



Date: _____

Internal Medicine

315 75th Street West • Bradenton, FL 34209 • 941-792-2211

PATIENT REGISTRATION

(Please complete all blanks)

PATIENT INFORMATION

Name: _____ Marital Status: S M W

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____

SSN#: _____ Date of Birth: _____ Sex: _____

Employer's Name and Address: _____

Employer's Phone: _____ Occupation: _____

Spouse's Name: _____ Employer'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#: _____

Employer's Phone: _____ Occupation: _____

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 aware that 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.

Signature of Patient or Authorized Individual Relationship: _____ Date: _____

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.

Signature of Patient or Authorized Individual Relationship: _____ Date: _____

Reason Patient is unable to sign: _____

Witness Signature: _____ Date: _____



Date: _____

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MEDICAL HISTORY

(Please complete all blanks)

Name: _____ Age: _____ Sex: _____ DOB: _____

Address: _____

Phone (Home): _____ (Work): _____

Occupation: _____ If retired, what did you do before? _____

Are you married?: Y N _____ What is your spouse's name? _____

Who should we notify in case of emergency: _____ Phone: _____

Who referred you to this office? _____

In your own words, describe what is bothering you right now (what made you contact the doctor): _____

Are you experiencing any of the following symptoms?

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Trouble talking | <input type="checkbox"/> Cloudy urine |
| <input type="checkbox"/> Earaches | <input type="checkbox"/> Nausea | <input type="checkbox"/> Numbness anywhere | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Weakness | <input type="checkbox"/> Urinating at night |
| <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Trouble Swallowing | <input type="checkbox"/> Dizzy spells | <input type="checkbox"/> Hard to start stream |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Constipation | <input type="checkbox"/> Blackouts | <input type="checkbox"/> Involuntary loss of urine |
| <input type="checkbox"/> Eye problems | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Pain in joints | <input type="checkbox"/> Abnormal periods |
| <input type="checkbox"/> Chest pain or pressure | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Back pain | <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> Short of breath | <input type="checkbox"/> Black stools | <input type="checkbox"/> Muscle aches | <input type="checkbox"/> Excessive thirst |
| <input type="checkbox"/> Sleep on more than one pillow | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Excessive urination |
| <input type="checkbox"/> Ankles swelling | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Prolonged bleeding | <input type="checkbox"/> Excessive appetite |
| <input type="checkbox"/> Rapid heartbeat | <input type="checkbox"/> Yellow skin | <input type="checkbox"/> Skin rash | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Heart skipping beats | <input type="checkbox"/> Urine burns | <input type="checkbox"/> Breast lump | <input type="checkbox"/> Trouble walking |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Blood in urine | | |

Previous Operations: _____

Past History - Have you ever had any of the following?

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Heart rhythm problem | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney trouble |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Prostate trouble |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Asthma | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Anemia | <input type="checkbox"/> Colitis | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Urinary infection | <input type="checkbox"/> Sugar diabetes |
| <input type="checkbox"/> Blood clots in legs | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Blood clots in lungs | <input type="checkbox"/> Broken bones | <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Trouble with periods |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Diverticulosis | | |

What medicines are you taking now? _____

What allergies do you have? _____

Do you smoke tobacco? yes No How long? _____ How much? _____

If you used to smoke but quit, when did you quit? _____

Do you drink alcoholic beverages? _____ How much per day? _____

Family History: _____

I certify that the above information is correct to the best of my knowledge.

Signed _____

Physician's Signature: _____ Date: _____