BRENTWOOD EAST FAMILY MEDICINE

Patient Registration Form (eCW)

PATIENT INFORMATION

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last) ________________________ (First) ____________ (MI) _____ Previous Name ________________________

Address Line 1 ____

City, State ________________________________ ZIP___________

Pharmacy______________________________ Pharmacy Phone_______________

Home Phone ______________________ Cell No. _____________________

E-Mail Address:____Social Security Number _______-_______-_______

Date of Birth MM _______/DD _________/YYYY _____________ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other ___________

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Employer Name ____Work Phone ____________________________Ext. __________

Emergency Contact Name ________________________________Phone Number ___________________________

Emergency Contact Relationship to Patient ____

Do you have a living will? ☐ Yes ☐ No

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self **Check here if information is same as patient** ☐

Responsible Party Name (Last) ___________________________ (First) ___________________________ (MI) ___________

Guarantor Account Number ____________________________ Date of Birth MM _________/DD _________/YYYY ____________

Social Security Number _______-______-________ Telephone ______________________________Sex ☐ F – Female ☐ M - Male

Address Line 1 ____

City, State ________________________________ ZIP ___________________

Employer____ Employer Phone Number__________________________

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number____ (______)_________________

Name of Insured____ Patient Relationship to Insured_____________________

Subscriber ID (Policy Number)_________________ Group ID_________________ Copay Amount____________________

Effective Date_____________________ Termination Date_______________ Date of Birth MM _______/DD _______/YYYY _____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number____ (______)_________________

Name of Insured____ Patient Relationship to Insured_____________________

Subscriber ID (Policy Number)_________________ Group ID_________________ Copay Amount____________________

Effective Date________________________ Termination Date________________Date of Birth MM _______/DD ______/YYYY____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature____ ***Date***_________________

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BRENTWOOD EAST FAMILY MEDICINE

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: Will the Protected Health Information (PHI) be created or used for research and include treatment of the patient? If yes, complete the Authorization for Research Form. If no, proceed to Section B.

Section B: Required for all Authorizations for Release of PHI or Right to Access

Patient Name:	Birth Date:	Social Security No. *(optional)*:
Patient's Address:	Requestor's Name/Phone Number (if patient is not the requestor):	

PHI Recipient Name:	Address/City/State/Zip	Phone Number: Fax Number:
PHI Sender Name:	Address/City/State/Zip	Phone Number: (__) ________ Fax Number: (__) ________

This authorization will expire on the following: (Fill in the Date or the Event, but not both.)
Date: Event:

Purpose of Disclosure:

Is this request for psychotherapy notes?
☐ Yes, then this is the only item you may request on this authorization.
☐ No, then you may check as many items below as you need.

Description:	Date(s)	Description:	Date(s)	Description:	Date(s)
☐ All PHI in record ☐ History and Physical ☐ Consult Report ☐ Operative Report ☐ Progress Notes		☐ Physician Orders ☐ Laboratory ☐ Imaging/Radiology ☐ Nursing Notes ☐ Medication Record		☐ Demographics ☐ Rehabilitation Services ☐ Special Test/Therapy ☐ Itemized Bill/Claims ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. ________________ (Initial). If not, applicable, check here ☐

I understand that:

1. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings).
2. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
4. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
5. I will receive a copy of this form after I sign it.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/Patient Representative:	Date:
Print Name of Patient's Representative:	Relationship to Patient:

HEALTH HISTORY

Name: ______________________________ Birth date: ____________________

Today's Date: ____________________ Date of last physical examination:____________________

SYMPTOMS - Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ❑ Chills
- ❑ Dizziness
- ❑ Fainting
- ❑ Fever
- ❑ Loss of weight
- ❑ Numbness
- ❑ Sweats

EYE, EAR, NOSE, THROAT
- ❑ Bleeding Gums
- ❑ Blurred vision
- ❑ Crossed eyes
- ❑ Difficulty swallowing
- ❑ Double vision
- ❑ Earache
- ❑ Ear discharge
- ❑ Hay fever
- ❑ Hoarseness
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Persistent cough
- ❑ Ringing in ears
- ❑ Sinus problems

CARDIOVASCULAR
- ❑ Chest pain
- ❑ High blood pressure
- ❑ Irregular heart beat
- ❑ Low blood pressure
- ❑ Poor circulation
- ❑ Rapid heart beat
- ❑ Swelling in ankles

RESPIRATORY
- ❑ Cough
- ❑ Shortness of Breath
- ❑ Decrease in exercise capacity

GASTROINTESTINAL
- ❑ Abdominal pain
- ❑ Appetite poor
- ❑ Bloating
- ❑ Bowel changes
- ❑ Constipation or diarrhea
- ❑ Gas
- ❑ Heartburn or indigestion
- ❑ Hemorrhoids
- ❑ Nausea or vomitting

GENITO-URINARY
- ❑ Blood in urine
- ❑ Frequent urinating
- ❑ Lack of bladder control
- ❑ Painful Urination

MUSCLE/JOINT/BONE
- ❑ Arms
- ❑ Back
- ❑ Feet
- ❑ Hands
- ❑ Hips
- ❑ Legs
- ❑ Neck
- ❑ Shoulders

SKIN
- ❑ Bruise easily
- ❑ Hives
- ❑ Itching
- ❑ Change in moles
- ❑ Rash
- ❑ Scars
- ❑ Sore that won't heal

NEUROLOGICAL
- ❑ Dizziness or lightheadedness
- ❑ Weakness
- ❑ Fainting
- ❑ Seizures

PSYCHIATRIC
- ❑ Depression
- ❑ Headache
- ❑ Loss of sleep
- ❑ Nervousness
- ❑ Stress
- ❑ Trouble concentrating

ENDOCRINE
- ❑ Diabetes
- ❑ Hypertension
- ❑ Thyroid disease

HEMATOLOGICAL
- ❑ Anemia
- ❑ Bleeding disorder

ALLERGIES
- ❑ Asthma
- ❑ Hayfever or allergic rhinitis

WOMEN only
- ❑ Abnormal pap smear
- ❑ Bleeding between periods
- ❑ Breast lump
- ❑ Extreme menstrual pain
- ❑ Hot flashes
- ❑ Nipple discharge
- ❑ Painful intercourse
- ❑ Vaginal discharge

Date of last menstrual period

____

Date of last pap smear

____

Have you had a mammogram __________

Are you pregnant? ________

Number of children ________

CARDIOVASCULAR
- ❑ Erection difficulties
- ❑ Lump in testicles
- ❑ Penis discharge

Date of last prostate exam

____

CONDITIONS - Check (✓) conditions you have or have had in the past year.

- ❑ AIDS
- ❑ Alcoholism
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical dependency
- ❑ Chicken pox
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heart disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herpes
- ❑ HIV positive
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Measles
- ❑ Migraines
- ❑ Miscarriages
- ❑ Mononucleosis
- ❑ Mumps
- ❑ Pacemaker
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate problem
- ❑ Psychiatric care
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Stroke
- ❑ Tonsilitis
- ❑ Tuberculosis
- ❑ Typhoid fever
- ❑ Ulcers
- ❑ Venereal disease

Please complete the back of this form also

PAST MEDICAL HISTORY: List surgeries you have had and the year.	
1.	2.
3.	4.

MEDICATIONS: List medications you are currently taking.		**ALLERGIES:** To medications or substances.
1.	8.	
2.	9.	
3.	10.	
4.	11.	
5.	12.	
6.	13.	
7.	14.	
Pharmacy Name:		**Phone:**

Fill in health information about your family

	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Pregnancy History:

Year of Birth	Sex of Birth	Delivery Type	Complications if any

SOCIAL HISTORY:

Check (✓) the substance you use and describe how much you use.		
	Caffeine	
	Tobacco	
	Alcohol	
	Other	

FAMILY HISTORY:

List any illnesses that run in your family.	
1.	5.
2.	6.
3.	7.
4.	8.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _______________ **Date** _______________

Physician Signature _______________ **Date Reviewed** _______________

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

____ ___________________________

Signature of Patient or Personal Representative **Date**

____ ___________________________

Printed Name of Patient or Personal Representative **Relationship to Patient**

Brentwood East Family Medicine

PATIENT NAME____DATE OF BIRTH____________

PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

1. ____________(Patient or Guardian Initials)

Financial Agreement.

- I acknowledge, that as a courtesy, Brentwood East Family Medicine may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

2. ___________(Patient or Guardian Initials)

Third Party Collection. I acknowledge that Brentwood East Family Medicine may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. ___________(Patient or Guardian Initials)

Assignment of Benefits. I hereby assign to Brentwood East Family Medicine any insurance or other third-party benefits available for health care services provided to me. I understand Brentwood East Family Medicine has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Brentwood East Family Medicine I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. ______________(Patient or Guardian Initials)

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to Brentwood East Family Medicine by the Medicare or Medicaid program.

5. ______________(Patient or Guardian Initials)

Consent to Telephone Calls for Financial Communications. I agree that, in order for Brentwood East Family Medicine Brentwood or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that Brentwood East Family Medicine or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or Brentwood East Family Medicine or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. ______________(Patient or Guardian Initials)

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X____Date_________________

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below):

Spouse	Guarantor
Parent	Healthcare Power of Attorney
Legal Guardian	Other (please specify)_____________________________________