Physicians Health Center(PHC)

PATIENT REGISTRATION

Last Name: _____ **First Name:**_____

Middle Initial: _____

DOB:___ /___ /___ **Sex:** ☐ ***Male*** ☐ ***Female***

Social Security # _____

Marital Status: ☐ ***Single*** ***Married*** ☐ ***Divorced*** ☐ ***Widowed*** ☐ ***Other:***

Home Address: _____

City: _____ **State:**_____ **Zip:**

Home #:(_____)_____ **Work #:(_____)_____** **EXT:** _____ **Cell #:(_____)_____**

Preferred Daytime Phone: ☐ **Home** ☐ **Cell** ☐ **Work**

Email:_____ **Employer:**_____

IF WINTER VISITOR, PLEASE LIST YOUR PERMANENT ADDRESS

Address: **City:** **State:** **Zip:**

ADDITIONAL INFORMATION

Race: ☐ American Indian ☐ Asain ☐ African American ☐ Caucasian ☐ Other**:**

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Other:

Preferred Language: ☐ English ☐ Spanish ☐ Other:

☐ **I do not want to provide this information**

EMERGENCY CONACT INFORMATION

Name:_____ **Relationship:** _____

Home #: (_____) _____ **Work #: (_____** _____**)**

Name: _____ DOB: ___/___/___

PREFERRED PHARMACY

Name: _____ **Phone #: (_____)** _____

Address: _____

Mail- Order Pharmacy: _____

PREVIOUS PHYSICIAN INFORMATION

Physician Name: _____

Last Annual Wellness or Physical: **/ /___**

Office Address: _____

Phone #: ( ) **Fax #: (_____)** _____

Financial/Insurance Information

PRIMARY INSURANCE

Insurance Name: _____

Policy Holder's Name: _____ **Employer:** _____

Policy Holder's Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other: _____

Policy Holder's DOB: ___ /___ /___ **SS#:** ___-___-___ **Sex:** ☐ ***Male***

Female **Member ID#:** _____ **Group #:** _____

SECONDARY INSURANCE

Insurance Name: _____

Policy Holder's Name: _____ **Employer:** _____

Policy Holder's Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other: _____

Policy Holder's DOB: ___ /___ /___ **SS#:** ___-___-___

Member ID#: _____ **Group #:** _____

Name: _____ DOB:____/____/___

COMPLETE IF RESPONSIBLE PARTY IS OTHER THAN PATIENT

Responsible Party Name:_____ **DOB: ___ /___ /___ SS#: _____-_____-**

Address:_____ **Relationship to Patient:** _____

City: _____ **State:**_____ **Zip:** _____

Employer:

Home #:(_____)_____ **Work #:(_____)** _____ **Cell #:(_____)**

BENEFIT ASSIGNMENT / ACKNOWLEDGMENT OF PRIVACY PRACTICES

I hereby authorize **PHC** to treat the above-named patient. I authorize the release of medical information necessary to process insurance claims concerning the patient's illness and treatment. Photocopies are valid as original. I authorize payment of medical benefits for medical care rendered to my dependents or myself. I understand that I am financially responsible for any amounts not covered by health insurance. It is my responsibility to notify the office of changes in information.

Signature:_____ Date: ____/____/____

Medical History

MEDICATIONS

Medication Name:	*Strength:*	*Dose:*	*Frequency:*

Name: _____ DOB:____/____/___

ALLERGIES

☐ Penicillin ☐ Latex ☐ Keflex ☐ Sulfa ☐ Ciprofloxin ☐ Iodine

☐ No known ***drug*** allergy ☐ Other:

_____

PAST / PRESENT MEDICAL CONDITIONS

Cardiac: ☐ Heart Attack ☐ A-fib ☐ Congestive Heart Failure ☐ Hypertension ☐ Irregular Heart Beat

Neurologic ☐ Stroke ☐ Seizures/Epilepsy ☐ Dementia ☐ Alzheimer's ☐ Parkinson's

Endocrine: ☐ Diabetes ☐ Thyroid Disorder ☐ Osteoprosis ☐ Elevated Cholesterol

Pulmonary: ☐ Asthma ☐ COPD ☐ Valley Fever ☐ Sleep Apnea

Gastrointestinal: ☐ GERD ☐ IBS ☐ Cirrhosis/Liver Disease

Urinary: ☐ Kidney Stones ☐ Kidney Failure ☐ Enlarged Prostate

Rheumatology: ☐ Arthritis ☐ Fibromyalgia ☐ Lupus

Blood: ☐ Anemia ☐ Leukemia ☐ Lymphoma ☐ Bleeding Disorder

Psychiatric: ☐ Anxiety ☐ Depression ☐ Bipolar Disorder ☐ Schizophrenia

Circulation: ☐ DVT ☐ Pulmonary Embolus ☐ Peripheral Vascular Disease ☐ Carotid Atrery

Cancer:

Other Condition(s) <u>not</u> listed:

☐ ***None***

HOSPITAL / SURGERY

Date:	*Reason:*

Name: _____ DOB:____/____/___

FAMILY HISTORY

FAMILY MEMBER:	AGE:	ALIVE *OR* DECEASED:	ANY MEDICAL CONDITION(S):
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Siblings			
Children			

PREVENTATIVE CARE

Date of last Mammogram: _____

Date of last Colonoscopy: _____

Date of last Bone Density (DEXA): _____

Date of last Pap Smear:

Date of last PSA: _____

Date of last Stool Test: _____

Shingles: ☐ Yes ☐ No Date received:

TB: ☐ Yes ☐ No Date received:

MMR: ☐ Yes ☐ No Date received:

COVID-19: ☐ Yes ☐ No Date received:

FINANCIAL POLICY

Physicians Health Center (PHC)

Thank you for choosing PHC as your primary care physician office. **Please carefully read and sign below.** This policy has been put in place to ensure that financial payments due are recovered. It is important that we work together to ensure that payment for services is as simple and straightforward as possible. Our practice manager and billing department will be glad to discuss these policies with you.

1. I understand that all copayments and outstanding balances are due at the time of service. If I do not have my insurance card, and/or copayment, my appointment may be rescheduled based on availability until such a time that I can provide the required documents or payments.

2. I understand that although we are contracted with several insurance companies, it is my responsibility to know my insurance benefits.

3. I understand that if I do not have the correct PCP assigned by my insurance company, my appointment will be rescheduled.

4. I understand that if my insurance company has not paid a claim on my behalf within 90 days because of information that I have not provided, the balance will be transferred to my account, and I will be responsible for payment. If we receive payment later, we will reimburse you.

5. I understand that a $35 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds (cashier's check, money order or cash).

6. I understand that there is a charge of $50 for any forms that I request the doctor to complete on my behalf. The payment for completion of these forms will be paid when the forms are accepted for the doctor to complete. These forms include but are not limited to FMLA paperwork, Life Insurance forms, Assisted Living forms and any other form requiring doctor completion when the patient is not present. Document completion could require you to be seen by a provider. Please allow 7-10 business days for completion.

7. I understand that there may be fees associated with medical records requests and that I may be responsible for these fees.

8. I **have read and I understand the above Financial Policy and I agree to abide by its terms.**

_____

Printed Name (patient or guarantor)

_____

Signature (patient or guarantor) Date

OFFICE POLICY

These policies at **PHC** are designed to make the care we provide more streamlined, efficient and patient-centered for you.

1. APPOINTMENTS

To accommodate everyone's needs, we offer appointments days, weeks or months in advance as well as same day scheduling. If you have an urgent need, please call us and we will get you in as soon as possible.

2. LATE/ NO SHOW POLICY

We pride ourselves on taking your time seriously and hope you will do the same for us. If you are running 10 or more minutes late, we will have to reschedule you to a different day. We do ask that you call at least 24 hours in advance if you cannot make your appointment. After your 3rd No Show appointment we can dismiss you from the practice.

3. MEDICATION REFILLS

- If possible, it is best to get refills during your regular office visit. For your convenience we can e-prescribe or fax your prescriptions directly to your pharmacy.
- We encourage patients to contact their pharmacy for refills or use the Patient Portal to request refills.
- Please allow our office 72 hours to complete the refill process.
- Please note that no prescription refills, routine OR controlled substances are done after hours or on weekends.
- If your medications need prior authorization, please note this may take 5-7 business days for processing.

4. AFTER HOURS CARE

If you have an emergency, please call 911 or go directly to the nearest emergency room. For less urgent medical concerns please call our main number and you will be connected to the on-call Provider. Routine calls, such as medication refills or referrals will be handled during regular office hours.

5. GROUNDS FOR TERMINATION OF THE PATIENT-PHYSICIAN RELATIONSHIP

A physician may terminate a relationship with a patient by giving 30-day notice, during which the physician is responsible only for responding to urgent medical matters. We will reserve this action for patients who demonstrate repeated non-compliance with medical advice, missing multiple appointments, failing to pay their balances, disregarding the stated policies of the practice or acting in a way this is deceptive, dishonest or abusive.

6. REFERRALS/ PRE-CERTIFICATIONS

If you need to see a specialist, your insurance company may require a referral. It is your responsibility as the patient to determine if your insurance requires a referral, to verify that the specialist is on your plan and to obtain a referral from our office before visiting the specialist. New referrals require an office visit for documentation of medical necessity. Referral requests require one to two weeks' notice before your visit to the specialist.