PREMIER
PRIMARY CARE
Where Passion for Care is Primary

REGISTRATION FORM

PATIENT INFORMATION		
Patient's Name:		Marital Status:
Social Security Number:	Birth Date:	Sex: O M O F
Address: (Address/P.O. Box, City, State, and Zip Code)		
Home Phone Number:		Cell Phone Number:
Employer:		Employer Phone Number:
Preferred Method of Contact: ____email ____home phone ____letter ____mobile phone ____text		
Spouse's Name: (If applicable)	Spouse's Date of Birth:	Spouse's Phone Number:
Please name any physicians you have seen in the last 3 years:		
Do you have a Living Will or Advanced Directive? Would you like Premier Primary Care to retain a copy of your Living Will or Advanced Directive?		
How did you hear about Premier Primary Care? (friend/online/doctor)	Email Address: Can we send you email updates? Yes No	

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at the same address):	Relationship to Patient:	Home Phone #	Cell phone #

INSURANCE INFORMATION	
Primary Insurance:	Subscriber:
	Relationship to Patient: _____ Subscriber DOB: _____ Subscriber Employer: _____
Secondary Insurance:	Subscriber:
	Relationship to Patient: _____ Subscriber DOB: _____ Subscriber Employer: _____

The above information is true to the best of my knowledge. By signing below, I give my consent to all medical care, examinations, and tests determined by Premier Primary Care that are necessary for me.

_____ _____

Patient/Guardian Signature Date

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Name: _____ Age _____ Date of Birth_____ Today's Date_____

Current pharmacy (Name and Location): _____

Current Medications

Please list all medications you are now taking, including those you buy without a prescription (such as cold medicine or aspirin.) Please list name, dosage, and how many times per day they are taken.

1._____ 5._____ 9._____

2._____ 6._____ 10._____

3._____ 7._____ 11._____

4._____ 8._____ 12._____

Allergies: _____

Current Medical Problems

Please list the medical problems for which you came to see your provider for today. About when did they begin?

1. _____

2. _____

3._____

Please list any previous illnesses or chronic conditions:

_____

_____

Immunizations:

Last tetanus? _____ Zostavax (shingles)? _____ Hepatitis B? _____ Gardasil? _____

Last Tuberculin (TB) skin test? _____ Was it _____positive ____negative

Have you had the chicken pox? ____NO _____ YES At what age? _____ Have you received the Varicella vaccine? _____ What age? _____

Social:

How many cigarettes do you smoke per day? _____ How many years have you smoked? _____

Are you ready to quit? ___YES ___NO Do you use illegal drugs? _____ What kind? _____

How much alcohol do you consume per day? _____ Per week? _____ Per month? _____

Do you exercise regularly? _____YES ____NO If yes, how many times per week? _____

What type of work/school do you do? _____

Who lives in the home with you? _____

Please list all past surgeries (List by date with age.) _____

_____

_____

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Name: _____ Date: _____

Family History Use √ to indicate positive history									
	Self	Father	Mother	Sisters	Brothers	Aunts	Uncles	Daughters	Sons
Deceased									
Hypertension									
Heart Disease									
Stroke									
Kidney Disease									
Obesity									
Genetic Disorder									
Alcoholism									
Liver Disease									
Depressive/maniac Depressive disorder									
Colon/Rectal Cancer									
Other cancer									
Diabetes									
Thyroid									

Other Physicians and Providers of Care		
Name and Specialty Provider Type	Type of Care	Date Discontinued

Past Tests and Procedures		
Test	Date Test Was Performed	**Provider Who Performed the Test**
Pap Smear (Women)		
Mammogram (Women)		
PSA (Men)		
Digital Rectal Exam		
Colonoscopy		

Do you receive a flu shot yearly? Yes No

When was your last flu shot? _____

Have you ever received a pneumonia shot? Yes No

If yes, when was your last pneumonia shot? _____

Allergy Questionnaire - Intake Questions

To Be Filled Out by Patient

Patient Name _____ Birthdate _____

Reviewed by _____ Date _____

1. Do you experience any of these symptoms more than twice per year? (Check all that apply)

❑ Cough	❑ Cold	❑ Congestion
❑ Difficulty breathing	❑ Headaches	❑ Wheezing
❑ Runny nose	❑ Sore throat	❑ Itchy/irritated eyes
❑ Sinus pain	❑ Ear pain	❑ Unexplained fatigue
❑ Skin irritation	❑ Snoring	

2. Have you ever been diagnosed with asthma or bronchitis? ❑ Yes ❑ No

3. Do you experience symptoms of allergies? ❑ Yes ❑ No

4. Regarding possible food allergies, do you experience any of the following? (Check all that apply)

❑ Bloating after eating	❑ Diarrhea	❑ Cough
❑ Constipation	❑ Upset stomach	❑ Wheezing
❑ Stomach pain	❑ Indigestion	❑ Nausea
❑ Vomiting	❑ Tingling of the mouth or any other unusual sensation	

Premier Primary Care

Financial Policy Agreement

Thank you for choosing Premier Primary Care for your medical care. We are committed to providing you with quality personal health care, and appreciate your commitment to adhere to this **Financial Policy Agreement**. By understanding our policy, we can provide you with the best service. Agreement to this policy is required for all medical care.

Except, as indicated below, ***payment is required at the time services are provided***, unless other arrangements have been made in advance. We accept cash, personal in-state checks, Visa, MasterCard, Discover, and American Express credit cards. There is a **$25.00** service charge for returned checks.

INSURANCE: We participate in most managed care plans and will bill your insurance plan as may be necessary. If we do not participate with your managed care plan, payment in full is required at the time of service, unless other arrangements have been made in advance. We may be able to bill your plan as a courtesy to you and credit your account if we receive additional payment. Knowing your insurance benefits, including eligibility, covered benefits, and medically necessary procedures is your responsibility; please contact customer service at your insurance company for questions you have regarding your coverage. ***You are responsible for any charges not covered by your plan.***

- **Proof of Insurance**: All patients must complete and/or update their patient information at each office visit or via the patient portal prior to each visit. You must furnish up-to-date proof of insurance coverage and a copy of your driver's license. If you provide false or expired insurance information, you will be responsible for the remainder of the claim. **Please notify us of any changes in coverage prior to the time of service**. Insurance denials for termination of coverage will be automatically billed to you.

- **Co-pays and Deductibles:** All co-pays and unsatisfied deductibles must be paid at the time of service. By contractual law, your insurance company requires us to charge for, and you to pay for, all required co-pays, co-insurances, deductibles, and non-covered services.

- **Claim submission:** We will submit your insurance claims and assist you in any way reasonable to help get the claim paid. Your insurance company may need you to supply information directly to them. It is your responsibility to comply with their request in a timely manner.

- **No Shows and Cancellations:** We may every effort to provide prompt medical care to all of our patients. If you are unable to keep a scheduled appointment, please let us know 24 hours in advance. A **NO SHOW** is when a patient fails to keep a scheduled appointment. A **NO SHOW** will generate a $50 fee and three no shows may require that you seek your medical care elsewhere. In the event that you have a special circumstance regarding your missed appointment, please contact our office manager. We understand that there may be issues beyond your control and want to be understand of special circumstances.

I have read, understand, and agree to comply with the terms of Premier Primary Care's Financial Policy.

Signature: _____ Date: _____

Printed Name : _____

Authorization for Premier Primary Care Associates

To Disclose my Health Care Information

Patient Name: _____ **Date of Birth:** _____

You may disclose my health information to:

Name: _____ **Relation:** _____

Name: _____ **Relation:** _____

With this consent, Premier Primary Care may call my home or other alternative location and leave a message or voicemail or in person in reference to any items that assist the practice in carrying treatment, payment, and healthcare operations, such as appointment reminders, insurance items, availability of lab results, among other items.

_____ **YES** _____ **NO**

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Premier Primary Care may decline to provide treatment to me.

Signature: _____ **Date:** _____

Premier Primary Care

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to my under the Health Insurance Portability and Accountability Act of 1996 (HIPPA.) I understand that by signing consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment.)
- Obtaining payment from third party payers (e.g. my insurance company.)
- The day-to-day healthcare operations of Premier Primary Care

I have also been informed and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclose to carry out the treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signature: _____ **Date:** _____

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PRIMARY CARE
Where Passion for Care is Primary

1208 Edwards Street
Union City, TN 38261
731-885-8884
Fax 731-599-9713

Authorization to Release Medical Information

I authorize the named health care provider to release the information or records specified by Premier Primary Care upon request via secure fax or by mail at the time of the requests.

Provider: (Name, address, phone #)	Patient: _____ SS#: _____ DOB:

RECORDS AUTHORIZED TO BE RELEASED:

o Admission History and Physical	o Lab Reports
o Discharge Summaries	o Radiology Images and Reports
o Office Notes	o Psychiatric/Mental Health Records
o Other (Specify)	
o Extent or nature of records to be released:	

This authorization will expire one year from the date of the signature below. I understand that I may revoke this authorization at any time in writing to the healthcare provider, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I understand that:

- I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.
- I am entitled to receive a copy of this authorization.

_____

Patient or Representative Date

_____

Printed Name of Representative

_____

Relationship to Patient