

FAMILY PRACTICE PATIENT REGISTRATION FORM

**Today's Date: _____

PRESTIGE MEDICAL, P. A. /SAI PRIMARY CARE

PATIENT INFORMATION: (Please use full legal name, no nicknames) *Required Fields for Billing

*Last Name: _____ *First Name: _____ Middle Initial: _____

*Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: (_____) _____ - _____ *Sex: _____ *Date of Birth: _____ Age: _____

Cell phone: _____

*Spouse Name: _____

Work phone: _____ *Spouse Cell: _____

Emergency Contact Name: _____ Phone #: (_____) _____ - _____

GUARANTOR INFORMATION: (List person or insured name responsible for bill - use full legal name, no nicknames)

*Relationship of Guarantor to Patient: Self _____ Spouse _____ Parent _____ Other _____

*Last Name: _____ *First Name: _____ Middle Initial: _____

*Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: (_____) _____ - _____ *Social Security #: _____

*Date of Birth: _____ Age: _____ *Sex: Female _____ Male _____

*Employer Name and Phone Number: _____

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance cards.

IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS

PRIMARY INSURANCE:

Plan Name: _____ * Insured's Name: _____

Insured's SS#: _____ *Insured's DOB: _____

*Policy/ID#: _____ *Group: _____ Eff. Date: _____

Claims Address & Phone: _____

SECONDARY INSURANCE:

Plan Name: _____ *Insured's Name: _____

*Insured's SS#: _____ *Insured's DOB: _____

Policy/ID #: _____ *Group: _____ Eff. Date: _____

PLEASE ALLOW RECEPTIONIST TO MAKE A COPY OF YOUR INSURANCE AND ID.

DISCLOSURES & CONSENTS

Patient Name: _____ **Date of Birth:** _____
First Name M.I. Last Name

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to PRESTIGE MEDICAL, P. A. for services rendered to my dependents or me by the physician or mid level practitioner working under the physician's supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that PRESTIGE MEDICAL, P. A. is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to PRESTIGE MEDICAL, P. A. on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have received and read a copy of the PRESTIGE MEDICAL, P. A.'s Patient Information Privacy Policy. I hereby authorize PRESTIGE MEDICAL, P. A. or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a PRESTIGE MEDICAL, P. A.'s representative or my health care provider to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying PRESTIGE MEDICAL, P. A. to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing, and treatment as directed by my physician or his or her designee.

PATIENT SIGNATURE: _____ **DATE:** _____

GUARANTOR SIGNATURE: _____ **DATE:** _____
(If different from patient)

GUARANTOR NAME (Please Print): _____

GUARANTOR RELATIONSHIP TO PATIENT: _____

FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name:	_____	Date of Birth:	_____
	First Name M.I. Last Name		

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any medical service or visit, preventative exam or physical, lab testing, X-ray, EKG, and any other Screening service or Diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility and not the responsibility of the Physician or Clinic to know if my insurance will pay for my Medical service or visit, Preventative exam or physical, Lab testing, X-ray, EKG, or any other Screening service or Diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility to know if my insurance has any Deductible, Co-payment, Co-insurance, Out-of-Network amount, Usual and Customary Limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.

I understand and agree it is my responsibility to know if my PCP choice has been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.

Signature: _____

Date: _____

(Please sign here – Patient or Responsible Party)

Responsible Party Name: _____

(Please print name of Responsible Party if different from Patient)

PRESTIGE MEDICAL, P.A. /SAI PRIMARY CARE

In our efforts to comply with the Health Insurance Portability and Accountability Act (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.

Please circle your response to the following:

May we leave **messages** on a voice mail at work? Yes No N/A

May we leave messages concerning your **appointments** with another person at your place of work?
Yes No N/A

If yes, please specify whom: _____

May we discuss your **appointments/treatment** with any other family member?
Yes No N/A

If yes, please specify
NAME: _____
Relationship to patient: _____ PH# _____
NAME:: _____
Relationship to patient: _____ PH# _____

For patients over the age of 18; may we discuss your **appointments/treatments** with your parent(s) or guardian?
Yes No N/A

I have received a copy of the Notice of Patient information Privacy. Yes No

This form must be signed by the patient or legal guardian. All legal guardians must be listed on separate form. You must inform us, **in writing**, of any changes in your directives. This record will be kept in your file along with your acknowledgement of receipt of your Notice of Privacy Practices.

Patient's Name: _____ Date of Birth: _____

Signature: _____ **Date:** _____

Printed Name: _____

Relationship to Patient: _____

PRESTIGE MEDICAL, P. A. /SAI PRIMARY CARE

3945 CR 58, MANVEL, TX, 77578

281-412-6606

Appointment Policies

Welcome to our office! We are pleased that you have chosen us to take care of your medical needs. To make our time together most efficient and enjoyable, we have listed several office policies. Please read them carefully.

1. **YOUR APPOINTMENT**: Be on time for your appointments, preferably 10-15 minutes early. If you are late, you risk cancellation of your appointment.
2. **CANCEL OR RESCHEDULE POLICY**: We require a minimum of 24 hour notice to cancel or reschedule your appointment. All no show, cancellation will have a \$35 charge applied to their account.
3. **BROKEN APPOINTMENT POLICY**: If a confirmed appointment is missed without proper cancellation or rescheduling you are provided a one-time notice and reminder of the policy. Any appointment missed without proper cancellation or rescheduling thereafter could result in a dismissal from the office as well as the \$35 charge. Our answering service is available 24 hours a day.
4. **PROOF OF INSURANCE**: Bring your Insurance card to every appointment. We cannot file a claim without a current Insurance or Medicaid card on file.

I acknowledge that I am fully responsible for making and keeping my appointments as well as providing proof of insurance at every appointment.

I have read and completely understand my obligations to the office policies.

Signature: _____ Date: _____

Relationship to patient: _____

PRESTIGE MEDICAL, P. A. /SAI PRIMARY CARE

MEDICAL HISTORY PAGE 1

Name _____ DOB: _____ Phone number: _____

ALLERGIES: _____

Pharmacy _____ Phone # _____

Occupation: _____

Marital Status: Married / Single / Widow

IMMUNIZATIONS/ YEAR

(Please provide us with a copy of your most recent Immunization/shot records to keep on file)

Tetanus Vaccine _____ Measles Mumps Rubella (MMR) Vaccine _____ Pneumonia Vaccine _____ Influenza/Flu Vaccine _____
Hepatitis B Vaccine _____ Shingles Vaccine _____

SCREENINGS

Last Pap smear _____ Last Colonoscopy _____ Last Mammogram _____

Last Prostate Screening _____ Last Dexa Scan _____ Last Physical _____ Last Eye Exam _____

Do you have a Living Will? YES NO

If no, do you wish to receive a copy of Advanced Directives today? YES NO

Medical Problems:

Vision problems Hearing problems bleeding from the nose Pain – tooth Chest pain

Shortness of breath Diabetes High Blood Pressure Heartburn Abdominal Pain

Constipation Tobacco Use Alcohol Use Fractures Tattoos Hepatitis B/C

Chickenpox Pain in the joints Tingling/numbness Headaches Seizures Fatigue

Trouble sleeping Urinary Incontinence Depression Anxiety/Panic attacks

Sexually Transmitted Diseases Blood or blood product transfusion

Other _____

• List of surgeries / Year / Reason

1. _____

2. _____

3. _____

4. _____

5. _____

• Hospitalizations other than for surgeries /Year/Reason

1. _____

2. _____

3. _____

Name: _____ Date of Birth: _____

• **Current List of medications/ Strength/ Number of times a day** *(Please keep an updated copy of your medications for every office visit)*

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Herbal Supplements

Females Only:

Obstetric History

Number of pregnancies: _____ Number of live births: _____ Gestational Diabetes: Yes No High Blood Pressure: Yes No

Contraception: Barrier Oral Contraceptives Depo Provera IUD _____ Year of IUD Insertion: _____
 Natural Methods Other _____ None

Menstrual History: Age of first menstrual cycle: _____ Regular Yes No **Last Menstrual Cycle:** _____

Family History: Y / N Relation

Asthma: _____

Cancer: _____

Heart disease: _____

Stroke: _____

Diabetes: _____

High Blood Pressure: _____

Seizures: _____

Mental Illness: _____

Please list any specific concerns you wish to discuss with your health care provider:

