Patient Registration Form

PINNACLE HEALTHCARE

PATIENT INFORMATION

Patient Information

Time In:

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

Mailing Address:	City	State	Zip

Social Security No.:	Marital Status: ☐ Single ☐ Married ☐ Divorced	Gender: ☐ Male ☐ Female

Home Phone:	Cell Phone:	Work Phone:

E-mail Address:	Preferred method of contact: ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ E-mail	Can we leave a message regarding your medical care & test results? ☐ Yes ☐ No

Preferred Pharmacy:	Pharmacy Location / Crossroads	Preferred Language: ☐ English ☐ Spanish

EMERGENCY CONTACT

Emergency Contact:

Last Name:	First Name:	M.I.	Relation:

Address of Emergency Contact:	City	State	Zip

Phone:

INSURANCE / EMPLOYMENT INFORMATION

Employer Information or Parent/Guardian

Employer or Guardian:	Phone:

Address:	City	State	Zip

The following is for work related injuries ONLY

* Length of Employment: * Job Title: * Date of Injury:

Primary Medical Insurance		**Secondary Medical Insurance**	
Insurance:		Insurance:	
Address:		Address::	
City: State: Zip:		City: State: Zip:	
Subscriber Name:		Subscriber Name:	
Phone:		Phone:	
Subscriber Social Security #:	Subscriber Date of Birth:	Subscriber Social Security #:	Subscriber Date of Birth:
Subscriber ID #:	Group #:	Subscriber ID #:	Group #:
Relationship to Subscriber:	Subscriber Employer:	Relationship to Subscriber:	Subscriber Employer:
Co-Pay:	Deductible:		

PLEASE SEE REVERSE SIDE

PLEASE INITIAL THE FOLLOWING STATEMENTS IN ACKNOWLEDGMENT

☐ It is understood that this authorization for medical treatment and/or testing is given in advance for any specific diagnosis, treatment of emergency care or testing that may be required by the provider in the exercise of their best medical judgment.

☐ I understand that it is my responsibility to know the specific benefits of my insurance coverage. Insurance coverage is an agreement between myself and my insurance company. Therefore, it is my responsibility to make payment for non-covered services, including co-payments of co-insurance and deductibles. I hereby authorize the release of any pertinent medical information or records to the insurance carrier, if deemed necessary to process my medical claim.

☐ I hereby acknowledge that I have received a copy of Pinnacle HealthCare's notice of Privacy Practices. I further acknowledge that a copy of the current Privacy Practice notice is posted in the reception area, and that I will be offered a copy of any amended notice of Privacy Practice at each appointment.

FINANCIAL AGREEMENT: <u>Please initial each of the statements below prior to initiating medical services.</u>

☐ I recognize that I am requesting treatment by Pinnacle Medical Group, dba Pinnacle HealthCare, and that I am responsible for any costs for that treatment, regardless of whether or not I have insurance coverage. I agree to promptly pay upon receipt, any statement for services rendered.

☐ I further agree that if any amount remains outstanding for a period of ninety (90) days, that the balance will be considered delinquent and may be turned over to a collection agency, or an attorney for collection. If the account is turned over to a collection agency or an attorney for delinquency, I agree that in addition to the charges made by Pinnacle HealthCare for medical services, I will also pay the charge made by the collection agency [40% of total balance] and/or reasonable attorney's fees and costs incurred collecting the unpaid balance of my account. Returned checks or credit card charge back will be charged a $35.00 service fee.

I have read and understand the entire Registration and Financial Agreement above. I have had the opportunity to have my questions answered in full and my signature below designates full acceptance of the policies, terms and expectations of services provided by Pinnacle HealthCare.

If not signed by the patient, please indicate: ☐ Parent or guardian of minor patient

Patient or Responsible Party
SIGNATURE: **X** _____ **Date:** _____

Patient or Responsible Party
PRINTED NAME: **X** _____

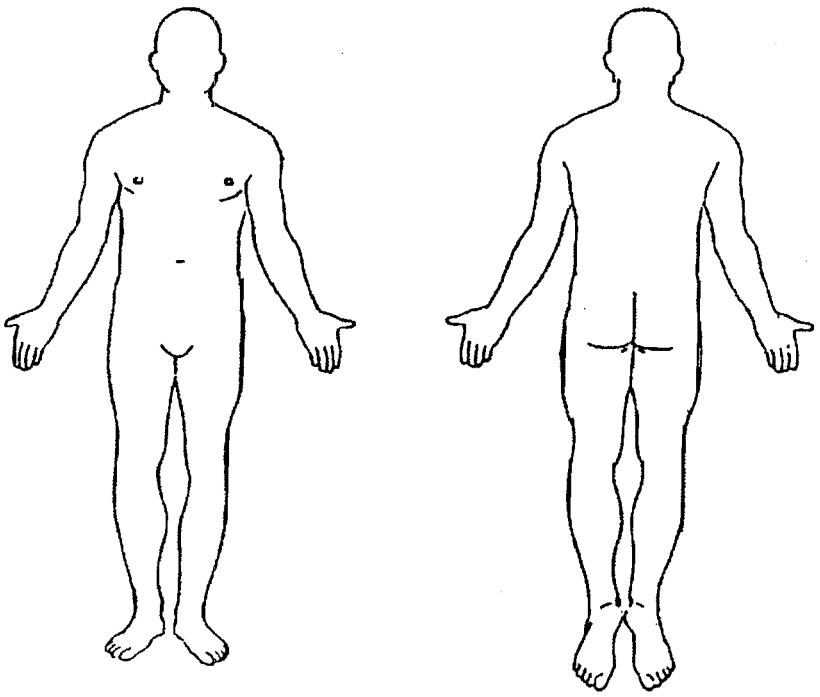
PATIENT INFORMATION SHEET

PINNACLE HEALTHCARE

NAME: _____ GENDER: _____ DOB: _____ DATE: _____

REASON FOR TODAY'S VISIT: _____

PLEASE MARK LOCATION OF PAIN / INJURY ON DIAGRAM SHOWN



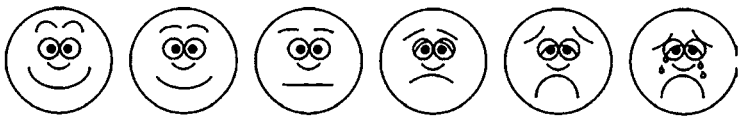
Describe Any Pain:

What makes your pain worse?

What relieves your pain?

CURRENTLY what is your pain level on the following scale? (please circle below)

(no pain)



(extreme pain)

ALLERGY HISTORY: List known allergies (including medication, environmental, contactants, and food allergies) and reactions if exposed.

ALLERGIES: _____

_____

CURRENT MEDICATION LIST

LIST ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins.

MEDICATION NAME (ex. Vicodin)	DOSAGE (ex. 5 mg)	USAGE (ex. 1-2 pills twice a day)	Start Date	UPDATES

(PLEASE SEE REVERSE SIDE)

SURGICAL HISTORY: Please list all prior surgeries and approximate dates performed.

_____ _____

_____ _____

IMMUNIZATION HISTORY:

Child Immunizations Current Y / N Last Tetanus Vaccine: _____

Hepatitis A series Y / N Last PPD (TB Skin Test) _____

Hepatitis B series Y / N

SOCIAL HISTORY:

Smoking/Tobacco Use: ☐ Current ☐ Past ☐ Never Type:_____ Amount/day:_____ Number of Years: _____

Alcohol: ☐ Current ☐ Past ☐ Never Drinks/week: _____

Recreational Drug Use: ☐ Current ☐ Past ☐ Never Type: _____

PROBLEM LIST / PAST MEDICAL HISTORY: Have you been diagnosed with any of the following (currently or in the past)?

☐ Anemia
☐ Arthritis
☐ Asthma
☐ Blood Clots
☐ Cancer
☐ Carpal Tunnel
☐ Chronic Bronchitis
☐ Emphysema
☐ Diabetes Type II
☐ Diabetes Type I
☐ Disease of Back / Neck
☐ Heart Murmur
☐ High Blood Pressure
☐ HIV
☐ Kidney Disease
☐ Liver Disease
☐ Rheumatoid Arthritis
☐ Stroke
☐ Seizure Disorder
☐ Tuberculosis
☐ Ulcer of Stomach

Last Menstrual Period	Date:	Normal Abnormal
Colonoscopy	Yes / No Date:	Normal Abnormal
Mammogram	Yes / No Date:	Normal Abnormal
Dexa (Bone Density)	Yes / No Date:	Normal Abnormal
Pap Smear	Yes / No Date:	Normal Abnormal
Currently Pregnant	Yes / No Date:	

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

_____

_____

_____

_____

_____

I hereby certify to the best of my knowledge the answers to the above are complete and accurate.

Patient Signature:_____ **Date:**_____

Printed Name: _____ **Reviewed by:** _____