

Patient Registration

PATIENT DEMOGRAPHICS					
Last Name		First Name		M	PCP: Referring Physician:
Address			City	State	Zip Code
Home Phone	Cell Phone	Work Phone	Birthdate (MM/DD/YYYY)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender	
Practice communication preference for Appts, Rx Notices, Test Results: <input type="checkbox"/> Phone <input type="checkbox"/> Text (SMS) <input type="checkbox"/> Both		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Social Security Number	
Employer Name			Occupation/Job Title		<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
Employer Address			City	State	Zip Code
GUARANTOR INFORMATION (only if different from patient)					
Last Name		First Name		M	Relationship to Patient
Address			City	State	Zip Code
Home Phone	Cell Phone	Birthdate (MM/DD/YYYY)	Social Security Number		
EMERGENCY CONTACT					
Relation <input type="checkbox"/> Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Care Giver <input type="checkbox"/> Sibling <input type="checkbox"/> Child <input type="checkbox"/> Other _____			Last Name		First Name M
Address			City	State	Zip Code
Home Phone	Cell Phone	Work Phone			
PRIMARY INSURANCE INFORMATION					
Primary Insurance Company				Policy ID Number #	
Coverage Start Date(MM/DD/YYYY)	Subscriber/Insured Name			Patient Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____	
Group Number #			Group Name		
SECONDARY INSURANCE INFORMATION					
Secondary Insurance Company				Policy ID Number #	
Coverage Start Date(MM/DD/YYYY)	Subscriber/Insured Name			Patient Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____	
Group Number #			Group Name		

Rx HISTORY CONSENT and ADVANCE DIRECTIVE

Indicate whether you consent for your provider to view your Rx history from external sources.

Yes No

Advance Directive protects your right to refuse medical treatment that you do not want or to request treatment you do want.

Do you have an Advance Directive? Yes No

If NO, would you like more information? Yes No

PATIENT PORTAL INFORMATION

Enable Web Portal? Yes No

Email Address (Required for Web Portal)

ADDITIONAL INFORMATION

Race

Asian Black
 Hispanic White
 Other _____

Ethnicity

Hispanic or Latino
 Non-Hispanic or Non-Latino

Language

English Spanish
 Sign Language (ASL)
 Other _____

INSURANCE PREFERRED LAB AND RADIOLOGY SERVICES

If the preferred facility is not designated by the patient, their tests will be sent to St. Joseph's/Candler facilities and the patient will be responsible for payment.

Laboratory

St. Joseph's/Candler LabCorp Quest
 Other _____

Radiology/X-ray

St. Joseph's/Candler
 Other _____

PHARMACY INFORMATION

Pharmacy Name (Primary)

Phone #

Fax #

Address

City

State

Zip Code

AUTHORIZATION TO TREAT

I do hereby consent to and Authorize the performance of all treatments, surgeries and medical services deemed advisable by the health care providers and staff of St. Joseph's/Candler Medical Group to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true.

Yes No Initial _____

ASSIGNMENT OF BENEFITS

I authorize release of information and payment of medical benefits to St. Joseph's/Candler for any services furnished. I understand that I am financially responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage.

Yes No Initial _____

I have read and understand the above statements and agree to be bound by its terms and conditions. I also understand and agree that such terms may be amended occasionally by the practice.

Patient Signature OR Authorized Representative

Date

Printed Name of Authorized Representative

Authorization for Release of Information for Specific Purposes of HIPAA DISCLOSURE

I hereby authorize SJC Medical Group to release OR receive the following information from the health records of:

Patient

Name: _____ SSN: _____ DOB: _____

To be released to:

Name	Relationship	Date of Birth	Phone

INFORMATION TO BE RELEASED: (Check All That Apply)

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Entire Record | <input type="checkbox"/> Lab Results | <input type="checkbox"/> Nursing Notes | <input type="checkbox"/> Demographics |
| <input type="checkbox"/> Emergency Room Notes | <input type="checkbox"/> Radiological Results | <input type="checkbox"/> Physician Orders | <input type="checkbox"/> Medication Records |

FOR THE PURPOSE OF:

- Anything on behalf of patient
- Creating/Changing/Canceling appointments
- View or correct demographic information to include signing in on my behalf
- Receive documents containing my PHI (Protected Health Information) on my behalf with an authorization for release of information signed by me.
- Picking up prescriptions/forms and or medications on my behalf.
- Speaking to SJC Medical Group staff regarding my PHI including but not limited to billing and insurance information on my behalf.
- Other: _____

I understand that I can revoke this authorization by providing written notice to the Health Information Department of St. Joseph's/Candler Medical Group or in a manner described in the Notice of Privacy Rights. I also understand that if information has been released by relying upon this Authorization, that revocation will not be valid.

I PLACE NO LIMITATIONS ON HISTORY OF ILLNESS OR DIAGNOSTIC AND THERAPEUTIC INFORMATION, INCLUDING ANY TREATMENT FOR ALCOHOL, DRUG ABUSE OR DEPENDENCY, PSYCHIATRIC OR PSYCHOLOGICAL ILLNESS, MENTAL ILLNESS OR RETARDATION AND ACQUIRED IMMUNE DEFICIENCY (AIDS) SYNDROME.

The physician's office listed above may not condition treatment, payment, on the signing of this authorization, unless allowed by law.

I understand that I am waiving my rights to privacy by releasing my medical information to the parties listed above and this information may be re-disclosed by the receiving party. I hereby authorize the entity listed above to release the said information described above.

I understand that this Release of Information will expire within **ONE YEAR** from the date listed below.

Patient Signature

Date

Patient's Guardian or Capacity

Date

Relationship to Patient

Office Policies

Appointments and No Show Policy

We believe that our patient's time is valuable and every effort is made to keep your waiting time to a minimum. If you are unable to keep your appointment, please notify the office as soon as possible. This courtesy allows us to give appointments to another patient. If you do not cancel your appointment 24 hours prior to the scheduled appointment time a No Show fee will be charged to your account. If you have 3 or more No Shows within a 12 month period you could be discharged from the practice.

Financial Policy

Due to changes in today's healthcare, your insurance may not always pay for all services. Please make sure you understand your insurance plan and the services that are covered.

- Your Insurance Card(s) and Driver's License (Picture ID) will need to be presented each time you visit our practice to assure we have the most recent information. If your insurance card is not provided, your appointment will be handled as self-pay and payment for services will be collected prior to being seen.
- Co-payments must be paid prior to seeing the health care provider on the date service is rendered. Patients are responsible for their deductibles or charges not reimbursed by insurance. As a courtesy to you, we file your insurance claims, therefore, it is your responsibility to provide our office with up-to-date billing information.
- Please understand that your insurance is a contract between you and your insurance company, and you are ultimately responsible for the bill. If you have not received an explanation of benefits within 30 days of seeing your health care provider, you are expected to contact your insurance company for an explanation as to why payment has been delayed.
- Self-pay patients are required to pay for services prior to being seen for their visit and will be balance billed for the remainder of the fees at the time of charge posting.
- It is understood that checks made payable to this office returned for insufficient funds, stop payments, or other reason for non-payment will be assessed a \$30.00 NSF fee for which the patient will be held responsible.
- Patients with no financial ability to pay St. Joseph's/Candler charges may be screened for eligibility under Medicaid and other state programs and/or evaluated against established guidelines for financial assistance upon request. Please notify the front desk staff if you would like more information about how to apply for financial assistance.

Patient Portal

The patient portal allows patients to manage their personal health information at their own convenience. You will be able to securely and confidentially exchange non-emergent messages with our practice, request prescription refills, request and keep track of appointments, view referrals to specialists, view lab and imaging results and update your contact information.

Prescription Refills and Samples

You must contact your pharmacy directly for more expedient prescription refills. Please allow your pharmacy up to 48 hours to process your refill request. Please note that prescriptions will not be refilled after hours, on weekends or holidays. Some prescriptions cannot be refilled if you have not seen your health care provider within the last 3-6 months. If you have mail-away prescriptions, please allow 7-10 business days for the necessary forms to be completed. It is very important you plan ahead with mail-away prescriptions to allow adequate time for paperwork to be processed.

Test Results

Laboratory tests can be performed in our in-house lab, but some special tests may be sent out. You must have an appointment for lab tests and a lab order from your provider. Your health care provider will review your lab/imaging results and notify you via voice message, letter or electronically sent to your patient portal. If you have not heard from us within 7 days, please call our office.

Referrals

Most insurance plans require a patient to be seen by their primary care provider prior to seeing a specialist. If your insurance plan requires a prior authorization, you must verify your insurance has approved the visit before seeing the specialist. Otherwise, you will be responsible for any incurred charges.

Medical Records

Please note that requests for any health information cannot be processed without a signed medical record release from the patient or legal representative. This service is outsourced and processed weekly. Please allow up to 7 business days for your request to be processed. A fee may be charged for this service.

ACKNOWLEDEMENT OF RECEIPT AND UNDERSTANDING OF OFFICE POLICIES

I have read and understand the above statements and agree to be bound by its terms and conditions. I also understand and agree that such terms may be amended occasionally by the practice.

Patient Signature OR Authorized Representative

Date

Printed Name of Authorized Representative

Family History

Check all that apply:

Family Members	Status (Alive, Deceased, Unknown)	Age	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer	Unknown	Other
Father										
Mother										
Son(s)										
Daughter(s)										
Brother(s)										
Sister(s)										
Paternal Grandfather										
Paternal Grandmother										
Maternal Grandfather										
Maternal Grandmother										

How many of the following do you have?

Brothers _____ Sisters _____ Sons _____ Daughters _____

Social History

Tobacco Use

- Current smoker Date started? _____ How often? Every day Some days
 How many? 5 or less 6-10 11-20 21-30 31+
 How soon after you wake? Within 5min 6-30min 31-60min after 60min
 Interested in quitting? Ready to quit Thinking Not ready

 Former smoker Date last smoked? _____
 How long since last smoked? 1-3 months 3-6 months 6-12 months 1-5 years 5+ years
 What type? Cigarettes Cigars Smokeless Pipe Other
 Never a smoked

Alcohol Use

- Did you have a drink in the past year? Yes No
 How often? Monthly 2-4 times mth 2-3 time week 4 or more a week
 How many drinks on a typical day? 1-2 3-4 5-6 7-9 10+
 How often you have 6 or more on occasion Never Monthly Weekly Daily

Illicit Drug Use

- Have you used drugs other than those for medical reasons in past year? Yes No
 What type? Amphetamines Cocaine Ecstasy LSD Crack Meth
 Prescription Opiates Heroin Marijuana Suboxone PCP
 Route? Injected Intranasal Smoked
 Frequency? Daily Weekly Monthly
 Are you in treatment? Yes No

Drug Allergies

Name of Drug	What kind of reaction do you have?

Current Medications

Are you taking any medications? YES NO If yes, list all current medications below you are taking and bring your prescription bottles to your visit.

Medication	Dose	Frequency	Reason for Medication	Prescribing Physician

Review of Systems

Please check box next to symptoms you currently have:

Gastrointestinal	Cardiovascular	Constitutional Symptoms
<input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Heartburn <input type="checkbox"/> Burping <input type="checkbox"/> Blood in stool <input type="checkbox"/> Other	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Varicose veins <input type="checkbox"/> Palpitations <input type="checkbox"/> Swelling of extremities <input type="checkbox"/> Other	<input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Sweating <input type="checkbox"/> Weight loss <input type="checkbox"/> Weakness <input type="checkbox"/> Other
Skin	Eyes	Musculoskeletal
<input type="checkbox"/> Skin rash <input type="checkbox"/> Boils <input type="checkbox"/> Persistent itch <input type="checkbox"/> Change in fingernails <input type="checkbox"/> Hair loss <input type="checkbox"/> Other	<input type="checkbox"/> Blurred Vision <input type="checkbox"/> Double Vision <input type="checkbox"/> Other	<input type="checkbox"/> Joint pain <input type="checkbox"/> Back pain <input type="checkbox"/> Neck pain <input type="checkbox"/> Other
Ear / Nose / Throat	Hematologic / Lymphatic	Neurological
<input type="checkbox"/> Ear pain <input type="checkbox"/> Hard of hearing <input type="checkbox"/> Sore throat <input type="checkbox"/> Runny nose <input type="checkbox"/> Other	<input type="checkbox"/> Swollen glands <input type="checkbox"/> Easy bruising <input type="checkbox"/> Other	<input type="checkbox"/> Tremors <input type="checkbox"/> Dizzy spells <input type="checkbox"/> Memory Problems <input type="checkbox"/> Frequent Headaches <input type="checkbox"/> Other
Respiratory	Endocrine	Allergic / Immunologic
<input type="checkbox"/> Wheezing <input type="checkbox"/> Frequent cough <input type="checkbox"/> Sputum <input type="checkbox"/> Other	<input type="checkbox"/> Excessive thirst <input type="checkbox"/> Fatigue <input type="checkbox"/> Other	<input type="checkbox"/> Seasonal allergies <input type="checkbox"/> Sneezing <input type="checkbox"/> Watery/Itchy Eyes <input type="checkbox"/> Other
Female Genitourinary		Male Genitourinary
<input type="checkbox"/> Frequent urination <input type="checkbox"/> Urgent urination <input type="checkbox"/> Pain on urination <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Urine leakage <input type="checkbox"/> Lower abdominal pain <input type="checkbox"/> Blood in urine <input type="checkbox"/> Painful menstruation <input type="checkbox"/> Other		<input type="checkbox"/> Pain in the testicles <input type="checkbox"/> Penile discharge <input type="checkbox"/> Blood in urine <input type="checkbox"/> Night time urination <input type="checkbox"/> Frequent urination <input type="checkbox"/> Dribbling of urine <input type="checkbox"/> Difficulty starting urine <input type="checkbox"/> Other