Patient Registration Form

RossLegacy MEDICAL GROUP

Patient Information

Last Name:	First Name:	M.I.:	Date of Birth:

Sex: ☐ Male ☐ Female | Marital Status: | Employment Status: | Email Address:

Mailing Address: | Apt # | City/State/Zip:

Home Phone: | Cell Phone: | Work Phone: | Please Select Preferred Number: ☐ Home ☐ Cell ☐ Work

Primary Insurance company:	*Insurance ID / member number:*
Policy holder's name:	Policy Holder's Date of Birth:
Patient Relationship to Policy Holder:	
Can we leave a message regarding your medical care & test results? ☐ Yes ☐ No WHAT NUMBER MAY WE USE?	

Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW)

Emergency Contact Name:	Emergency Contact Phone #:	Relation to patient?

Race (please select): ☐ White ☐ Hispanic ☐ Other ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Decline ☐ Native Hawaiian or Pacific Islander ☐ Indian (including Hindi & Tamil) ☐ Russian ☐ Other

Ethnicity (please select one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

Preferred Language:

Responsible Party- PLEASE COMPLETE if the patient is a minor (under the age of 18),

Last Name:	First Name:
Date of Birth:	Phone:
Relationship to Patient:	

Address of Person Responsible:

Secondary Medical Insurance Information

Ins. Co. Name	Policy Holder Name:
Policy Holder's Date of Birth:	Patient Relationship to Policy Holder:
I have reviewed a copy of Ross Legacy Medical Group's Privacy Notice.	☐ **(Initials)**

I have read and agree to Ross Legacy Medical Group's (RLMG) payment policy. I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to RLMG all money to which I am entitled for medical expenses related to the services performed from time to time by RLMG, but not to exceed my indebtedness to RLMG. I authorize RLMG to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $30.00 returned check fee will be charged for checks returned due to insufficient funds. By choosing text messaging and/or email as a communication method, I acknowledge that Ross Legacy Medical Group is not liable for any wireless charges I may incur and that unencrypted patient information may be sent to me via text message or email.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to Karl Gebhard, MD, APC, dba Ross Legacy Medical Group. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of Responsible Party: X _____ **Date:**

Printed Name of Responsible Party: X _____ **Date:**

Ross Legacy Medical Group

Patient Partnership Plan

Dear Patient,

Welcome to Ross Legacy Medical Group. We intend to provide you with the care and service that you expect and deserve. Achieving your best possible health requires a "partnership" between you and your doctor. As our "partner in health" we ask you to help us in the following ways:

1. Take responsibility for scheduling and attending follow-up appointments (as recommended). Depending on your individual medical condition, failure to comply with a follow-up may cause your condition to retrogress. Even if you are not due for a follow-up visit, but you have a concern regarding your condition, feel free to call the office for an appointment.

2. Assist our office in obtaining and communicating the results of your ordered diagnostic studies and other services. We will determine and communicate to you which studies are appropriately required for optimizing your medical treatment and we will do our best to obtain and communicate those results to you in the timeliest manner. However, it is your responsibility to comply with these orders, and also we ask that you assist us in ensuring that these results are received. In the event that your results are not obtainable (either for patient privacy reasons, or other reasons, etc.), we may ask that you participate in obtaining these results directly from the facility/entity which has provided the testing service.

3. Assist our office in obtaining the appropriate authorization(s) for the delivery of medical services and products. Depending on your individual insurance coverage, certain services or products (i.e. splints, etc.) may require special pre-certification. Please be patient if our office delays the delivery for certain services and/or dispensing of products due to pending prior-authorization. We may ask that you contact your insurance representative, and/or primary healthcare provider to help expedite the pre-certification process.
4. Communicate your decision to follow, or to NOT follow, our "Recommended Treatment Plan." Based on your individual medical condition, recommendations will be made regarding which treatment course is best for you. This may, or may not, include prescribing medication, ordering further diagnostic evaluations, conservative observation versus surgery, therapy, or referring you to another physician/specialist. If you do not agree with the treatment plan recommended, or you change your mind after having been seen, please communicate your decision to us. If you fail to do so, our office will not be able to advise you of any associated risks or consequences which may result from your decision to delay or refuse treatment. Lastly, we want you to know that as our patient, you have the right to be fully informed of your medical condition and the care associated. We encourage you to ask questions, report symptoms, and discuss any concerns you have regarding your care. We look forward to servicing you, and once again, welcome to our office and thank you for your participation.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you at any time, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

Patient Signature _____ Date _____ Physician Signature _____

Ross Legacy Medical Group

PAYMENT POLICY

It is the policy of Ross Legacy Medial Group to receive payment in full at the time services are rendered unless other arrangements have been made in advance.

If you wish our office to bill an insurance company, a copy of the insurance card is required and must be presented before services are rendered. Enrollment in an insurance plan is not a guarantee of payment. Deductibles, co-payments and patient responsibility are due at time of service.

Ross Legacy does not assume responsibility for verification of insurance benefits and/ or coverage. Please contact your insurance company to verify your benefits and doctor participation in your plan *BEFORE* services are rendered.

Any portion of the balance that is not paid by the insurance company due to patient co pays or deductible amounts, non covered services, deemed by the insurance company as not medically necessary, doctor non participating in a plan or any other reason for nonpayment or reduced payment is the responsibility of the patient or responsible party.

PATIENT NAME PATIENT SIGNATURE DATE

Adult History and Review of Systems Questionnaire

Note: This is a confidential record of your medical history. As your doctors, it is important for us to know this information so we can provide you with the best health care possible. The information contained here will not be released to anyone without your prior consent.

Name _____ Date _____

Date of Birth _____ ☐ Male ☐ Female Spouse\Significant Other _____

SOCIAL HISTORY:

Birthplace _____ Your Occupation _____

Nationality _____ Education _____

Religion _____ Marital Status _____ How many years_____

Drug Use _____ Children _____

Tobacco Use ☐ Yes ☐ No Type _____ _____

Packs per day _____ for _____ years Quit _____ Pets _____

Alcohol Use _____ Exercise (type/how often?)_____

Drinks _____ per ☐ day ☐ week ☐ month Recent or Frequent Travel Destinations _____

_____

If heavy use, how many years _____ Quit _____

Caffeine (coffee, tea, soda, chocolate) Servings per day_____

Have YOU ever had? (IF YES, CHECK APPROPRIATE BOXES)

- ☐ Cancer Type:_____
- ☐ Heart Attack/Coronary
- ☐ Artery Disease
- ☐ Rheumatic Fever
- ☐ Heart failure
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Stroke
- ☐ Diabetes
- ☐ Gallstones
- ☐ Liver Disease
- ☐ Hepatitis/Jaundice
- ☐ Ulcer disease
- ☐ Heartburn / Reflux
- ☐ Asthma
- ☐ Seizures
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Positive TB Skin Test
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Gout
- ☐ Frequent Bladder Infection
- ☐ Kidney Stones
- ☐ Kidney Disease
- ☐ Polio
- ☐ Chicken Pox
- ☐ Infectious Mono
- ☐ Anemia
- ☐ Frequent Sinus Infections
- ☐ Glaucoma
- ☐ Thyroid Trouble
- ☐ Hives
- ☐ Depression
- ☐ Head Injury
- ☐ Broken Bones
- ☐ Blood transfusions
- ☐ Sexually Transmitted Diseases: Herpes, HIV,
- ☐ Gonorrhea, Chlamydia,
- ☐ Syphilis
- ☐ Intravenous drug abuse
- ☐ Needle injury
- ☐ Mumps
- ☐ Migraines
- ☐ Prostate Enlargement
- ☐ Cystic Fibrosis
- ☐ Malaria
- ☐ Other_____

_____

IMMUNIZATIONS:

- ☐ Measles, Mumps and Rubella Vaccine
- ☐ Chicken pox vaccine
- ☐ Hepatitis B vaccine
- ☐ Influenza vaccine
- ☐ Pneumococcal vaccine
- ☐ Tetanus booster

PAST SURGICAL HISTORY: If yes, please check the box and enter the year.

- ☐ Eyes (Laser or Vision Corrected) _____
- ☐ Eyes (Cataract/Glaucoma) _____
- ☐ Ears _____
- ☐ Sinus/Nasal Septum _____
- ☐ Tonsils/Adenoid _____
- ☐ Thyroid _____
- ☐ Heart _____
- ☐ Stomach _____
- ☐ Varicose Veins _____
- ☐ Gall Bladder _____
- ☐ Appendix _____
- ☐ Intestine/Colon _____
- ☐ Hemorrhoids _____
- ☐ Hernia _____
- ☐ Breast _____
- ☐ Uterus/Hysterectomy _____
- ☐ Ovaries _____
- ☐ Spinal Surgery/Neck _____
- ☐ Prostate _____
- ☐ Spinal Surgery/Back _____
- ☐ Orthopedic (Hips/ Knee _____
- ☐ Shoulder/ Feet/Hands) _____
- ☐ C-section _____ _____
- ☐ Vasectomy _____
- ☐ Tubal Ligation _____

☐ OTHER _____

ALLERGIES and Bad Reactions to Medications: _____ _____

_____ _____

_____ _____

MEDICATIONS: Name Dosage Times a day

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Has anyone in your FAMILY ever had? **(If yes check box and list relationship)**

- ☐ Cancer & Type _____
- ☐ Diabetes _____
- ☐ Cardiac Dysrhymthia _____
- ☐ Congestive Heart Failure _____
- ☐ Coronary Artery Disease _____
- ☐ Valvular heart Disease _____
- ☐ High Blood Pressure _____
- ☐ High Cholesterol _____
- ☐ Stroke _____
- ☐ Kidney stones _____
- ☐ Kidney disease _____
- ☐ OTHER _____

- ☐ Dialysis _____
- ☐ Chronic lung disease _____
- ☐ Tuberculosis _____
- ☐ Rheumatoid Arthritis _____
- ☐ Thyroid trouble _____
- ☐ Osteoporosis _____
- ☐ Cystic Fibrosis _____
- ☐ Asthma _____
- ☐ Peptic Ulcer _____
- ☐ Gallstones _____

- ☐ Crohn's/colitis _____
- ☐ Alzheimer's _____
- ☐ Alcoholism _____
- ☐ Bleeding tendency _____
- ☐ Anemia _____
- ☐ Gout _____
- ☐ Depression _____
- ☐ Mental illness _____
- ☐ Seizures _____
- ☐ Migraine headaches _____

GYNECOLOGICAL/ OBSTETRICAL HISTORY:

Name of OB-GYN _____

Age when you Started Menstruating? _____ Number of Pregnancies? _____

Date of Last PAP? _____ Number of Births? _____

History of abnormal Pap's Yes / No (Please circle) Vaginal / C-section (Please Circle)

Date of Last Mammogram? _____ Method of Contraception _____

History of Abnormal Mammograms Yes / No (Please circle)
Menstrual Cycles? Regular / Irregular (Please Circle)
Pain with Periods? Yes / No (Please Circle)
Age at Menopause? _____

CONFIDENTIAL COMMUNICATION REQUEST AUTHORIZATION

Many of our patients allow family members such as their spouse, parents, or others to call and request medical or billing information. Under the requirements of HIPPA, we are not allowed to give this information to anyone without the patients consent. If you wish to have information released, you must complete and sign below.

I authorize the use of the following means of communication for information related to my personal health, medical treatment, or payment of treatment/billing information.

PLEASE SELECT ALL THAT APPLY:

____Phone Phone Numbers:

Home:_____

Cell: _____

Work:_____

____You have my consent to leave a message regarding my treatment on my voicemail.

____Do not leave a message regarding my treatment on my voicemail.

____Written communication to mailing address:_____

Please specify the person(s) allowed to receive medical information:

_____	_____	_____
Name	Phone Number	Relationship
_____	_____	_____
Name	Phone Number	Relationship
_____	_____	_____
Name	Phone Number	Relationship

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected information to be disclosed.

I understand that the information disclosed to any above recipient is no longer protected by federal or state law and may be subject to disclosure by the above recipient.

I have the right to revoke this consent in writing.

Signature:_____ Date of Birth: _____ Date: _____

Print Name_____