PINNACLE MEDICAL GROUP

Neurology-Neurosurgery

7005 Cortez Road West, Bradenton, FL 34210 • 941-750-0602

Date:_______________

PATIENT REGISTRATION

(Please complete all blanks)

PATIENT INFORMATION

Name:_______________ Marital Status: ❑ S ❑ M ❑ W

Address:_______________ Home Phone: _______________

City_______________ State:_______________ Zip: _______________

SSN#:______ -______ -_________ Date of Birth:_______________ Gender: ❑ M ❑ F

Ethnicity:_______________ Preferred Language: _______________

Race: ❑ American Indian or Alaska Native ❑ Black or African American ❑ Asian

❑ Native Hawaiian or Other Pacific Islander ❑ Unreported/Refused to Report ❑ White

Email:_______________

Occupation: _______________

Spouse's Name: _______________ Spouse's Phone: _______________

Spouse's Date of Birth: _______________ Spouse's SSN#:______ -______ -_________

PERSON RESPONSIBLE FOR PAYMENTS: (Complete this section only if different from above)

Name: _______________ Home Phone:_______________

Address: _______________ City, State, Zip: _______________

Relationship to Patient: _______________ D.O.B._______________ SSN#:______ -______ -_________

Referred By:_______________

Medicare Policy #: _______________ Name as it appears on card: _______________

Secondary Carrier: _______________

Policy #: _______________ Name as it appears on card: _______________

Primary Insurance (if not Medicare): _______________

Policy #: _______________ Name as it appears on card: _______________

Emergency (Notify in case of emergency):_______________

CONSENT FOR GENERALIZED CARE AND TREATMENT

I, the undersigned, hereby voluntarily consent to medical care and/or diagnostic treatment by Pinnacle Medical Group and its employees and to medical and diagnostic treatments as explained to me by the attending physician and whomever he/she may designate as his/her assistant.

I am award the practice of medicine is not an exact science. I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

I authorize the release of any medical information necessary to process insurance claims. I further authorize payment to the physician or organization providing services to me in the event they file for the insurance.

_______________ Relationship:_______________ Date: _______________

Signature of Patient or Authorized Individual

Reason Patient is unable to sign: _______________

Witness Signature:_______________ Date: _______________

If You Are Covered By Medicare, Please Complete The Following:

LIFETIME MEDICARE B SIGNATURE AUTHORIZATION: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or any other insurance carrier as stated by me, any and all information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits, either to myself or to the party who accepts assignment.

_______________ Relationship:_______________ Date: _______________

Signature of Patient or Authorized Individual

Reason Patient is unable to sign: _______________

Witness Signature:_______________ Date: _______________

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NEW PATIENT HISTORY

Date:__________________

Name: ____ Phone #: ____________________

Primary reason for appointment:

____

____

____

____

Family History: Please check all that apply, if deceased please state cause

						Grandparents	
	Self	**Father**	**Mother**	**Siblings**	**Children**	**Mothers**	**Fathers**
Heart Disease							
Hypertension							
Diabetes							
Stroke							
High Cholesterol							
Seizures							
Anemia							
Kidney Disease							
Liver Disease							
Glaucoma							
Thyroid Disease							
Mental Illness							
Allergies							
Easy Bleeding							
Arthritis							
Cancer (specify type)							
Migraines							
Osteoporosis							

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Name: ____

Previous Hospitalizations - Please include dates and reasons:

____
____
____

Prior Surgical History - Please include dates

____
____
____
____

Social History
Occupation (past/present): ____
Marital Status: ___Single ___ Married ___Divorced ___Widowed #of children ________

Habits:
Alcohol: ____ Never _____ Yes # of drinks _____ per _____
Quit ___No ____ Yes if yes, how many years ____?

Tobacco: ____ Never ____ Yes ____ Chew ___ Smoke ___ packs per day for ____ years
Quit ___No ____ Yes if yes, how many years ____?

Recreational Drugs: _____ Never ____ Yes If yes, ____ oral ____ IV
Quit ___No ____ Yes if yes, how many years ____?

Coffee: ____ Never ____ Yes ____ if yes, _____regular ____ decaf ______# of cups per day

Soft Drinks: ____ Never ____ Yes ____ if yes, _____regular ____ decaf ______# of cups per day

Tea: ____ Never ____ Yes ____ if yes, _____regular ____ decaf ______# of cups per day

Medication you are currently taking - Please include over the counter medications:

____
____
____
____
____

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Name: ____

Allergies/Reactions to any medication:
____

Adult Immunizations - Please provide date of last immunization:

Influenza	
Tetanus	
Pneumonia	
Hepatitis	

General Health History:

	Year	Normal or Abnormal
Chest X-Ray		
HIV		
Bone Density		
Stool Occult Blood		
Tuberculin		
Colonoscopy		

Height (without shoes): ____________ Highest weight: __________
Current Weight: ____________ Lowest weight: __________

Female:

	Year	Normal or Abnormal
Mammogram		
PAP test		

Last Menstrual Period: ______________________ Number of Pregnancies: ______
Name of Gynecologist: ______________________

Male:

	Year	Normal or Abnormal
PSA		
Prostrate Check		

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Name: ____________________

Please check below any symptoms you may have had:

Weight Loss		Urinary Incontinence	
Constant Fatigue		Urinary Infections or Stones	
Insomnia Difficulty		Urinating	
Severe Headaches		Enlarged Glands	
Dizziness		Frequent Infections	
Allergies (Hay Fever)		Joint Pain/Deformity	
Asthma		Ulcer in Stomach	
Persistent Cough		Thyroid Problems	
Chest Pain		Seizures	
Heart Burn		Hepatitis	
Persistent Diarrhea		Anemia	
Persistent Constipation		Easy Bleeding	
Blood in Stool		Depression	
Albumin in Urine		Other	
Blood In Urine		Persistent Anxiety	
Swollen Legs		Sinusitis	
Hemorrhoids		Shortness of Breath	
Varicose Veins		Hernia	
Diabetes		Forgetfulness	
Pneumonia		Irritability	
Circulatory Problems		Persistent Back Pain	
Decreased Vision		Erectile Dysfunction	
Decreased Hearing		High Blood Pressure	
Pain in Legs when walking		High Cholesterol	

Additional information you would like to share with physician:

____

____

____

____

____

____

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PATIENT CONTROLLED SUBSTANCE DISCLOSURE

Please list all types of controlled substance medication you have taken in the last 6 months; including prescribing physician and pharmacy where prescription was filled. Medications in this category include any taken for sleep, anxiety, pain and depression.

Drug	Dosage	Physician	Pharmacy

The physicians will only write for the types of medications described above, if you are not receiving prescriptions from other providers.

Medications will only be renewed when you are eligible based on appropriate usage. No early refills will be given under any circumstance, this includes if the prescription(s) are lost, stolen, or destroyed. Please note you are responsible for keeping your medications safe.

Seeking prescriptions for the above medications from other sources, including but not limited to, walk-in clinics and emergency rooms, without notifying this office is a violation of office policy and could result in discharge from this practice. Please notify the office of changes in medication usage, as well as any side effects you may experience.

It is the patient's responsibility to anticipate the need for any prescription refills. Prescription refills are to be requested during normal office hours only. Please note, you must allow 1 business day for requests to be processed. Written prescription requests will not be taken on Fridays. Office hours are Monday - Thursday 8:30 am - 4:30 pm and Friday 8:30 am - 12:00 pm.

Please provide the office with the pharmacy location and phone number you will use when filling prescriptions provided by this office. You must notify the office if you change pharmacies.

Please note this office uses random drug screening to monitor medication and dosing compliance. You may be asked at anytime to participate in this screening process.

The above rules constitute an agreement between the patient, ________________________________
and Pinnacle Medical Group. Any violation of this agreement may result in discharge from the practice.

____ ____________________

Patient Signature Date

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Patient Consent to Receive Mail, Telephone and/or E-mail Message

____ DOB: ______________
Please print (Last Name) (First Name) (M.I.)

Do we have permission to?

Send a yearly appointment card to your home? Yes ❑ No ❑
Send test results to your home? Yes ❑ No ❑
Send test results to your email? Yes ❑ No ❑
Email address: ____

Leave the following information on your home answering machine/voice mail/email:

Appointment information Yes ❑ No ❑
Billing information Yes ❑ No ❑
Medical information Yes ❑ No ❑

Leave the following information on your work answering machine/voice mail:

Appointment information Yes ❑ No ❑
Billing information Yes ❑ No ❑
Medical information Yes ❑ No ❑

I give permission to share appointment information with the person named below:

Name: ____

I give permission to share medical information (including biopsy/lab results, prescriptions, etc.) with the person(s) listed below:

Name: ____

Name: ____

I give permission to share billing information with the person listed below:

Name: ____

Signature of Patient: ________________________________ Dale: __________

For internal purposes only - Account No: