Pinnacle Physicians Group, LLC

Demographic Information

_____ _____ _____
Last Name First Name Middle Initial

_____
Address City State Zip

_____ _____ _____
Home Phone Cell Phone Work Phone

_____ _____
Date of Birth Social Security Number Sex: (circle) M or F

Email: _____

Would you like to receive email or text message appointment reminders? __email __text

Race: (circle) White African American American Indian Asian Hispanic Other

Marital Status: _____ Spouse's Name: _____

Employer: _____ Occupation: _____

_____ _____ _____
Emergency Contact Relationship Phone

How were you referred to our office? _____

Which of our doctors would you like to see? _____

Guarantor Information

****Person responsible for bills if other than the patient;Required for patients under age 18****

_____ _____
Last Name First Name

_____ _____ _____
Social Security Number Date of Birth Relationship to Patient

_____
Address City State Zip

Insurance Information

_____ _____ _____
Primary Insurance ID# Group#

_____ _____ _____
Subscriber Name Subscriber Date of Birth Relationship

_____ _____ _____
Secondary Insurance ID# Group#

Please complete these forms and return to ***your*** Pinnacle Physicians Group

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Authorizations

AUTHORIZATION FOR TREATMENT AND FINANCIAL RESPONSIBILITY
I (or designated guardian) authorize the physician to provide treatment and to release medical information that may be necessary for payment of physician claims. I hereby authorize payment directly to my physician for insurance benefits otherwise payable to me, but not to exceed regular charges for physician claims. I understand that I am financially responsible to the physician for charges not covered by my insurance.

_____ _____
Patient and/or Guardian Signature Date

MEDICARE PATIENTS (Please sign if you have Medicare Benefits)
I certify that the information given by me in applying for payment under Title XVIII of the Social Administration or its intermediaries of carriers any information needed for physician claims and other related medical claims. I request that payment of claims be made on my behalf for authorized benefits under my health insurance. I hereby authorize payment directly to my physician for insurance benefits otherwise payable to me. Payments are not to exceed the balance due of the practice's regular charges for claims. I understand that I am financially responsible to my physician for charges not covered by this authorization. I understand that my physician will bill HCFA claims using the term "signature on file" and I am aware that my signature as written below constitutes that signature.

_____ _____
Patient and/or Guardian Signature Date

CONSENT FOR TREATMENT FOR MINOR OR INCAPACITATED PATIENTS
I hereby authorize the physician to provide medical treatment to _____ _____. The patient is unable to consent to medical treatment because he/she is _____

_____ _____ _____
Signature of Guardian Name of Guardian Date

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Medical Information

Patient Name:_____ Date of Birth:_____

ALLERGIES: _____

PAST MEDICAL HISTORY- Please circle if you have or had any of the following:

Diabetes	Low Back Problems	Colitis	Hay Fever
Pneumonia	Arthritis	Ulcers	Blood Disorders
Asthma	Skin Diseases	Stomach Disorders	Migraines
Bronchitis	Kidney Stones	Heart Disease	Thyroid Disease
Depression	Tuberculosis	Kidney Disease	High Blood Pressure
Hepatitis	Venereal Disease	Other:_____	

MEDICATIONS: (Prescription, Over-the-counter, Vitamins, Herbs, etc.)

Drug Name:_____ Dose:_____

Drug Name:_____ Dose:_____

Drug Name:_____ Dose:_____

Drug Name:_____ Dose:_____

Drug Name:_____ Dose:_____

SURGERY AND HOSPITALIZATIONS- (PLEASE LIST THE DATE AND REASON)

Surgery: Gallbladder_____ Appendix _____ Hysterectomy _____
Other: _____

Hospitalization other than for surgery: _____
_____
_____

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Family History- has any member of your family (including parents, grandparents and siblings) ever had the following?

Illness:	**Which family member:**
Cancer	_____
Hypertension	_____
Heart Disease	_____
Diabetes	_____
Strokes	_____
Mental Disease (anxiety, depression)	_____
Drug or Alcohol addiction	_____
Glaucoma	_____
Bleeding Disease	_____
Other	_____

Preventative Care:

Name of Gynecologist: _____
Method of birth control: _____
Last Mammogram: _____
Last Colonoscopy: _____
Last Bone Density Scan: _____

Prevention: Please circle yes (Y) or no (N)

Y N Do you smoke?
Y N Do you drink alcoholic beverages?
Y N Do you drink tea or coffee?
Y N Do you use illegal drugs?
Y N Have you ever engaged in activity putting you at risk of getting AIDS/HIV?
Y N Do you wish to be tested for AIDS/HIV?
Y N Have you ever worked with chemicals, paints, asbestos or other hazardous materials? If yes, explain: _____
Y N Are you in a relationship in which you have been physically hurt?
Y N Do you wear seatbelts?
Y N Do you visit the dentist on a regular basis?
Y N Do you have a "Living Will"? (If yes, please provide a copy for your chart)
Y N Do you have a power of attorney for health care decision making? If yes, please provide name and contact information: _____
Y N Are you an organ donor?

_____ _____
Patient Signature Date

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Request for Confidential Communication of Your Protected Health Information

In our efforts to comply with the Health Insurance Portability and Accountability Act (HIPAA), we need to be certain that we protect your privacy to your wishes when it comes to your family, friends and co workers.

Please circle your response to the following:

- May we leave a detailed message (lab results, etc.) on a cell voicemail?
  Cell number: _____ Yes No N/A
- May we leave a detailed message (lab results, etc.) on a home voicemail?
  Home number: _____ Yes No N/A
- May we leave a detailed message (lab results, etc.) on a work voicemail?
  Work number: _____ Yes No N/A
- May we discuss your appointments/treatment with your spouse? Yes No N/A
  Spouses Name: _____
- If you are over the age of 18, may we discuss your appointments/ treatments (lab results, etc.) with your parents or guardian? Yes No N/A
- If you are over the age of 18. may we discuss your appointments/treatments (lab results, etc.) with your children? Yes No N/A
- May we leave a message concerning your appointments with a co worker or receptionist that regularly answers your calls? Yes No N/A

You must inform us in writing of any changes in your directives. This record takes effect immediately and will be kept in your chart along with your acknowledgement of receipt of your Notice of Privacy Practices.

_____ _____
Signature Date

_____ _____
Name Printed Date of Birth

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PATIENT REGISTRATION FORM
DISCLOSURES & CONSENTS

Patient Name: _____ Date of Birth: _____

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits to Frankford Avenue Family Practice's affiliated professional associations or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-payment or balance due that Frankford Avenue Family Practice is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Frankford Avenue Family Practice's affiliated professional associations or the physician on my behalf.

LAB/X-RAY/DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

ACKNOWLEDGEMENT OF POTENTIAL FINANCIAL INTEREST IN ANCILLARY SERVICES
I acknowledge that my treating physician may have a financial interest in the overall performance of ancillary services as part of his/her affiliation with a group practice. I understand that I should contact my treating physician if I have any questions regarding his/her potential financial interest in the ancillary services. I further understand that I am free to choose where I receive medical services and that I may discuss with my physician the availability of alternative treatment facilities if I so desire.

CONSENT TO TREATMENT
I hereby consent to evaluation, testing and treatment as directed by my Frankford Avenue Family Practice physician or his or her designee.

_____ _____
Patient Signature Date

_____ _____
Guarantor Signature Date
(if different from patient)

_____
Guarantor Name Printed

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Please be advised our providers will **NOT** prescribe or refill any prescriptions for pain medications, sleep medications or controlled substances prescribed previously by **another provider** *under any circumstances*. If you are a new patient currently taking any medications that fall under these categories, you must seek treatment with a specialist who will prescribe those medications.

If you do not agree with this policy, we ask that you find another primary care office to better suit your healthcare needs.

I am aware and fully understand that my provider at Pinnacle Physicians Group will not write or refill any previously prescribed controlled substance medications, pain medications or sleep medications under any circumstances.

_____ _____

Patient Signature Name Printed

_____

Today's Date

Please complete these forms and return to ***your*** Pinnacle Physicians Group