Southwest General Medical Group, Inc.

Internal Medicine

Southwest General Medical Group, Inc.

Patient Registration Form

Patient Acct #M: _____

PATIENT

Patient's Name: Last	**First *(legal)*:**	**Middle Initial:**	
Address:			
City:	State:	Zip:	
Sex: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
SSN#:	Birthdate:	Age:	
Home Phone #:	Cellular #:	Work #:	Ext:
Employer:			
Email Address:			
Can a message be left at your home? ☐ Yes ☐ No	Left on your answering machine? ☐ Yes ☐ No		

Race	**Ethnicity**	**Student:**
☐ White ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Alaskan Native-American Indian ☐ More than one race ☐ Unreported/Refused	☐ Hispanic ☐ Non Hispanic ☐ Unreported / Refused **Preferred Language :**	☐ Full Time ☐ Part Time ☐ Not Attending **How would you like to get notification of preventative reminders** ☐ US Mail ☐ Phone

Preferred Local Pharmacy:

Preferred Mail Order Pharmacy:

Emergency Contact:

Relationship to Patient: Home Phone: ( ) Cell Phone: ( )

**** Please present your insurance card to the receptionist so that a copy can be made for our records****

INSURANCE

Primary Insurance:_____ ID# _____Group # _____

Subscriber's Name: _____ DOB _____ SSN _____

Relation to Patient ☐ Self ☐ Spouse ☐Father ☐ Mother ☐ Guardian ☐ Other
Employer Name: _____

Secondary Insurance _____ ID # _____Group # _____

Subscriber's Name: _____ DOB: _____ SSN: _____

Relation to Patient ☐ Self ☐ Spouse ☐Father ☐ Mother ☐ Guardian ☐ Other

FINANCE

Insured / Responsible Party (who is responsible for payment)

Name Last: First (legal) Middle Initial:

Address (if different than patient)

City:	State:	Zip:
SSN#:	Birth date:	
Phone #:	Relation to patient: ☐ Self ☐ Spouse ☐Father ☐ Mother ☐ Guardian ☐Other	

Authorization for Treatment and Financial Disclosure

I authorize *SGMG, INC physicians* to release any information that may be necessary to comply with subpoenas, governmental regulations and laws. I also authorized this physician to release the following parties, any information they request from the physician: Medicare and/or insurer. For physician services provided to me, I assign to the physician all insurance or other payments made by other for my physician services. I request that payment of authorized benefits be made either to me or on my behalf to the above provider for services furnished by that physician. I authorize release to the indicated insurance carrier any medical information about me needed too determine these payments for related services.

I understand that I am responsible for payment of all bills for any services provided by an *SGMG physician*. If I do not provide the name of an insurance company or other party obligated to pay my bills, I will provide the physician with personal credit information and cooperate with physicians in establishing plan for payment of my physician services.

_____ _____

Patient or Responsible Party Signature Date

Southwest General Medical Group

Patient History

Name:_____ Age: _____ DOB: _____ Date: _____
Occupation: _____ Last Physical Exam date: _____
Previous Physician: _____

Below are a number of questions concerning possible present symptoms and / or past medical history. Please answer the questions as accurately as possible. This will enable us to become completely familiar with your medical history as well as enable us to expedite proper medical services to you. This is a confidential record of your medical history and will not be released to anyone without your prior consent.

List all past medical conditions:

_____
_____
_____
_____

Operations / Hospitalization	Yes	No	Date
Tonsils			
Appendix			
Gall Bladder			
Stomach			
Kidney			
Colon			
Thyroid			
Hernia			
Uterus (women)			
Ovaries (women)			
Prostate (man)			
Joint Replacement			
Pregnancy / C-Section			
Other:			

Female Only Menstrual History:

Onset at age:_____
Days of flow: _____
Length of cycle: _____
Number of pregnancies: _____
Last mammogram (date): _____
Last Pap / Pelvic / Breast exam (date):_____

List below all medications you are presently taking
(including birth control and diet pills).

List all allergies to medications:

SOCIAL HISTORY

Do you:	Yes	No	Daily consumption
Use tobacco			packs
Drink coffee			cups
Alcohol			servings
Hard liquor / wine consumption			servings

Other information:
Have you received a blood or plasma transfusion ☐ Y ☐ N
Substance abuse: ☐ Y ☐ N

IMMUNIZATION ***(check those you have had and please note year)*:**

☐ Tetanus ☐ Pneumonia ☐ Hepatitis B
☐ Chicken Pox ☐ Childhood Immunization(s)
☐ Other:_____

FAMILY HISTORY

	Living			Health Problems	
	Age	Health			Age at death	Health Problems Cause of Death
		Good	Fair	Poor		
Father						
Mother						
Brother(s)						
Sister(s)						

Please ✓ box below and list blood relative next to illness:

☐ Anemia_____ ☐ Heart Disease_____
☐ Arthritis_____ ☐ High Blood Pressure_____
☐ Asthma_____ ☐ Stroke_____
☐ Cancers_____ ☐ Thyroid Disease_____
☐ Depression / Suicidal ☐ Tuberculosis_____
_____ ☐ Uncontrolled Bleeding_____
☐ Diabetes_____ ☐ Ulcer_____
☐ Epilepsy_____ ☐ Other: _____

Doctor's Use Only – Summary:

Continued on Reverse

Have you had problems with any of the following within the **PAST** year?

General
- ☐ Weight Loss or Gain
- ☐ Fever
- ☐ Trouble Sleeping
- ☐ Chronic Fatigue
- ☐ Excessive Bleeding
- ☐ Easy Bruising
- ☐ Abnormal Thirst

Eyes
- ☐ Itchy, Red eyes
- ☐ Vision Problems

Ears
- ☐ Ear Pain
- ☐ Ringing in Ears
- ☐ Hearing Loss

Nose
- ☐ Sinus Problems
- ☐ Nose Bleeds

Mouth
- ☐ Sore Throat
- ☐ Mouth Sores
- ☐ Dental Problems

Lungs
- ☐ Coughing up Blood
- ☐ Shortness of Breath
- ☐ Chronic Cough
- ☐ Blood Clot in Lungs
- ☐ Painful Breathing
- ☐ Wheezing

Cardiovascular
- ☐ Chest Pain
- ☐ Irregular Heart Beat
- ☐ Ankle or Hand Swelling

Gastrointestinal
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Blood Stools
- ☐ Nausea / Vomiting
- ☐ Hemorrhoids

Urinary
- ☐ Incomplete Urination
- ☐ Loss of Urine
- ☐ Painful Urination
- ☐ Bloody Urine

Musculoskeletal
- ☐ Muscle Weakness
- ☐ Joint Pains
- ☐ Joint Swelling
- ☐ Clot in Leg Vein

Neurologic
- ☐ Frequent / Severe Headaches
- ☐ Dizziness
- ☐ Seizures
- ☐ Numbness
- ☐ Trouble Walking
- ☐ Fainting Spells

Skin
- ☐ Acne
- ☐ Unwanted Hair Growth
- ☐ Unusual Lump or Growth
- ☐ Dry Skin

Emotional
- ☐ Excessive Worry
- ☐ Depression
- ☐ Frequent Crying
- ☐ Serious Thoughts of harming yourself or others

Menstrual Problems
- ☐ Cramps / Pain
- ☐ Heavy Bleeding
- ☐ Too Frequent Periods
- ☐ Bleeding Between Periods
- ☐ Missed a Period
- ☐ Other Period Issues

Pre-Menstrual Problems
- ☐ Bloating / Swelling
- ☐ Mood Changes
- ☐ Breast Changes
- ☐ Headaches
- ☐ Acne
- ☐ Other PMS Issues

Menopause Issues
- ☐ Hot Flashes
- ☐ Night Sweats

Breast Problems
- ☐ Breast Pain
- ☐ Breast Lump
- ☐ Nipple Discharge
- ☐ Other Breast Issues

Other Gynecologic Issues
- ☐ Vaginal Discharge
- ☐ Itching / Irritation
- ☐ Vulvar Pain
- ☐ Vulvar Lumps / Growth
- ☐ Vulvar Sores

Sexual Problems
- ☐ Painful Intercourse
- ☐ Bleeding after Intercourse
- ☐ Decreased Desire
- ☐ Orgasm Problems
- ☐ Dryness
- ☐ Possible Exposure to STD
- ☐ Other Sexual Issue

Would you like to discuss any of the following?
- ☐ Contraception
- ☐ Menopause Issues
- ☐ Pregnancy Issues
- ☐ Self Breast Exam
- ☐ Sexuality Issues
- ☐ STD's
- ☐ Other

Other (please explain):

Doctor's Use Only – Summary:

Continued from Front

Southwest General Medical Group, Inc.

General Consent for Treatment and Release of Medical Information

Date of Birth: _____ I, _____ ____ _____,
First Name M.I. Last Name

Southwest General Medical Group, Inc. (SGMG) is a multi-specialty group practice. I have received care from one or more SGMG physicians and I hereby voluntarily give my consent to SGMG to provide such diagnostic and medical treatment as deemed necessary.

I authorize SGMG to release any information that may be necessary to comply with subpoenas, governmental regulations and laws. I also authorize SGMG to release to the following parties, any information they request form SGMG regarding treatment I received from any SGMG physician:

- Any insurance company that may be obligated to pay my physician bills
- Medicare or Medicaid (if applicable)
- Any other party who may be obligated to pay my physician bill (example: An employer or HMO)
- Any agent, independent contractor, intermediary or other party who is obtaining information at the request of or for the benefit of any of the foregoing parties

For physician services provided to me, I assign to my SGMG physician and SGMG all insurance or other payments made by other for my physician services. This simply means that any insurance company or other party obligated to pay my physician bills may pay the physician or SGMG directly.

I understand that I am responsible for payment of all bills for any service provided by SGMG physicians. If I do not provide the name of an insurance company or other party obligated to pay my bills, I will provide the physician with personal credit information and cooperate with SGMG in establishing a plan for payment of my physician services.

_____ _____/_____
Patient or Responsible Party Signature Date Time

Southwest General Medical Group, Inc.

NOTICE OF PRIVACY PRACTICE

Acknowledgement of receipt of notice of privacy practices

I hereby acknowledge that I received the Notice of Privacy Practices of Southwest General Medical Group, Inc. which sets forth the ways in which my electronic personal health information may be used or disclosed by Southwest General Medical Group, and which outlines my rights with respect to such information.

_____ _____ _____

Print Name **Signature** **Date**

Patient DOB _____

1. I would like the person specified below (family member or friend) to have access to my medical information. My signature below gives the doctor and staff of Southwest General Medical Group, Inc my permission to discuss test results and /or my health status with that individual.

_____ _____

Signature **Date**

_____ _____

Specified Person (print name) **Relationship**

OR

2. My signature below indicates that I DO NOT give my permission to release information about my health to anyone other than the insurance company and myself.

_____ _____

Signature **Date**

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibit obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement

Other (please specify): _____

- ☐ Noted in EHR- consents
- ☐ Scanned into EHR medical record by _____