Prime Internal Medicine Associates

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Internet	❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ Aetna	❑ BCBS	❑ Cigna	❑ Coventry	❑ First Health

❑ Humana	❑ Medicare	❑ Secure Horizon	❑ United Healthcare PPO	❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

NEXT OF KIN (Emergency Contact):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Della Mathew, MD, Shalini Katikaneni MD, PA, Prime Internal Medicine Associates or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

CONFIDENTIAL

MEDICAL HISTORY

Date _____

SS/HIC/Patient ID# _____ Date of Birth_____

Patient Name _____

Patient Concerns:_____

_____ Date of Last Physical Exam _____

FAMILY MEDICAL HISTORY

	✔ if Alive	Age at Death	Present Health or Cause of Death		# Alive	# Deceased	Present Health or Cause of Death
Father				Brothers			
Mother				Sisters			
Spouse				Children			
				Ages of Living Children:			

CHECK (✔) THE ILLNESSES THAT HAVE OCCURRED IN YOUR IMMEDIATE FAMILY

☐ DIABETES ☐ CANCER ☐ BLEEDING TENDENCY ☐ KIDNEY DISEASE ☐ TUBERCULOSIS

☐ HEART DISEASE ☐ STROKE ☐ HIGH BLOOD PRESSURE ☐ DEPRESSION ☐ ALLERGIES

MEDICATIONS

LIST THE MEDICATIONS YOU ARE CURRENTLY TAKING.
ALSO LIST ANY VITAMINS, HERBS, SUPPLEMENTS, ETC.

_____

_____

_____

_____

ALLERGIES

CHECK (✔) IF YOUR ARE ALLERGIC TO:

☐ ADHESIVE/TAPE ☐ ASPIRIN

☐ IBUPROFEN ☐ IODINE

☐ LATEX ☐ LOCAL ANESTHESIA

☐ PENICILLIN ☐ SULFA

LIST ALLERGIES TO MEDICATIONS OR SUBSTANCES:

_____

_____

DO YOU TAKE ORAL CONTRACEPTIVES? ☐ YES ☐ NO

PLEASE LIST ANY
CHRONIC CONDITIONS

_____

_____

ACCIDENTS

_____

_____

PLEASE LIST ANY RECENT
DIAGNOSTIC TESTS

_____

_____

PLEASE LIST ANY RECENT
INJURIES/ILLNESSES

_____

_____

HOSPITALIZATIONS

_____

_____

SURGERIES

_____

_____

OTHER HEALTH CARE PROVIDERS

PRIMARY CARE PROVIDER_____

OB/GYN_____

OTHER_____

PREFERRED PHARMACY

_____
Name

_____
Location

_____
Phone Number

DO YOU HAVE A LIVING WILL OR ADVANCE DIRECTIVES? ☐ YES ☐ NO MAY WE HAVE A COPY FOR YOUR CHART? ☐ YES ☐ NO

CERTIFICATION
To the best of my knowledge, the above information is complete and correct.
I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Medication Sheet

Patient: _____ **D.O.B.**_____

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____

Notes: _____

Pharmacy Name/Addr/Phone #:_____

_____

Food/Drug Allergies_____

Patient Financial Policy Sheet

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept most major credit cards.

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept and assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This office's policy is to collect this copayment when you arrive for your appointment.
- If you have insurance coverage with a plan for which we do not have a prior arrangement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for you care and treatment are due at the time of the service.
- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

_____

Printed Name of the Patient

_____ _____

Signature of Patient Date

Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major benefits to which I am entitled. I hereby authorize and direct my insurance carrier, including Medicare, private insurance and any other health/medical plan, to issue payment check directly to **Prime Internal Medicine Associates** for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize **Prime Internal Medicine Associates** to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical service from **Prime Internal Medicine Associates** on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient/Responsible Party Signature Date

_____ _____

Witness Date

ACKNOWLEDGMENT OF OFFICE POLICIES

Thank you for choosing Prime Internal Medicine Associates as your primary care physician. We have provided you with the following information to assist you with any questions or concerns you may have in regards to the operations of our office.

APPOINTMENTS: Appointments can be scheduled by phone or in person at the office. Patients arriving more than 15 minutes late for their appointments will be rescheduled.

CANCELLATIONS: If you need to cancel an appointment, please contact the office 24 hours PRIOR to your scheduled appointment time. If you do not show up or cancel your scheduled appointment 24 hours prior to, a fee of **$50.00** will be incurred for each appointment missed/cancelled. When you are scheduled for an appointment, that time slot is made unavailable to any other patient. If you do not show up as planned, we have lost the opportunity to provide services to another patient. We reserve the right to terminate our doctor-patient relationship with anyone who we feel is abusing appointments.

PRESCRIPTION REFILLS: For your safety, we do not routinely call in prescriptions, including antibiotics to treat acute illnesses over the phone. We ask that you schedule an appointment so we can properly evaluate and treat you in a safe and effective manner. For pharmacy prescriptions requests, please allow 24-48 hours processing time. Prescriptions are filled only during office hours. Call for refills well before you run out. If a refill is denied, you must schedule an appointment.

PAPERWORK: There will be a $25.00 charge for FMLA, disability or any other forms that need to be filled out by our office. Copies of medical records to the patient will incur a $25.00 fee. There is no fee for medical records transfered to another physician.

The purpose of these policies is to ensure that effective communication is implemented in order to provide quality services for our patients. I have read and agree to the above office policies.

_____ _____

Patient Name Date

AUTHORIZATION TO LEAVE PERSONAL HEALTH INFORMATION BY ALTERNATE MEANS

Patient Name: _____ DOB: _____

(Please check all that apply):

☐ May leave detailed message on voicemail at:_____.

☐ May correspond via email at:_____.

☐ Do not leave any detailed message on phone or email.

Please note that detailed messages may include lab and test results.

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change one or more of the telephone numbers listed above.

_____ _____

Signature **Date**

Prime Internal Medicine Associates
12200 Park Central Dr., Suite 189
Dallas, Texas 75251
Ph. (972) 239-5445
Fax (469) 729-6691

HIPAA Privacy Communication Form

PATIENT INFORMATION

Date

Name (Last, first, middle initial) Social Security # or Patient ID

Street address City State ZIP Code

Primary phone number Other phone number E-mail address

Type of Request

☐ Access/Copy/Communication ☐ Restriction

Doctor is allowed to discuss patients (named above) medical condition with family members listed below:

Patient Signature _____ Date _____