Patient Registration Form

Name: _____ DOB: ___/___/_____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____Language: _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____ Sex: □ Male □ Female

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Prefer Not to Answer

Primary Insurance: _____ Member ID: _____

Secondary Insurance: _____ Member ID: _____

Emergency Contact: _____ Phone: (_____) _____-_____ Relationship: _____

Local Pharmacy: _____ Phone Number: (_____) _____-_____

Name of Previous Primary Care Physician: _____ Phone Number: (_____) _____-_____

Race:
□ Asian
□ Black/African American
□ Caribbean
□ Hispanic
□ Native Hawaiian/ Other Pacific Islander
□ White
□ Other
□ Prefer Not to Answer

Ethnicity:
□ Hispanic / Latino
□ Non-Hispanic
□ Prefer Not to Answer

Do you have a: Living Will, Advance Directives, DNR, Power of attorney or none? Please circle.

I authorize PrimeNet Medical Group Inc. to leave messages regarding my treatment, including lab or imaging test results, names of medications, information pertaining to my treatment and office updates by the following method:

□ Home answering machine □ Cell phone/Voicemail □ Text □ E-mail: _____

PrimeNet Medical Group Inc. complies with HIPAA and wants to exchange text messages with you.
SMS Opt-in □ Yes □ No

I will ensure all information is up to date at every visit.

_____ _____ ____/____/_____
Patient Name **Signature** **Date**

Medical History

Review of Systems (ROS)

Please check mark Yes or No to any of the following below

Constitutional	**Y**	**N**	**Ear/Nose/Throat**	**Y**	**N**	**Eyes**	**Y**	**N**
Chills/fevers			Hearing Loss			Glasses/contacts		
Fatigue			Sinus problems			Blurry/double vision		
Night Sweats			Nose bleeds			Eye disease/injury		
Weight loss			Sore throat			Glaucoma		
Cardiovascular	**Y**	**N**	**Respiratory**	**Y**	**N**	**Hematology**	**Y**	**N**
Chest pain			Shortness of breath			Anemia		
Irregular heartbeat			Cough			Easy bleeding		
Hand/Feet swelling			Wheezing			Swollen glands/Nodes		
Heart trouble			Coughing up blood			Slow to heal		
Musculoskeletal	**Y**	**N**	**Endocrine**	**Y**	**N**	**Allergy/Immunologic**	**Y**	**N**
Back pain			Excessive thirst			Food allergies		
Joint pain			Hormone problems			Aspirin allergies		
Stiffness/Swelling joints			Thyroid disease			Antibiotic allergies		
Muscle cramps/pain			Heat/Cold intolerance			Seasonal allergies		
Genital - Female	**Y**	**N**	**Genital - Male**	**Y**	**N**	**Integumentary**	**Y**	**N**
Painful periods			Testicular pain			Change in hair/nails		
Sexual dysfunction			Sexual dysfunction			Rash/Itching		
Birth Control use			Difficult urination			Breast lump/pain		
Blood in urine			Prostate problems			Dry skin		
Psychiatric	**Y**	**N**	**Neurological**	**Y**	**N**	**Gastrointestinal**	**Y**	**N**
Insomnia			Convulsions/Seizures			Nausea/Vomiting		
Confusion/memory loss			Dizziness/Fainting			Reflux/Heartburn		
Anxiety			Muscle weakness			Constipation		
Depression			Headaches			Rectal bleeding		
Bipolar			Numbness/tingling			Abdominal pain		
	Y	**N**		**Y**	**N**		**Y**	**N**
High Blood Pressure			Stroke			Kidney disease/stones		
High Cholesterol			Diabetes			Cancer		
Heart Attack			Liver Disease			Type:		
HIV/AIDS			Asthma			Other:		
Skin disease			Autoimmune disease					

_____ _____ ____/____/_____

Patient Name **Signature** **Date**

Surgical History:

	Y	N		Y	N		Y	N
Appendix Removal			Bladder surgery			C-section		
Gallbladder surgery			Prostate surgery			Hernia repair		
Back surgery			Open heart surgery			Other:		
Hysterectomy			Cardiac Catheterization					
Breast Surgery			Cataract surgery					

Allergies: □ **No Known Drug Allergies**

_____

_____

Hospitalizations in the last year:

_____

_____

Medications:

Name of medication	Dosage & frequency	Reason for taking

Family History:

Mother: _____

Father: _____

Grandmother: _____

Grandfather: _____

Son: _____

Daughter: _____

Siblings: _____

_____ _____ ____/____/_____

Patient Name **Signature** **Date**

Social History:

Have you ever smoked? □ Yes □ No

• If you stopped smoking when did you quit? _____

• If yes, number of years? _____

• If you currently smoke, how many packs per day? _____

• Do you use smokeless tobacco? (i.e. chewing tobacco) □ Yes □ No

Do you drink alcohol? □ Yes □ No

• If yes, how much a week? _____

Do you currently use recreational drugs? □ Yes □ No

• If yes, which drugs? _____

Are you on a special diet? □ Yes □ No

• If yes, please describe: _____

Do you exercise? □ Yes □ No

• If yes, what type and how often? _____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Other

Occupation: _____

What was the date of your last Flu vaccine? (Month/Year) _____/_____

Did you get the COVID 19 vaccine? □Yes □ No

Female ONLY:

Date of Last Menstrual Period: ____/____/_____ Number of pregnancies: _____

Complications in pregnancy (e.g. diabetes, high blood pressure, protein in urine): □ Yes □ No

_____ _____ ____/____/_____

Patient Name **Signature** **Date**

Patient's History & Health Assessment:

Have you seen any **specialists or prior physicians** from whom we can get records to assist in your care? □ **Yes** □ **No** If yes, please provide below the specialists and/or physician name and phone number.	
Physician Name:	Phone Number:
Physician Name:	Phone Number:
Specialist Name:	Phone Number:
Specialist Name:	Phone Number:
Have you ever been admitted to the **hospital**? □ **Yes** □ **No** If yes, please provide below hospital name and date.	
Hospital:	Date of visit:
Hospital:	Date of visit:
Have you ever had any **CT and/or MRI scan** or any other imaging done? □ **Yes** □ **No** If yes, please provide below location and date.	
Location:	Date of test:
Location:	Date of test:
Have you ever had a **Stress test, Echocardiogram (ultrasound of the heart) and/or Cardiac Catheterization**? □ **Yes** □ **No** If yes, please provide below location or physician name and date of procedure.	
Location:	Date of procedure:
Location:	Date of procedure:
Have you ever had a **Mammogram and/or Colonoscopy**? □ **Yes** □ **No** If yes, please provide below location or physician name and date.	
Location:	Date:
Location:	Date:
Have you ever had an **Eye exam**? □ **Yes** □ **No** If yes, please provide below location or physician name and date of exam.	
Location:	Date:
Are there any additional records you would like to retrieve? □ **Yes** □ **No** If yes, please provide below location or physician name.	
Physician name or location:	
Physician name or location:	

_____ _____ ____/____/_____

Patient Name **Signature** **Date**

PrimeNet MEDICAL GROUP INC.

7189 Pembroke Road
Pembroke Pines, FL 33023
954-983-1220
954-983-0687
www.primenetmedical.com
faxpp@primenetmedical.com

Authorization for Release of Medical Records

Patient Name: _____

DOB: _____ SS#: _____

I hereby authorize: _____

Phone number: (_____) _____-_____ Fax number:(_____) _____-_____

ATTENTION: MEDICAL RECORDS DEPARTMENT

Release of Medical Information To:
PrimeNet Medical Group Inc.
7189 Pembroke Road, Pembroke Pines, Florida 33023
Phone: (954)983-1220 Fax: (954)983-0687
Email: faxpp@primenetmedical.com

Purpose of Disclosure: □ Continuation of Care □ Other: _____

Please include all information regarding assessment, diagnosis, treatment, and laboratory results for the above listed patient. Date of service release FROM: _____ / _____ TO: _____ / _____

I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the practice manager. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization and consent will expire one year from the date of authorization written below, unless revoked by me (or my legal representative) through written notice presented to PrimeNet Medical Group Inc.
I understand and acknowledge that the requested health information may contain information regarding physical and mental illness, sexually transmitted diseases, HIV test results or diagnosis, and alcohol or drug abuse. I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether I sign this authorization.
I understand that the sender of my health information may charge for the service of disclosing medical information and I am responsible for inquiring about these potential charges.
I understand that authorizing the disclosure of this health information is voluntary. You may refuse to sign this authorization. Such refusal will not affect your ability to obtain treatment except to the extent that the information being requested may assist your health care provider in determining appropriate treatment.
I have read the above foregoing authorization for release of information and do hereby acknowledge that I am familiar and fully understand the terms and conditions of this authorization.

_____ _____ ____/____/_____
Patient Name **Signature** **Date**

Authorizations and Consents

Access to Prescription History

Our medical practice has adopted an electronical medical records system which will further enhance the quality of our services. This system allows us to collect and review your medical history. A medication history is a list of prescription medicines that we or other doctors have prescribed to you. This list is collected from a variety of sources, including your pharmacy and your health insurer. An accurate medication history is very important in helping us treat you properly and avoid potentially dangerous drug interactions. By signing this consent form you give us permission to collect your medication history without limitation or exclusion as is required and/or reasonably necessary for your care and treatment. Please understand that your medication history might not include over the counter medicines, supplements, or herbal remedies.

Authorization to Share Health Information

I authorize PrimeNet Medical Group Inc to release any information regarding my treatment, including lab or imaging test results, names of medications, information pertaining to my treatment and office updates. This includes leaving messages on the designated contact phone numbers. PrimeNet Medical Group Inc may not release information to the named individuals and or entities unless you identify them below.

Name: _____ Relation: _____ Phone: (_____) _____-_____

Name: _____ Relation: _____ Phone: (_____) _____-_____

Acknowledgement of Receipt of HIPAA Privacy

I understand that PrimeNet Medical Group Inc may use and disclose my protected health information for purposes of treatment, payment, and health care operations. I also acknowledge that I have received, have been offered, or have received in the past a copy of the notice of privacy practices for PrimeNet Medical Group Inc, which provides information about how the physicians, facilities and individuals involved in my care may use and disclose my protected health information. As provided in the notice, the terms of the notice may change. To obtain a copy of any current notice, I may contact the office at (954) 983-1220. I understand that I have the right to request that the practice restrict how my protected health information is used or disclosed for treatment, payment, or healthcare operations, but I also understand that the practice is not required to agree to a requested restriction.

Telehealth/Telemedicine Consent

I consent to use the use of telehealth/telemedicine in the provision of care and understand that I will be given information about tests, treatments, procedures and alternate choices for my medical care through the telehealth/telemedicine service.

_____ _____ ____/____/_____

Patient Name **Signature** **Date**

General Consent Form for Treatment

I, _____, hereby authorize PrimeNet Medical Group, Inc., the attending physician or nurse practitioner and other employees of the group to examine and treat me. I also authorize such treatments and procedures as deemed necessary by the physician or nurse practitioner, including but not limited to the taking and doing of diagnostic tests such as electrocardiograms, medications, blood and urine samples, insertion of a peripheral intravenous catheter (IV), immunizations and other therapies as deemed necessary. I am aware that the practice of medicine is not an exact science and acknowledge that no guarantee or assurance has made or implied to me as to the results that may be obtained by examination and treatment.

I hereby certify that I understand the above authorization.

_____	_____	____/____/_____
Patient Name	**Signature**	**Date**

Patient Financial Agreement

Thank you for choosing us as your Primary Care Physician. We are committed to being a partner in providing conscientious medical care for you. Payment of the bill is considered an important part of that partnership. Thank you for reading our financial agreement. Please let us know if you have questions or concerns.

The following is a statement of our Financial Policy, which we require you to read and sign.

It is your responsibility:

• To understand your benefits plan.

• To know if a referral is required.

• The know if pre-authorization is required prior to a procedure.

• To know what services are covered.

Full payment for self-pay patients, co-payments and deductibles are due at the time of service. You may also be asked to pay your coinsurance at the time of service.

We accept cash, checks, Visa/MasterCard/Discover/AMEX. Any other arrangements must be made in advance with our Billing Office.

Your insurance policy is a contract between you and your insurance company. Payment of your bill is ultimately your responsibility. PrimeNet Medical Group Inc. is contracted with and bills most insurance carriers.

1. I have read and agree to this financial agreement.
2. I authorize and consent to the release of medical information necessary to bill and process insurances claims.
3. I authorize payment of medical benefits directly to the physician.
4. If we cannot successfully collect an outstanding balance and payment arrangements are not established within 30 days of statement, the cost of collection, including reasonable attorney fees shall be included as part of the obligation dues.

_____	_____	____/____/_____
Patient Name	**Signature**	**Date**

Policies and Procedures Agreement

In the effort to serve all our patients equally, fairly and to the best of our ability, we ask that you review and understand our Patient Policies and Procedures.

Late Policy- Every effort is made to keep our physicians schedules on time therefore if you are more than 15 minutes late, we cannot guarantee that you will be seen immediately, but we will do our best to work with you into the schedule as time permits. If schedule is full you will be asked to reschedule your appointment to a later date.

Missed/Cancelled Appointments- Every effort is made to accommodate our patients request for appointment. Therefore, it is important that you make every effort to keep your scheduled appointment. We understand that there are times when you miss an appointment due to emergencies or obligations for work or family. Our office will charge a **$25.00 cancellation fee** for all the appointments that are not cancelled at least 24-hours in advance.

Transferring of Records- All patients must sign a records release form to have their records copied, electronically downloaded, or sent to another provider or organization. There is no fee to transfer records directly to another provider or health care organization.

Payment for Services for Patients with insurance- According to your health insurance plan you are responsible for paying your copayment/coinsurance at the time of service.

Payment for Services for Patients without Insurance- You will be responsible for payment by cash, check, credit card on the day of service.

_____	_____	____/____/_____
Patient Name	**Signature**	**Date**

ADVANCE DIRECTIVE FORM

Designation of Health Care Surrogate

In the event that it has been determined that I am unable to express my wished regarding my healthcare, including the withholding, withdrawal or continuation of life-prolonging procedures, I, _____, born on _____/_____/_____, wish to designate as my SURROGATE to carry out the provisions of this declaration:

Name: _____ Relation: _____

Address: _____

Phone number: (_____) _____-_____

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my ALTERNATE SURROGATE:

Name: _____ Relation: _____

Address: _____

Phone number: (_____) _____-_____

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility. When making health care decisions for me, my health care surrogate should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in Part Two (if I have filled out Part Two), my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care surrogate should make decisions for me that my health care surrogate believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

_____	_____	____/____/_____
Patient Name	**Signature**	**Date**