PrimeCare
URGENT & FAMILY CARE

PATIENT REGISTRATION

Reason for Today's Visit _____

Last Name_____ First Name_____ MI_____

Social Security #_____ Date of Birth_____ ☐ Male ☐ Female

Street Address_____ City_____ State_____ Zip_____

Home #_____ Cell # _____ Work # _____

I give permission to leave a detailed message including results at the following numbers ☐ Home ☐ Cell ☐ Work

E-mail _____ Are you interested in our Patient Portal? ☐ Yes ☐ No

Primary Care Physician_____ Preferred Pharmacy_____

How did you hear about PrimeCare? _____

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

List names of those authorized to receive your PHI and their relationship to you. We will **not** discuss your PHI with anyone who is **not** listed by name on this form. Please include spouse, parent/legal guardian names, as applicable.

1. I authorize you to speak to_____ Relationship_____
2. I authorize you to speak to_____ Relationship_____
3. I authorize you to speak to_____ Relationship_____

GUARANTOR/RESPONSIBLE PARTY INFORMATION

(Complete only if patient is not financially responsible, i.e. minor child)

Guarantor Name _____ Relationship to Patient ☐ Parent ☐ Legal Guardian

Guarantor Date of Birth_____ Guarantor SSN_____

Street Address_____ City_____ State_____ Zip_____

INSURANCE INFORMATION

Primary Plan Name _____

Policyholder Name _____ Policyholder Date of Birth_____

Policyholder SSN _____ Policyholder Relationship_____

Secondary Plan Name _____

Policyholder Name _____ Policyholder Date of Birth_____

Policyholder SSN _____ Policyholder Relationship_____

Patient/Guarantor Signature_____ Date_____

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Your answers to the following questions will help us to understand your medical history and the concerns you'd like to discuss with your doctor. Please fill out as much of this questionnaire as possible.

PATIENT NAME: _____ **BIRTHDATE:** _____ **DATE:** _____

MEDICAL HISTORY

Please list any medication allergies or reactions:

_____ _____

_____ _____

_____ _____

Please circle to indicate if you have ever had the following conditions:

Arrythmia	Emphysema	Seizures
Asthma	Eye Problems*	Sexually Transmitted Disease*
Cancer*	Heart Attack	Stroke
Coronary Artery Disease	Hepatitis	Tuberculosis
Depression	High Blood Pressure	Thyroid
Diabetes	Kidney Disease	

Other and conditions circled with asterisks (*), please explain:

_____

_____

_____

Please list any surgeries or hospital stays you have had and their approximate date/year:

Type of surgery / reason for hospitalization / location *Date*

_____ _____

_____ _____

_____ _____

Number of pregnancies: _____ Miscarriages: _____ Abortions: _____ Living children: _____

Do you have regular periods? ___Yes ___No

If no, please explain: _____

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PATIENT NAME: _____ **BIRTHDATE:** _____ **DATE:** _____

Please list <u>all</u> medications, including vitamins, herbal or natural supplements and prescription medications, which you are currently taking. Please note the dosage if possible.

Medication Name	*Dosage*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you currently receiving care from any other doctors, chiropractors, or other health care professionals? If yes, we would like to know whom so that we can coordinate your care:

Provider's name	*Condition they are treating you for*
_____	_____
_____	_____
_____	_____

Please note dates of your most recent immunizations:

	Approximate Date		*Approximate Date*
Influenza	_____	Hepatitis B	_____
Tetanus	_____	Other, name & date:	_____
Pneumonia	_____	Other, name & date:	_____

Please note when the following tests done, if applicable, and what the results were, if known:

Cholesterol	_____	HIV	_____
Pap smear/pelvic	_____	Colonoscopy	_____
Mammogram	_____	Hepatitis C	_____
Blood in stool	_____		

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PATIENT NAME: _____ **BIRTHDATE:** _____ **DATE:** _____

FAMILY HISTORY

Check any of the diseases that run in your family **and** please note who had it:

	None	Mother	Father	Sister	Brother	Grandmother mother's side)	Grandfather mother's side)	Grandmother father's side)	Grandfather father's side)	Child	Other Please explain)
Alcoholism or Drug Use											
Cancer											
Cancer Type											
Diabetes											
Heart Disease											
High Blood Pressure											
High Cholesterol											
Osteoporosis											
Mental Illness											
Stroke											
Thyroid Disease											
Other											

Other Comments Regarding Family History:

_____

_____

_____

_____

_____

_____

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PATIENT NAME: _____ **BIRTHDATE:** _____ **DATE:** _____

SOCIAL HISTORY

Please check yes/no for each question and explain as necessary:

Do you smoke or use any tobacco products? ___Yes ___No

Number of cigarettes each day? _____ Types of tobacco used? _____

For how many years? _____ Quit smoking, date: _____

How much alcohol do you drink? _____ How often? _____

Have you ever felt you should cut down on drinking? ___Yes ___No

Have you regularly used drugs? ___Yes ___No

If yes, what kind? _____ If yes, are you still using them? ___Yes ___No

Are you currently married or living with a significant other? _____

Who lives with you at home? _____

How many children do you have? _____

Are you employed? ___Yes ___No Occupation: _____

Do you ever feel sad or depressed? ___Yes ___No

Any financial issues limiting access to food, shelter, or medical care? ___Yes ___No

Any major life changes within the last year? ___Yes ___No
(i.e. marriage, divorce, death of loved one, illness/injury, or job change)

Do you have some form of church or spiritual support? ___Yes ___No

Sexual Preference: ___Women ___Men ___Both

Do you use any form of birth control? ___Yes ___No If yes, what type? _____

Do you feel you are at risk for HIV/AIDS? ___Yes ___No

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Treatment and Financial Policy Agreement

By signing below, you indicate you are the patient or have legal authority to consent to medical treatment on the patient's behalf. You consent to, understand and agree to the following treatment policies:

- The physician or provider will explain the risks and benefits of treatment and you will have the opportunity to ask questions and discuss your treatment plan
- Prime Care strives to provide quality care based on accepted standards of medical practice but cannot guarantee results of treatment
- Prime Care participates in the Virginia Prescription Monitoring Program which may be reviewed prior to prescribing any controlled substances
- Prime Care reserves the right to refuse non-emergency services for any threatening, intimidating, or abusive behavior of any kind

To provide the most cost-effective care, you consent to, understand and agree to the following financial policies:

- If Prime Care participates with your insurance, claims will be filed as a courtesy if we have complete and accurate information. This in no way relieves you of your financial responsibility for services rendered.
- If Prime Care does not participate with your insurance, you will be considered self-pay and required to pay at the time of service, and any remaining balance will be collected upon check out. If you are covered under workers' compensation and your claim is denied, a claim will be submitted to your private insurance on file. We do not file claims to automobile insurance carriers.
- You agree to pay at the time of service any required co-payments, co-insurance and deductible amounts, as well as non-covered services, outstanding balances, and delinquent accounts. We accept cash, checks and credit cards. If a check is returned for any reason, there is a $50 fee.
- You are responsible for, and agree to pay, the cost of any services that your insurance plan determines are not covered, or services that are covered but applied to a deductible. It is your responsibility to determine whether services to be provided by Prime Care are covered by your insurer.
- If your insurance plan requires a referral from your primary care physician or insurance plan prior to a visit and you did not obtain the proper approval or referral, you agree to pay any costs determined not covered under your plan.
- You assign Prime Care all health care benefits to which you are entitled under any policy of insurance and authorize, to the extent permitted by law, payment of those benefits directly to Prime Care.
- The parent or guardian who brings the patient into our office will be held financially responsible, regardless of provisions in a divorce decree, custody agreement, or who is the policyholder.
- You are responsible for paying balances in full unless payment arrangements are approved by Prime Care. For payment arrangements, you must contact our office. For questions regarding insurance payment, you must contact your insurance company directly.
- All overdue accounts will be sent to a collection agency. You agree to be responsible for a $40 collection fee, and all associated legal fees, such as interest and court costs, in addition to the amount owed.

PLEASE NOTE: Prime Care reserves the right to deny non-emergency services for delinquent accounts.

I certify that I received, read, understand, and agree to all the terms and conditions of the Treatment and Financial Policy Agreement as described above applicable to Prime Care Family Care, Inc. and Prime Care Urgent Care, Inc. I also acknowledge I received or was offered a copy of the HIPAA Notice of Privacy Practices.

_____ _____

Signature of Patient/Responsible Party Date Signed

_____ _____

Printed Name of Patient/Responsible Party Relationship to Patient