Patient Registration Form

Patient Information

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

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

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

Home Phone: | Cell Phone: | Work Phone:

Please Circle a Preferred Contact # Home Cell Work

Can we leave a message regarding your medical care & test results on your preferred contact number? (Please Circle) Yes No

Primary Insurance Company:	Primary Insurance Subscriber's Name:
Patient Relationship to Insurance Subscriber: (Please Circle) Self Child Spouse Other:	Insurance Policy Subscriber's Date of Birth:
Emergency Contact Name:	Secondary Insurance Company:
Emergency Contact Phone:	**Emergency Contact Relationship:**

Race (Please Circle All That Apply): White, Hispanic, American Indian, Alaska Native, Asian, Indian, Russian, Black or African American, Pacific Islander, Native Hawaiian, Decline, Other:

RESPONSIBLE PARTY- COMPLETE ONLY IF THE PATIENT IS A MINOR. (UNDER 18 YEARS OLD)

Last Name:	First Name:	Relationship to Patient	Phone:

Consent to Treat Without a Parent Present?: (Please Sign and Completed Effective Dates)

Signature:	Relationship to Minor:
Effective Date:	End Date:(If Applicable) (Examples of End Dates: Age 18, One Month, 6 Months
Special Instructions:	

Payment Policy:

[illegible]

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.

I have reviewed a copy of Ross Legacy Medical Group's Privacy Notice:

Signature of Responsible Party: X ____________________ Date:

Printed Name of Responsible Party: X ____________________

Rev. 3.2016

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

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____

PPO MDCR PROVIDER_______________________ DATE:

HMO_____________PCP: Intake Form TIME CHART UP TIME ROOMED

NAME : ADDRESS____

D.O.B: AGE: ____

PLEASE FILL IN COMPLETELY FOR YOUR VISIT TODAY

I would like to focus on these issues at today's visit:

☐ **Preventive Exam (Health Screening):**

Diagnosing and treating a medical condition or illness, either acute or chronic is not part of a preventative exam. An office visit may be billed. Please see front office staff for further information.

List any medicine changes since your last visit:

List any tests or consultations since your last visit:

WHAT PHARMACY AND LOCATION DO YOU USE?

____

____

What number and email may we use to contact you?

Phone: ___________________________________

Email:___________________________________

My Family History (Parents, Brothers, Sisters):

__ Diabetes
__ Heart Disease
__ High Cholesterol
__ Hypertension
__ Breast Cancer
__ Colon Cancer
__ Prostate Cancer
__ Other Cancer: ________
__ Other Issues:
____
____
____

FOR STAFF USE ONLY*

______________ **Height**

______________ **Weight**

______________ **BMI**

______________ **Blood Pressure**

______________ **Temperature**

______________ **Pulse**

______________ **O2 Saturation**

Smoke/Chew: Never Currently Previously

Pack years_________**Year quit**____________

DM Distal Exam

Pharmacy:_________________

LOCATION: _______________

MA Initials: _____________________

Allergies:

Medications:

LMP_______________
FEMALE PRESENT
GC/CHL

Services Provided:

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 ______________________________

Nationality ______________________________

Religion ______________________________

Drug Use ______________________________

Tobacco Use ☐ Yes ☐ No Type ______________
Packs per day ____ for _____ years Quit __________
Alcohol Use ______________________________
Drinks _____ per ☐ day ☐ week ☐ month

If heavy use, how many years _____ Quit _________
Caffeine (coffee, tea, soda, chocolate) Servings per day_____

Your Occupation ______________________________

Education ______________________________

Marital Status ______________ How many years________

Children ______________________________

____

Pets ______________________________
Exercise (type/how often?)______________________________
Recent or Frequent Travel Destinations ______________________________
____

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 ______________________

PATIENT NAME ______________________ DATE__________

PATIENT DATE OF BIRTH______________________

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? ______