Patient Registration Form

Date of Appointment_____

Chart#_____

Patient Information

Patient Name _____

First MI Last (as it appears of insurance card)

_____ _____ _____ _____

Sex: M F Martial Status: Date of Birth: Social Security Number

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Patient Address City State Zip

_____ _____ _____

Home Phone Cell Phone Email Address

_____ _____ _____

Referred by Primary Care Physician Primary Care Physician Phone Number

_____ _____ _____

Pharmacy Pharmacy Phone Pharmacy Address

Billing and Insurance

<u>Primary Health Insurance</u>

Policy Holder Name_____

Policy Holder Date of Birth_____

Relation to Patient_____

Employer_____

<u>Secondary Health Insurance</u>

Policy Holder Name_____

Policy Holder Date of Birth_____

Relation to Patient_____

Employer_____

Emergency Contact Information

Emergency Contact Name:_____ Relation to Patient_____

Emergency Contact Phone Number:_____

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1. Communication: What is your desire method of us communicating with you?
   Home Phone Cell Phone Mail
2. Language: Please circle your preferred language
   English Spanish Other:_____
3. Race: Please circle one
   White Black Other:_____
4. Ethnicity: Please circle one
   Non-Hispanic Hispanic
5. Smoking: Please circle one
   Non-Smoker Former Smoker Current Smoker
6. Advanced Directives: Do you have a Living Will?
   Yes No I do not know
7. Advanced Directives: Do you have a HEALTHCARE Power of Attorney?
   Yes No I do not know

_____ _____

Patient Signature Date

_____ _____

Staff Signature of Entry Date

$PT INFO REVISED 09062017

Chart#_____ Patient Name:_____

What brings you to the office today? _____

How did you hear about us? □ Newspaper □Internet □ Our Location □A friend □Our Sign □Other

Current Medications

What medications are you currently taking?

Name	Dosage	Frequency

Allergies

Are you allergic to the following?

□Adhesive Tape □Antibiotics □Latex
□Barbiturates □Aspirin □Iodine
□Codeine □Sulfa □Local Anesthetics

Do you have any other allergies?

Name	Reaction

Past Medical History

□Alcoholism □Back Problems □Ear Problems □Hepatitis-A, B, or C □Measles □Skin Disorder
□Allergies □Bleeding Disorder □Eating Disorders □High Blood Pressure □Migraines □Stomach Ulcer
□Anemia □Blood Disease □Epilepsy □High Cholesterol □Osteoporosis □Substance Abuse
□Anxiety Disorder □Blood Transfusion □Glaucoma □Joint Disorder □Pneumonia □Thyroid Disorder
□Arthritis □Cancer □Gout □Kidney Disorder □Polio □Tuberculosis
□Asthma □Diabetes □Heart Disease □Liver Disorder □Rheumatic Fever □Venereal Disease
□AIDS/HIV □Depression □Heart Problems □Lung Disease □Stroke

Date of last colonoscopy_____Where_____

Family History

Family Member	Living/ Deceased	Age/Last Known Age	Elevated Cholesterol	Diabetes	Hypertension/Heart Disease	Depression/Anxiety	Dementia	Blood Clotting Disorder	Cancer: Type
Paternal Grandfather									
Paternal Grandmother									
Maternal Grandfather									
Maternal Grandmother									
Biological Father									
Biological Mother									
Biological Sibling(s)									

Lifestyle Factors

Are you sexually active

□Yes ____# of Partners in last Year □No

Do you wish to be checked for STDs?

□Yes □No

Has anyone in your home ever physically or verbally hurt you?

□Yes □No

Have you ever smoked?

□Yes □No _____# of years _____# packs/day

Do you smoke now?

□Yes □No ____#packs/day

Do you use recreational drugs?

□Yes □No type(s)_____

How much alcohol do you drink per week?

____# drinks/week

How much caffeine do you drink per day?

____# drinks/day

How often do you exercise?

____#times/week

Women Only

Date of last Pap Smear:_____Where_____

Hysterectomy □Yes □No

Date of last Mammogram:_____Where_____

$PT HX REVISED 05312018

High Rock Internal Medicine, PA

Patient Payment Policy

Patient Name: _____Chart#_____

Welcome to **High Rock Internal Medicine, PA**. As a patient of ours, we strive to provide you the best medical care possible at the lowest cost. The following information will help us do this. If you have any questions, please feel free to call our billing department at
(336)224-0931.

The following explains our policies:

- We will ask for your present address and insurance card at each appointment. Your insurance card will be copied at **EVERY** visit. This is to keep our records current.
- We require a copy of a valid driver's license at initial appointment and annually to your record.
- Co-payments are due at check in. If you do not have your co-payment your appointment may be rescheduled.
- Deductible, co-insurance, and payment for non covered services is due at the time of service. Our office requires a $100 deposit for all deductible plans, until upon verification of your benefits it is determined that your deductible is met.
- A parent or legal guardian who signs for the care of a minor patient is responsible for payment of fees.
- We file your insurance as a courtesy. All unpaid balances become your responsibility after insurance pays.
- We process all checks electronically and when you pay by check you authorize us to make a one (1) time transfer of funds from your account. Funds may be withdrawn as soon as the same day you make payment. Our office is unable to void electronic transactions for any reason, if for any reason a check amount is to be refunded a request must be made with the billing department to issue a refund check to you.
- Returned checks are processed by check verification system and a returned check fee of $25.00 will be assessed to you.
- In the event of a voided credit card transaction, the monies will take 5-7 business days to be restored to your account.

PLEASE READ AND SIGN BELOW

Authorization to pay benefit to physician: I, the undersigned, hereby authorize payment directly to the physician for his/her services. I hereby authorize the physician to release any information acquired in the course of my examination or treatment to specific insurance carriers, third party payers or others involved in processing or collection of claims.

DATE: _____ **RESPONSIBLE PARTY:** _____

Assignment and Release: I, the undersigned, certify that I (or my dependent) have insurance coverage and have provided that information and assign directly the physician all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

DATE: _____ **RESPONSIBLE PARTY:** _____

DATE: _____ **Staff Witness:** _____

NAME:_____ **Date:** _____ **Chart #:** _____

High Rock Internal Medicine, PA

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✔" to indicate your answer.	Not at all	Severa l days	More than half the days	Nearly Every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

For Office Coding: 0 + _____ + _____ + _____

= Total Score: _____

If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Medical Review of Systems

Click next to any symptom you have experienced recently, or for which you have concerns. Click again if you wish to remove the checkmark. Please print this form out after its complete and bring it with you to your appointment. If you don't understand something, write a question-mark by it on your print out. . Your doctor will discuss any positive responses with you.

Name: _____

Date: _____

General
Recent unexpected weight loss
Chronic Fatigue
Anemia
Lack of regular exercise
Overweight

Eyes
Failing Vision
Eye pain
Double Vision
Blurred vision
Frequent eye infections
Glaucoma
Cataracts

Ears, Nose, Mouth
Decreased hearing
Ringing in ear
Frequent ear infections
Frequent nose bleeds
Sinus trouble
Frequent sore throats
Prolonged hoarseness
Tooth or jaw pain

Cardiovascular
Chest pain
Dizzy spells
Fainting spells
High blood pressure
Swollen ankles
Irregular pulse
Shortness of breath

Pulmonary
Pneumonia / pleurisy
Bronchitis/chronic cough
Asthma/wheezing

Gastrointestinal
Recent loss of appetite
Difficulty swallowing
Heartburn/gastritis
Persistent nausea/ vomiting
Chronic abdominal pain
Gall bladder trouble
Jaundice (yellow skin)
Change in appearance of stool
Diarrhea
Constipation
Bloody or very black stools
Hemorrhoids
Hernia

Genito-Urinary
Frequent urine infections
Blood in urine
Kidney Stones
Painful urination
Loss of control of urine
Decrease in flow
Urination more than 2 times per night
Any venereal disease in the past? (Herpes, Chlamydia, gonorrhea)

Musculoskeletal
Pain in joints
Pain in muscles
Recurrent back pains
Past injury to bones, spine, or joints
Gout attacks in the past
Concerned about osteoporosis

Integumentary
Skin rashes
Hives
Skin moles-black or changing
Breast mass
Nipple discharge

Neurologic
Frequent headaches
Tremor/hands shaking
Muscle weakness
Numbness/tingling
Seizures/convulsions
Difficulty sleeping
Excessive daytime sleeping
Memory loss

Psychological
Feeling depressed
Nervous or anxious feeling
Excessive moodiness
Difficulty concentrating
Phobias/unexplained fears
No pleasure in life anymore

Endocrine
Excessive thirst and urination
Feet and hands numbness/pain
Low blood sugar problems
Intolerance to heat or cold

Hematologic / Lymphatic
Excessive bruising or bleeding
Swollen glands-neck, armpit or groin
Unexplained fever, chills, night sweats

Allergic / Immunologic
Hay fever/Allergies
Getting lots of infections
Desire HIV discussion

Substance/Chemical Use
More than 6 drinks/week
Use of tobacco products
Caffeine use
Over-the-counter medicine / vitamins

Anything else you want your doctor to be aware of?

Women Only
Periods Irregular
Excessive flow/pain
Hot flashes/night sweats
Abnormal PAP smear