALLERGIES: ○ NONE ○ PENICILLIN ○ SULFA ○ ASPIRIN ○ IODINE ○ LATEX ○ OTHERS _____

DESCRIPTION OF ALLERGIC REACTION _____

PAST MEDICAL HISTORY

- ○ ANEMIA
- ○ ARTHRITIS
- ○ ASTHMA
- ○ ATRIAL FIBRILLATION
- ○ BARRETT'S ESOPHAGUS
- ○ BLEEDING DISORDER
- ○ BLOOD TRANSFUSION
- ○ CANCER
- ○ CHRONIC
- ○ CIRRHOSIS
- ○ COLON CANCER
- ○ COLON POLYPS
- ○ CONGESTIVE HEART FAILURE
- ○ CONSTIPATION
- ○ COPD
- ○ CORONARY ARTERY DISEASE
- ○ CROHN'S DISEASE
- ○ DEPRESSION
- ○ DIABETES
- ○ DIVERTICULOSIS
- ○ FATTY LIVER
- ○ GALLBLADDER DISEASE
- ○ GASTRITIS
- ○ GERD (REFLUX)
- ○ GI BLEEDING
- ○ HEART ATTACK
- ○ HEART MURMUR
- ○ HEPATITIS
- ○ HIATAL HERNIA
- ○ HIGH BLOOD PRESSURE
- ○ HIGH CHOLESTEROL
- ○ HIV OR AIDS
- ○ IRREGULAR HEART BEAT
- ○ IRRITABLE BOWEL SYNDROME
- ○ KIDNEY DISEASE/FAILURE
- ○ LIVER DISEASE
- ○ NEUROLOGIC DISORDERS
- ○ OSTEOPOROSIS
- ○ OVARIAN CYST
- ○ PANCREATITIS
- ○ PARKINSON'S DISEASE
- ○ PEPTIC ULCER
- ○ PHLEBITIS
- ○ PNEUMONIA
- ○ PROSTATE ENLARGMENT
- ○ PSORIASIS
- ○ RHEUMATIC FEVER
- ○ SCIATICA
- ○ SEIZURES
- ○ SLEEP APNEA
- ○ STROKE
- ○ TB (TUBERCULOSIS)
- ○ THYROID DISORDER
- ○ ULCERATIVE COLITIS
- ○ VALVULAR HEART DISEASE

PREVIOUS HOSPITALIZATIONS

REASON:	DATE:

SURGERIES/PROCEDURES

- ○ APPENDECTOMY DATE _____
- ○ BARIUM ENEMA DATE _____
- ○ BREAST SURGERY DATE _____
- ○ CAPSULE ENDOSCOPY DATE _____
- ○ CHOLECYSTECTOMY DATE _____
- ○ COLON SURGERY DATE _____
- ○ COLONOSCOPY DATE _____
- ○ COLOSTOMY DATE _____
- ○ C-SECTION DATE _____
- ○ CT SCAN DATE _____
- ○ EGD DATE _____
- ○ ERCP DATE _____
- ○ GALLBLADDER SURGERY DATE _____
- ○ HEART BYPASS DATE _____
- ○ HEART VALVE REPLACEMENT DATE _____
- ○ HEMORRHOID SURGERY DATE _____
- ○ HIATAL HERNIA REPAIR DATE _____
- ○ HYSTERECTOMY DATE _____
- ○ JOINT REPLACEMENT DATE _____
- ○ KIDNEY SURGERY DATE _____
- ○ LIVER BIOPSY DATE _____
- ○ MRI DATE _____
- ○ OBESITY SURGERY DATE _____
- ○ OVARIAN SURGERY DATE _____
- ○ PACEMAKER PLACEMENT DATE _____
- ○ PROSTATE (TURP) DATE _____
- ○ RADIATION THERAPY DATE _____
- ○ SIGMOIDOSCOPY DATE _____
- ○ SMALL BOWEL RESECTION DATE _____
- ○ STOMACH SURGERY DATE _____
- ○ THYROID SURGERY DATE _____
- ○ TONSILLECTOMY DATE _____
- ○ TUBAL LIGATION DATE _____
- ○ ULCER SURGERY DATE _____
- ○ ULTRASOUND DATE _____
- ○ UPPER GI SERIES X-RAY DATE _____
- ○ UTERINE SURGERY DATE _____
- ○ OTHER DATE _____
- ○ NONE

MEDICAL AND FAMILY HISTORY FORM

	FATHER	MOTHER	BROTHERS	SISTERS
HEALTHY/ALIVE	○	○	○	○
DECEASED	○	○	○	○
COLON POLYPS	○	○	○	○
COLON CANCER	○	○	○	○
GASTRICULCER DISEASE	○	○	○	○
LIVER DISEASES	○	○	○	○
CROHN'S DISEASE	○	○	○	○
ULCERATIVE COLITIS	○	○	○	○
STOMACH CANCER	○	○	○	○
DIABETES MELLITUS	○	○	○	○
HEART ATTACK	○	○	○	○
BREAST CANCER	○	○	○	○
OTHER CANCER	○	○	○	○

MARITAL STATUS ○ SINGLE ○ MARRIED ○ DIVORCED ○ WIDOWED ○ SEPARATED ○ DOMESTIC PARTNER

OCCUPATION _____ ○ UNEMPLOYED ○ RETIRED ○ STUDENT

SMOKING HISTORY	○ NEVER	○ YES	____PACKS PER DAY FOR____YEARS QUIT (HOW LONG)_____
ALCOHOL USE	○ NO	○ YES	____AMOUNT PER DAY FOR____YEARS
DRUG USE	○ NO	○ YES	SPECIFY DRUGS AND AMOUNT_____
EXERCISE HABITS	○ NO	○ YES	HOW MUCH/HOW OFTEN _____
HAVE ANY TATTOOS?	○ NO	○ YES	
HAVE ANY PIERCINGS?	○ NO	○ YES	
RECENT TRAVEL OUTSIDE U.S.	○ NO	○ YES	WHERE _____
CAFFEINE USE	○ NO	○ YES	DETAILS _____

DATE OF LAST PNEUMOVAX _____ DATE OF LAST FLU SHOT _____

REVIEW OF SYSTEMS - CHECK ALL THAT APPLY AT THE **PRESENT** TIME

GENERAL
- ○ CHILLS
- ○ LOSS OF APPETITE
- ○ NIGHT SWEATS
- ○ WEIGHT GAIN
- ○ WEIGHT LOSS
- ○ FEELING TIRED OR POORLY

EYES
- ○ WORSENING OF VISION
- ○ BLURRED VISION
- ○ VISION DISTORTION
- ○ EYE PAIN

OTOLARYNGEAL SYSTEMS
- ○ EARACHE
- ○ NASAL DISCHARGE
- ○ MOUTH SORES
- ○ BLEEDING GUMS
- ○ HOARSENESS
- ○ THROAT PAIN
- ○ SINUS PAIN

CARDIOVASCULAR
- ○ CHEST PAIN/DISCOMFORT
- ○ FAST HEART RATE
- ○ SWELLING OF LEGS
- ○ VERICOSE VEINS

GASTROINTESTINAL
- ○ ABDOMINAL SWELLING/PAIN
- ○ BELCHING
- ○ BLACK STOOLS
- ○ RED BLOOD IN STOOLS
- ○ CHANGE IN BOWEL MOVEMENT
- ○ FREQUENCY
- ○ CONSTIPATION
- ○ DIARRHEA
- ○ DIFFICULTY SWALLOWING
- ○ FATTY FOOD INTOLERANCE
- ○ FULL AFTER EATING SMALL
- ○ GAS/BLOATING
- ○ HEARTBURN
- ○ HEMORRHOIDS
- ○ YELLOW SKIN OR EYES
- ○ NAUSEA
- ○ PAIN WITH SWALLOWING
- ○ DECREASE IN APPETITE
- ○ RECTAL PAIN
- ○ REGURGITATION OF FOOD
- ○ INCONTINENCE OF STOOL
- ○ VOMITING
- ○ VOMITING BLOOD

MUSCULOSKELETAL
- ○ JOINT PAIN
- ○ JOINT STIFFNESS
- ○ SWOLLEN JOINTS
- ○ LOW BACK PAIN
- ○ MUSCLE PAIN

SKIN SYMPTOMS
- ○ PRURITIS (ITCHING)
- ○ SKIN LESIONS
- ○ RASHES

NEUROLOGIC
- ○ NUMBNESS OR TINGLING
- ○ DIZZINESS/LIGHTHEADEDNESS
- ○ VERTIGO
- ○ HEADACHES
- ○ WEAKNESS IN ARMS OR LEGS
- ○ BLURRED VISION
- ○ MEMORY LAPSES OR LOSS

PSYCHIATRIC
- ○ ANXIETY
- ○ DEPRESSION
- ○ PANIC ATTACKS
- ○ LOSS OF SLEEP

ENDOCRINE
- ○ HEAT OR COLD INTOLERANCE
- ○ EXCESSIVE THIRST OR URINATION
- ○ HOT FLASHES

HEMATOLOGIC/LYMPHATIC
- ○ EASY BRUISING TENDENCY
- ○ SWOLLEN GLANDS
- ○ NOSEBLEEDS

URINARY
- ○ PAIN/DIFFICULTY WITH URINATION
- ○ FREQUENT URINATION
- ○ BLOOD IN URINE
- ○ INCONTINENCE OF URINE

GENITOREPRODUCTIVE (FEMALE)
- ○ VAGINAL DISCHARGE
- ○ HEAVY PERIODS

DATE OF LAST PERIOD _____

GENITOREPRODUCTIVE (MALE)
- ○ DISCHARGE FROM PENIS
- ○ TESTICULAR PAIN
- ○ TESTICULAR LUMP