### **Patient Registration Form**



Last Name:		First Name:		Л.I.:	Date of Birth:
Gender: Mari	ital Status: Emplo	pyment Status:	Email Address:		.1
Male Female		A + 11	0: /0: /=:		
Mailing Address:		Apt #	City/State/Zip:		:
Home Phone:  Please Circle a Preferred Con	utact # Home Cell	Cell Phone:  Work Can w	Wo re leave a message regarding you	ork Phone:	re & test results on your
Thease officient at the referred of the	Trome cen	WOIR	preferred contact number? (Ple		Yes No
Primary Insurance Compa	•		Primary Insurance Subscril	per's Name:	
Patient Relationship to Insurance St (Please Circle)	ubscriber: Self Child	Spouse Other:	Insurance Policy Subscriber	r's Date of B	irth:
<b>Emergency Contact Name</b>	:		Secondary Insurance Comp	eany:	
Emergency Contact Phone:		<b>Emergency Contact Relati</b>	onship:		
Race (Please Circle All That	Apply): White, Hispa	nic, American Indiai	n, Alaska Native, Asian, Indian, R	ussian, Black	or African American,
Pacific Islander, Native Hawa	aiian, Decline, Other:				
RESPONSIBLE PAR	ΓΥ- COMPLETE	ONLY IF THE	E PATIENT IS A MINOR	R.   (UND	ER 18 YEARS OLD)
Last Name:	First	Name:	Relationship to Patier	nt Phone	:
Consent to Treat Without	a Parent Present?: (P	lease Sign and Cor	mpleted Effective Dates)		
Signature:			Relationship to Minor:		
Effective Date:			End Date:(If Applicable)		
			(Examples of End Dates: A	ge 18, One N	Month, 6 Months
Special Instructions:			(Examples of End Dates: A	ge 18, One N	Month, 6 Months
Special Instructions:			(Examples of End Dates: A	<u>age 18, One N</u>	Month, 6 Months
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Fayment Policy:  ;f[efzWa'[lkaXDace>WSlk? W[s];Xkagi [ez/agdaXLWa I]*S [ egc YgScb fWwixbSlk Wise Wgw[T]*N [SV addahMSVMBVSWWa ISV kagw bSch[UbSf] Y[ Sb'S adS kafzwice read and agree to Ross Legacy Medical am entitled for medical expenses remation to my insurance carrier or third int due will result in submission to an oas a communication method, I acknow	F Wa_bS kl S Labka MZZ Lažosk_ Wres Vbsf Wf dk dl egos Wa_bs kfa hkl ka bsf Wf La bske ad Wyg uf laksa Xad a bsk_ Wf add al Group's (RLMG) payment lated to the services perform party payer to facilitate pro outside collection agency. A	W' egcb' LVUSdV [echlogich ba' ef II [fik SchWgWsf f] [IX laged I WWffes' V Value II VVB_ ag' fet 'a' Lah Wig LW bSk_ Wf [ef ZVM] policy. I understand that ned from time to time by cessing my insurance clai \$30.00 returned check fe	Jukschwhwwhlwg 'Aleafzwilschs' Yw w Hws v_gefTwichenwwwTwiachwhiftw . Waxehif[WaiDace>WsUk Vakw' af Seeg [achbsch]Ubsija* [* kagelb's* Twiachwhi Weldf(Wil Ww Wikfzw)* egos Uwa_	feZSHNIW _ S SCHNWWW WMbs 'e[I] fil f[UNSCHWW bS kSe' af _ V WScHZ f insurance cove s to RLMG. I aut anding balances to insufficient f	SWW/ SWH6 WW/ T da^_ WF[' S' [' egd6' WW/S' [e' af S W/Adl'M/JUS/[a' aX  egd6' WW/SS [e' a W/JS'k WW/Sdd VaUfad' a' rage. I hereby assign to RLMG all money thorize RLMG to release any medical within 90 days of notification of the funds. By choosing text messaging and/o
Payment Policy:  ;f[efzWba'[UkaXDaee>WSUk? W[Us.;Xkagi [eZagdaXXUWa T[^NS ]	F LWA bs ld S Labka MZ Laask LWES VISS[W cM ld eggs LWA bs ka hM laask Mc a' bsk W add al Group's (RLMG) payment lated to the services perform party payer to facilitate pro putside collection agency. A wledge that Ross Legacy Mec yment of authorized Medica	W' egcb' LWSdV [eclloigle Man' e[T] [flkScWgWsf f] Jk lage TTWWfe's VVal [TWB_ag' fel' a' Lahlal WgWbSk_W [efZWd policy. I understand that ned from time to time by cessing my insurance clai \$30.00 returned check fe dical Group is not liable for the benefits be made to K	JANSCHWIMMAN g` 'Mee af ZWISCHS' YW W.  JANSCHWIMMAN go 'Mee af ZWISCHS' YW W.  WARANT [UMDace> WSUK Va'W af Sceg_ lacibsch [Ubsf]a` [` lagcib's` TWACWAN  Wewlf [UM WW W Tk fZW egcb` UWa_  Wewlf [UM WW W Tk fZW egcb` UWa_  Wewlf [UM WW W Tk fZW egcb` UWa_  Wewlf [UM www W Tk fZW egcb` UWa_  Wewlf [UM www W Tk fZW egcb` UWa_  Wewlf [UM www w Tk fZW egcb` UWa_  Wewlf www w the fact was a fact of the common to the common	feZSHMIWW_S ScIMMWIWZ WMMFa`e[II[ffl HUWS kSe`af_V WSCHZ Finsurance cove s to RLMG. I aut anding balances to insufficient f at unencrypted p edical Group. I a	SWV/ SW16' UW/ 7 da^_ Wf[' S' [' egd6' UW/S' [e' af S SWidhWLYUSf[a' aX]' egd5' UW/Wffe W23' kbadf[a' aXfZWIS'S' UW/ZSf [e' a WLS'k' WW/Sdd VaUfad' a' rage. I hereby assign to RLMG all money horize RLMG to release any medical within 90 days of notification of the funds. By choosing text messaging and/o patient information may be sent to me vi
Flefzwa/UkaxDaee>Wsuk? Wis; Xiagi [eZagdaxXIWa Ti^S ] egc Ygsc fwaxisk Wz6Wguffrwi S V. adlahistyda Wewa ist fag bs[vTkfzw] egc wws. bs kafzwa Fad and agree to Ross Legacy Medic I am entitled for medical expenses re- nation to my insurance carrier or third int due will result in submission to an or as a communication method, I acknow nessage or email. CARE BENEFICIARIES: I request that pa nation about me to release to CMS and	E Wa_ bs kls LabkaMZ Laask_ Wies Vhsfiwf di (legs UWa_ bs kfa had fa bsfiwf Labskead Wysfi party payer to facilitate pro putside collection agency. A wledge that Ross Legacy Med yment of authorized Medica d its agents any information  copy of Ross Legacy Privacy Notice:	W egcb LWSdV [eclloigle Sha`e[II]ffkSdWgWsf f[ XklageTIWWfeS VVal II'WB_ag' fel`a` Lahlu WgWbSk_ Wf [efZWd policy. I understand that ned from time to time by cessing my insurance clai \$30.00 returned check fe dical Group is not liable for are benefits be made to K needed to determine the	Juschwin Willyg 'MeafZMischs' YW W. WS V_gef Twodwin WT Wadwalf W. Wilk Valle af Seeg_fadbscff [Uksfia   lagdbs' Twadwal Weldf [Uksfia   lagdbs' Twadwal Weldf [Uksfia   lagdbs' Twadwal Weldf [Uksfia   lagdbs' Twadwal Weldf [Uksfia   lagdbs' ef Twadwal W. WTkfZW eggs Weldf [W addwin ef Twadwal   lagdbs'	feZSHMIWW_S ScIMMWIWZ WMMFa`e[II[fil HUX SSE af_V WSCHZ Finsurance cove s to RLMG. I aut anding balances to insufficient f at unencrypted p edical Group. I a ated services.	SWY SW16 UW/ 7 da^ Wf ['S' ['egd6 UW/S' [e'afS & Midliw[XLSf]a'a M'egd6 UW/Wfe W23 kbad[a'a MZWIS'S UWZSf [e'a MUS'k WW/6di Valfad'a'  rage. I hereby assign to RLMG all money chorize RLMG to release any medical within 90 days of notification of the funds. By choosing text messaging and/o patient information may be sent to me vi authorize any holder of medical
Payment Policy:  ;f[efzWa/[UkaXDaee>WSUk? W[Us.;Xkagi [eZagdaXXUWa T[^S [^ egc YgSG fWaXISk WZ6WgUffTW]] S VI adlahMSYWB W8Wa iSI flags bS[VTkfzW] egc WS Wa iSI kafzWa bSch[UbSf] Yf Sb/S adS kafzWa egac Medic I am entitled for medical expenses renation to my insurance carrier or third int due will result in submission to an cas a communication method, I acknownessage or email.  CARE BENEFICIARIES: I request that panation about me to release to CMS and I have reviewed a	E Wa_ bS kl S Labka MZ Lažisk_ Wies VbSf Wf dk df egc UWa_ bS kra hw fa bSf Wf Labske ad Wg bf lasen X d' a` bSk_ Wf add al Group's (RLMG) payment lated to the services perform party payer to facilitate pro putside collection agency. A wledge that Ross Legacy Med yment of authorized Medica d its agents any information  copy of Ross Legacy Privacy Notice:	W egcb LWSdV [eclloigle Sha`e[II]ffkSdWgWsf f[ XklageTIWWfeS VVal II'WB_ag' fel`a` Lahlu WgWbSk_ Wf [efZWd policy. I understand that ned from time to time by cessing my insurance clai \$30.00 returned check fe dical Group is not liable for are benefits be made to K needed to determine the	JANSCHWIMMING 'MeafZMIScHS' YW W. JWS' V_gef 'TWodMWWTWichAMf (W. WASAMT (WADACE) WSUK VAW' af Seeg_ FachScht[UhSf]a`   lagglb's` TWMAMI WAMT (WM WW TKFZW) eggs' UWa_ WaMT (MI (MI SEE) WADACH (MI SEE) WADACH (MI SEE) WADACH (MI SEE) Band ef [Tifka MZ/WSG] W ack did with a failure to pay outstate will be charged for checks returned due or any wireless charges I may incur and that all Gebhard, MD, APC, dba Ross Legacy Market (MI SEE) was all Gebhard, MD, APC, dba Ross Legacy Market (MI SEE) was all Gebhard, MD, APC, dba Ross Legacy Market (MI SEE) was all Gebhard, MD, APC, dba Ross Legacy Market (MI SEE) was all Gebhard, MD, APC, dba Ross Legacy Market (MI SEE) was all Gebhard, MD, APC, dba Ross Legacy Market (MI SEE) was all Gebhard, MD, APC, dba Ross Legacy Market (MI SEE) was all gebhard.	feZSHMIWW_S ScIMMWIWZ WMMFa`e[II[fil HUX SSE af_V WSCHZ Finsurance cove s to RLMG. I aut anding balances to insufficient f at unencrypted p edical Group. I a ated services.	SWV/ SW16' UW/ T da^_ Wf[' S' [' egd6' UW/S' [e' af S SWdflwV/gusfja' axl' egd5' UW/Wffe W23' kbadfja' axl'zwus's' UW/ZSf [e' a WUS'k' WW/Sdd Valfad' a' rage. I hereby assign to RLMG all money horize RLMG to release any medical within 90 days of notification of the funds. By choosing text messaging and/o patient information may be sent to me vi

# 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 precertification. 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 patie	ent, you have the ri	ght to be informed about your health	care. We invite you,
at any time, to ask questions, report sympton	ns, or discuss any o	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:

Print Name

Phone	Phone Numbers:		
	Home:		
	Cell:		
	Work:		
You have my consen	t to leave a message regard	ling my treatment on my	voicemail.
Do not leave a messa	age regarding my treatmen	t on my voicemail.	
Written communicat	ion to mailing address:	Santalinia - Santa	
Please specify the person	(s) allowed to receive medi	cal information:	
Name	Phone Number	Relationship	
Name	Phone Number	Relationship	
Name	Phone Number	Relationship	
Patient Information			
I understand I have the rig the protected information		ation at any time and that	I have the right to inspect or copy
	ormation disclosed to any a sclosure by the above recip		r protected by federal or state law
I have the right to revoke	this consent in writing.		
Signature:		Date of Birth:	Date:

НМО	PCP:	Intake Form	TIME CHART UP	TIME ROOMED
NAME:		ADDRES	S	_
D.O.B:	AGE:			
P	LEASE FILL IN C	OMPLETELY	FOR YOUR VIS	SIT TODAY
<u></u> -		<u> </u>		<u></u>
I would like to foci	us on these issues at to	day's visit:	WHAT PHARM	ACY AND LOCATION DO YOU USE?
			Vend Rx	
			What number a	and email may we use to
			contact you?	•
	xam (Health Screenii			
Diagnosing and treating a medical condition or ill either acute or chronic is not part of a preventative exam. An office visit may be billed. Please see to		ventative		ory (Parents, Brothers, Sisters):
office staff for further information.  List any medicine changes since your last visit:			Diabetes	Prostate Cancer
List arry me	edicine changes since your is	asi visii.	Heart Disease High Cholester	<del></del>
			Hypertension	
List any tests of	or consultations since your la	st visit:	Breast Cancer Colon Cancer	
******	*******	***FOR STAFF U	JSE ONLY*****	*******
	_ Height	Allergie	es:	
	_ Weight			
	_ ВМІ	Medication	ons:	Services Provided:
	_ Blood Pressure			
	_ Temperature			
	_			
	_ O2 Saturation			
Smoke/Criew: Neve	r Currently Previously			
	Year quit			
DM Distal Exam				
Pharmacy:		LMP		
LOCATION:		FEMALE P	PRESENT	
MA Initials:		GC/CHL		

DATE:

PPO MDCR

PROVIDER\_

## **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	□ Mala □ Female	Spausal Significant Other	
SOCIAL HISTORY:	Male   Female	Spouse Significant Other	
		Your Occupation	
Nationality		Education	
Religion		Marital Status	How many years
Drug Use		Children	
Tobacco Use ☐ Yes ☐ No	Туре		
Packs per day for	years Quit	Pets	
Alcohol Use		Exercise (type/how often?)	
Drinks per □ day □ wee	ek □ month	Recent or Frequent Travel Des	stinations
If heavy use, how many years Caffeine (coffee, tea, soda, ch	Quit ocolate) Servings per day		
Have YOU ever had? (IF YES, CHE  ☐ Cancer Type:		☐ Glaucoma	□ Prostate Enlargement
☐ Heart Attack/Coronary	□ Pneumonia	☐ Thyroid Trouble	☐ Cystic Fibrosis
☐ Artery Disease	☐ Tuberculosis	☐ Hives	⊔ Malaria
☐ Rheumatic Fever	☐ Positive TB Skin Test	☐ Depression	□ Other
☐ Heart failure	☐ Osteoporosis	☐ Head Injury	
☐ High blood pressure	☐ Arthritis	☐ Broken Bones	
☐ High cholesterol	⊔ Gout	Blood transfusions	IMMUNIZATIONS:
⊔ Stroke	☐ Frequent Bladder Infection	☐ Sexually Transmitted	☐ Measles, Mumps and
☐ Diabetes	☐ Kidney Stones	Diseases: Herpes, HIV,	Rubella Vaccine
Gallstones	☐ Kidney Disease	☐ Gonorrhea, Chlamydia,	☐ Chicken pox vaccine
Liver Disease	Polio	□ Syphilis	☐ Hepatitis B vaccine
☐ Hepatitis/Jaundice	☐ Chicken Pox	☐ Intravenous drug abuse	□ Influenza vaccine
Ulcer disease	☐ Infectious Mono	☐ Needle injury	☐ Pneumococcal vaccine
☐ Heartburn / Reflux	☐ Anemia	□ Mumps	□ Tetanus booster
□ Asthma	☐ Frequent Sinus Infections	☐ Migraines	Trotainas booster
⊔ Seizures			
PAST SURGICAL HISTORY: If ye			Sunaam/Baak
☐ Eyes (Laser or Vision	□ Gall Bladder		Surgery/Back
Corrected)	Appendix		edic (Hips/ Knee
Eyes (Cataract/Glaucoma)	☐ Intestine/Colon		er/ Feet/Hands)
□ Ears	Hemorrhoids	C-secti	on
☐ Sinus/Nasal Septum	⊔ Hernia		
☐ Tonsils/Adenoid	_ □ Breast		
☐ Thyroid	☐ Uterus/Hysterectomy		Ligation
☐ Heart			
☐ Stomach	☐ Spinal Surgery/Neck		
	☐ Prostate	□OTHER □	

PATIENT NAME		DATE		
PATIENT DATE OF BIRTHALLERGIES and Bad Reactions to Med	ications:			
MEDICATIONS: Name	Dosage	Times a day		
2				
<ul><li>5.</li><li>6.</li><li>7.</li></ul>				
9.				
Has anyone in your FAMILY ever had?				
☐ 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	☐ Osteoporosis ☐ Cystic Fibrosis ☐ Asthma ☐ Peptic Ulcer	☐ Crohn's/colitis ☐ Alzheimer's ☐ Alcoholism ☐ Bleeding tendency ☐ Anemia ☐ Gout ☐ Depression ☐ Mental illness ☐ Seizures ☐ Migraine headaches		
GYNECOLOGICAL/ OBSTETRICAL Name of OB-GYN	L HISTORY:			
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 Menstrual Cycles? Pain with Periods? Age at Menopause?	Yes / No (Please circle) Regular / Irregular (Please Circle) Yes / No (Please Circle)			