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
☐ Adverse reaction to anesthesia	____________	☐ Blood clots/Pulmonary embolism	____________
☐ Bleeding disorders	____________	☐ Cancer Type & Age	____________
☐ Depression	____________	☐ Osteoporosis	____________
☐ Diabetes	____________	☐ Rheumatoid Arthritis	____________
☐ Heart Disease (age at first event)	____________	☐ Stroke (age at first event)	____________
☐ Hypertension	____________		

SURGICAL HISTORY

Please check below if you have had any of these surgeries ☐ **No Previous Surgeries**

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

HOSPITALIZATIONS

☐ **No Past Hospitalizations**

Date: (Mo/Yr)	Reason
____________________	____________________________
____________________	____________________________
____________________	____________________________

GYN HISTORY

	Year			Year
☐ LMB	________		☐ Last PAP Smear (date)	________
☐ Last Mammogram (date)	________		☐ Last Dexascan (date)	________
☐ Hx of Abnormal PAP smear		☐ **Yes** ☐ **No**		
☐ STD	________	☐ **Yes** ☐ **No**		
☐ Birth Control	________	☐ **Yes** ☐ **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 ____