Patient Registration & Health Questionnaire, cont'd

URGI-MED FAMILY MEDICAL CENTE
FAMILY MEDICINE WITH DEDICATIO
AND COMPASSION

MEDICAL HISTORY

Check box if you have had trouble with any of the following

Cardiovascular	Past	Present
High Blood Pressure		
Coronary Heart Disease		
Heart Murmur		
Palpitations		
Irregular Pulse		
Varicose Veins		
Genitourinary		
Kidney Stones		
Frequent Urination		
Prostate Problems		
Psychiatric		
Depression		
Mental Illness		
Hematologic		
Hepatitis		
Blood Clots		
Jaundice		
Bruising		
Anemia		
Excessive Sweating		

Ear, Nose, Throat	Past	Present
Hearing Problems		
Nose Bleeds		
Difficulty Swallowing		
Sinus Trouble		
Hoarseness		
Gastrointestinal		
Heartburn		
Peptic Ulcer Disease		
Colitis		
Musculoskeletal		
Gout		
Arthritis		
Dermatological		
Eczema		
Psoriasis		
Rash		
Cold Sores		
Excessive Scarring		
Endocrine		
Thyroid		
Diabetes		

Eyes	Past	Present
Glaucoma		
Cataracts		
Neurology		
Stroke		
Seizures		
Migraines		
Asthma/Allergies		
Asthma		
Hay Fever		
Allergies		
Hives		
Infectious Disease		
Venereal Disease		
Herpes		
Chlamydia		
Gonorrhea		
Tuberculosis		
Cancer		
Other, please list		

INSURANCE & BILLING INFORMATION

Billing name (if other than patient) Relationship ( ) – Phone

Billing Address

Payment required at time of service—unless prior arrangements have been made.

1 Insurance Company Address Effective Date

Name of Insured Relationship Group # ID # Benefit Code

2 Insurance Company Address Effective Date

Name of Insured Relationship Group # ID # Benefit Code

Medicare ID # Medicaid ID # Other Coverage ( ) –

Pharmacy Name Address Phone

ASSIGNMENT OF INSURANCE BENEFITS
I hereby authorize direct payment of surgical/medical benefits to Dr. _____ for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

MEDICARE/MEDICAID
I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf.

HIPAA PRIVACY PRACTICE
I acknowledge that I have received and/or have been given the opportunity to review this office's notice of HIPAA Privacy Practices for protected health information.

A photocopy of these assignments shall be valid as the original.

Patient/Guardian Signature

Date (Month/Day/Year)_____