Eastside Medical Group Patient Registration Form

PATIENT INFORMATION (Please Print)

	. Mrs. Ms							
		(Fi						
-		ZIP						
		Cell No					_Ext	
E-Mail Address:						_	_	
Date of Birth	MM/DI	O/YYYY		Sex	F – Female	M - Male	Transgen	der
Social Security 1	Number							
Race/Ethnicity	□Asian □ B	ack or African American	n Caucasian	Hispa	nic or Latino			
	American Ind	ian/Alaska Native	Native Hawaiian/	Other Pacif	ic Islander	Declined		
Language	English S	panish Other						
Marital Status	Married	Single Divorced	l Widowed	Legal	ly Separated	Partner		
Primary Care Pr	ovider (PCP)	Referrir	ng Provider					
Pharmacy		Pharmacy Phone	<u> </u>					
Employer Name			Empl	oyer Phone				
Employment Sta	ntus 🔲 1 - Full-7	Γime 2 - Part-Time	3 - Not Empl	loyed 2	4 - Self-Employe	ed 5 - Reti	red 6 - Ac	tive
•	tact Last Name				First Name			
	ving will? Yes			•				
•	ARTY INFORMATION		(inform	ation used	for patient balar	nce statements)	1	
_			,		·	,		
Self							2.5	
	ty Name (Last)		(First)		500		(MI)	
		/YYYY						
•	· · · · · · · · · · · · · · · · · · ·	Te	elephone					
	_				-			
					r Phone Number			
INSURANCE INFO	ORMATION (provide	your insurance card to	the front desk at	check-in)				
Primary Insuran	ce	Ins	sured			DOB		
·		Ins	sured			DOB		
How did you hea	ar about us?							
Wahsita	Internet Search	Internet Advertiseme	ent Family/I	Griends 🔝	Facebook	Magazina/Non	venaner Ad	
_		Internet Advertisem			Directory H	•		e
— mount nea	inicare provider			i iry siciali L	incomp in I	cospical MID IC	.c.i.a. – wicuilli	_

EASTSIDE MEDICAL GROUP Patient HIPAA Acknowledgment and Consent Form

Patient Name:		
Date of Birth:		
describes the ways in which the practice may use and and other described and permitted uses and disclosur a question or complaint. To the extent permitted by the practice's Notice of Privacy Practices.	d disclose my healthcare informati res, I understand that I may contac law, I consent to the use and disclo	t the Privacy Officer designated on the notice if I have osure of my information for the purposes described in
inpatient or outpatient care to release healthcare info		physicians or other health professionals involved in the payment, or healthcare operations.
 Healthcare information regarding a prior admiss affiliated admitting facilities to coordinate Paties person or entity liable for payment on the Paties related to benefit payment. Healthcare informative related to a claim under worker's compensation 	sion(s) at other HCA affiliated faci- ent care or for case management punt's behalf in order to verify covera- tion may also be released to my end.	ilities may be made available to subsequent HCA- arposes. Healthcare information may be released to any age or payment questions, or for any other purpose apployer's designee when the services delivered are
intermediaries or carriers for payment of a Med	icare claim or to the appropriate st story and physical, emergency reco	ormation to the Social Security Administration or its ate agency for payment of a Medicaid claim. This ords, laboratory reports, operative reports, physician orts, drug and alcohol treatment and discharge
health care industry participants and their subcoone another to accomplish goals that may include health records; decreasing the time needed to accomprovement purposes; and such other purposes more such organizations. This consent specific intellectual disability conditions, genetic informalimited to, blood borne diseases, such as HIV at Disclosures to Friends and/or Family Members I give permission for my Protected Health Information the family members and others listed below:	ontractors in order for these individed but not be limited to: improving excess my information; aggregating as as may be permitted by law. I ure ally includes information concernination, chemical dependency conditiond AIDS. on to be disclosed for purposes of	nderstand that this facility may be a member of one or ng psychological conditions, psychiatric conditions, tions and/or infectious diseases including, but not communicating results, findings and care decisions to
Name	Relationship	Contact Number
1: 2:		
Financial acknowledgement for Private Pay Patie Patients who do not have insurance coverage are exp financially responsible for all charges incurred durin Signature of Patient or Personal Representative	pected to pay charges in full at the	
Assignment and Authorization of Benefits for Pat I hereby assign all medical and /or surgical benefits, practice. I understand that I am financially responsil	tients with Insurance to which I am entitled, including I ble for all charges, co-payments, co	Medicare, private insurance, and other plans to the o-insurance and deductibles. To the extent necessary of portions of the patient's medical record. I authorize
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 reques	t this authorization also apply to all other in	surance. Patient Initial:
Consent	to Email or Text Usage for Appointment Ro	eminders and Other Healthcare Communications:
Patients	in our practice may be contacted via email a	and/or text messaging to remind you of an appointment, to obtain feedback on
your exp	perience with our healthcare team, and to pr	ovide general health reminders/information.
If at any	time I provide an email or text address at which	h I may be contacted, I consent to receiving appointment reminders and other
healthca	re communications/information at that email or	text address from the Practice.
	_ (Patient initials) I consent to receive text mes	ssages from the practice at my cell phone and any number forwarded or transferred to
that num	ber or emails to receive communication as state	ed above. I understand that this request to receive emails and text messages will apply
to all fut	ure appointment reminders/feedback/health infe	ormation unless I request a change in writing (see revocation section below).
The cell	phone number that I authorize to receive text n	nessages for appointment reminders, feedback, and general health
	rs/information is	
The ema	il that I authorize to receive email messages for	r appointment reminders and general health reminders/feedback/information
is	·	
-	~ *	ard text messaging rates may apply as provided in your wireless plan (contact your
carrier f	or pricing plans and details). Revocation	
	I hereby revoke my request for future commu_I hereby revoke my request to receive any fi_I hereby revoke my request to receive any fi_NOTE: This revocation only applies to comm_Patient Name:	uture appointment reminders, feedback, and general health via text messages. future appointment reminders, feedback, and general health via email.
		Time:
Consent	for Photographing or Other Recording for	
	0 1 0	pes, digital or audio recordings, and/or images of me being recorded for security
		rposes (e.g., quality improvement activities). I understand that the facility retains the
		l be allowed to request access to or copies of the images and/or recordings when
		law. I understand that these images and/or recordings will be securely stored and
	· ·	ntified will not be released and/or used without a specific written authorization from
me or m	y legal representative unless it is for treatment,	payment or health care operations purposes or otherwise permitted or required by law
Prescrip	otion Order Pick-up. There may be times whe	en you need a friend or family member to pick-up a prescription order (script) from
your phy	vsician's office. In order for us to release a pres	scription 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.
(Pa	tient initials) I wish to designate the following	family member / friend to pick up an order on my behalf:
	Name:	Date:
	Name:	
(Pa	atient initials) I do not want to designate anyone	e to pick-up my prescription order.
Patient S	signature	Date

Eastside Medical Group:	DATE:	
Name:	Date of Rirth	Д се∙
Male / Female (circle one)	Date of Birth: Pregnant Yes / No (circle one)	
interest of the control of the contr	creaming restrict (entire only)	
Reason you are here:		
SOCIAL HISTORY		
	rried Partner Divorced ion/Job	
HABITS		
—————————————————————————————————————	es \square No If yes, how much per day? _	
Smoking:		
	Date Quit Current smoker / Ho	w Long?Packs per day?
Do you drink alcoholic beverages? If	yes, how many per week?	
	caffeine: (coffee, tea, soda)	
Do you use recreational drugs? If yes	s, what and how often?	
	drugs. List and name dose. Using additional tor brought your medications DO NO	
	5	
•		
•	6	
ó	7	
l.	8	
MEDICATION ALLERGIES:		☐ No medication allergies
Are you allergic to latex?	□ No	
PAST MEDICAL HISTORY		
	had any of the following medical conditions	☐ No Past medical problems
Acid reflux	☐ Congestive heart failure	☐ HIV or Aids
Adverse reaction to anesthesia	☐ Dental disease	☐ Infections:
Alzheimer's significant memory loss	☐ Depression	☐ Kidney/Bladder disease
Anemia	□ Diabetes	☐ Leg pain
Angina or chest pain	☐ Emphysema	☐ Lung disease
Arthritis	☐ Epilepsy/Seizures	☐ Osteoporosis
Asthma Atrial fibrillation or erratic heartbeat	□ Fibromyalgia □ Gallbladder disease	☐ Peripheral vascular disease☐ Pneumonia
Bleeding problems	☐ Gout	□ Pneumonia□ Psychiatric disorder
Blood transfusion	☐ Heart disease	☐ Rheumatoid arthritis
Blood clot in leg(s) or lung(s)	☐ Hemophilia / Excessive bleeding	☐ Sickle cell
Bruise easily	☐ Hepatitis	☐ Sleep apnea / CPAP machine
Cancer Type:	☐ High blood pressure / Hypertension	□ Stroke
Thyroid Disease	☐ High cholesterol	
☐ Other not listed, explain:	☐ Tuberculosis	

FAMILY HISTORY Please check below if Mo	ther, Father, .	Siblings have had a	ny of the follo	owing: No family m	edical history to report
☐ Depression ☐ Diabetes ☐ Heart Disease (age at first event) ☐ Hypertension		Who	☐ Cance ☐ Osteo ☐ Rheur	er Type & Age	Who
SURGICAL HISTOR Please check below if you		y of these surgeries		No Previous Surgeries	
	Year		Year		Year
☐ Aneurysm – Abdominal		☐ Colon surgery			eart surgery
☐ Angioplasty / stents		☐ Fistula R or L			ker/Defibrillator
□ Appendectomy		☐ Gallbladder		Prostate	
☐ Artery bypass of arm/ leg		☐ Gastric bypas			
☐ Breast surgery		☐ Heart stents		Tonsils	
☐ Caesarean section		☐ Hernia surger			n / knee
☐ Carotid surgery		☐ Hysterectomy		□ Other n	
☐ Cataract surgery		□ Nasal surgery			
HOSPITALIZATIONS Date: (Mo/Yr)		Rea		ospitalizations	
GYN HISTORY					
	Year			Yea	
□ LMB	i ear		□ Loct	PAP Smear (date)	
☐ Last Mammogram (date)				D (1.1)	
☐ Hx of Abnormal PAP sme		□ Yes □ No	⊔ Last.	Dexascan (date)	
	tai				
□ STD		□ Yes □ No			
☐ Birth Control		□ Yes □ No			
To Be Filled Out By N		TEMD.		of symptoms negative	O2 SAT:
HEIGHT: W	EIGHT:	TEMP: RPI FFT APM·		_ PULSE:	O2 SAT:
	/EIGHT:	BP LEFT ARM: _		_ PULSE:	O2 SAT: