FAMILY PRACTICE PATIENT REGISTRATION FORM

****Today's Date:** _____ **PRESTIGE MEDICAL, P.A.**

PATIENT INFORMATION: (Please use full legal name, no nicknames) *Required Fields for Billing

***Last Name:** _____ ***First Name:** _____ **Middle Initial:** _____

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

Cell Phone #: (_____) _____-_____ ***Sex:** _____ ***Date of Birth:** _____ **Age:** _____

Work phone: _____ **Email:** _____

***Spouse Name:** _____ ***Spouse Cell:** _____

RACE: Please circle: WHITE WHITE-HISPANIC BLACK OR AFRICAN AMERICAN BLACK HISPANIC- LATINO AMERICAN INDIAN ALASKA NATIVE NATIVE HAWAIIAN FILIPINO CHINESE JAPANESE KOREAN OTHER ASIAN OTHER: _____ **Preferred Language:** _____

ETHNICITY: Please circle one: HISPANIC OR LATINO NOT HISPANIC OR LATINO REFUSE

Preferred pharmacy: _____ **Ph.#** _____

Emergency Contact Name: _____ **Phone #:** (_____) _____-_____

GUARANTOR INFORMATION: (List person or insured name responsible for bill - use full legal name, no nicknames)
***Relationship of Guarantor to Patient: Self** _____ **Spouse** _____ **Parent** _____ **Other** _____

***Last Name:** _____ ***First Name:** _____ **Middle Initial:** _____

***Address:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone #: (_____) _____-_____ ***Social Security #:** _____

***Date of Birth:** _____ **Age:** _____ ***Sex: Female** _____ **Male** _____

***Employer Name and Address:** _____

Work Phone #: (_____)_____-_____

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance cards.
IF SOMEONE OTHER THAN PAITENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS
PRIMARY INSURANCE:
Plan Name: _____ *** Insured's Name:** _____

Insured's SS#: _____ ***Insured's DOB:** _____

***Policy/ID#:** _____ ***Group:** _____ **Eff. Date:** _____

Claims Address & Phone: _____
SECONDARY INSURANCE:
Plan Name: _____ ***Insured's Name:** _____

***Insured's SS#:** _____ ***Insured's DOB:** _____

Policy/ID #: _____ ***Group:** _____ **Eff. Date:** _____

PLEASE ALLOW RECEPTIONIST TO MAKE A COPY OF YOUR INSURANCE AND ID

Patient Name: _____ **Date of Birth:** _____

First Name M.I. Last Name

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits to PRESTIGE MEDICAL, PA for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that PRESTIGE MEDICAL, P.A. is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID INSURANCE BENEFITS:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to PRESTIGE MEDICAL, P.A. or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have received and read a copy of the PRESTIGE MEDICAL, P.A. Patient Information Privacy Policy. I hereby authorize PRESTIGE MEDICAL, P.A. or the physician individually to release any of my or my dependent's medical or incidental non-public personal Information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:
I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a PRESTIGE MEDICAL, PA

representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such Things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying PRESTIGE MEDICAL, PA to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing, and treatment as directed by my physician or his or her designee.

PATIENT SIGNATURE: _____ **DATE:** _____

GUARANTOR SIGNATURE: _____ **DATE:** _____
(If different from patient)

GUARANTOR NAME (Please Print): _____

GUARANTOR RELATIONSHIP TO PATIENT: _____

FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: _____ **Date of Birth:** _____

First Name M.I. Last Name

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any Medical service or visit, Preventative exam or physical, Lab testing, X-ray, EKG, and any other Screening service or Diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility and not the responsibility of the Physician or Clinic to know if my insurance will pay for my Medical service or visit, Preventative exam or physical, Lab testing, X-ray, EKG, or any other Screening service or Diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility to know if my insurance has any Deductible, Co-payment, Co-insurance, Out-of-Network amount, Usual and Customary Limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.

I understand and agree it is my responsibility to know if my PCP choice has been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.

Signature: _____ **Date:** _____

(Please sign here – Patient or Responsible Party)

Responsible Party Name: _____

(Please print name of Responsibility Party if different from Patient)

PRESTIGE MEDICAL, P.A.

DR. LEKSHMI NAIR, MD

(NOTIFICATION AGREEMENT)

In our efforts to comply with the Health Insurance Portability and Accountability Act (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.

Our preferred method for communicating lab **results** is via Patient Portal Account.
Please share your email to ensure you receive your **results** via Patient Portal.
Email:_____@_____.

Please circle your response to the following:

May we leave **detailed messages** on voice mail at home? Yes No
May we leave **detailed messages** on voice mail on Cell phone? Yes No
May we leave **detailed messages** on a voice mail at work? Yes No
Home: (____)_____ Cell: (___)_____ Work: (___)_____
May we leave messages concerning your **appointments** with another person at home or your place of work?

Yes No N/A

If yes, please specify whom: _____

May we discuss your **appointments/treatment** with any other family member?

Yes No N/A

If yes, please specify Name: _____ and Ph.#: _____.
For patients over the age of 18; may we discuss your **appointments/treatments** with your parent(s) or guardian? Yes No N/A
If yes, please specify
NAME:_____
Relationship to patient:_____ PH# _____

I have received a copy of the Notice of Patient information Privacy. Yes No

This form must be signed by the patient or legal guardian. All legal guardians must be listed on separate form. You must inform us, **in writing,** of any changes in your directives. This record will be kept in your file along with your acknowledgement of receipt of your Notice of Privacy Practices.

Patient's Name: _____ Date of Birth_____
Signature: _____ ***Date:*** _____

Printed Name: _____ Relationship to Patient: _____

PRESTIGE MEDICAL, P.A.
3945 CR 58, MANVEL, TX 77578
Phone:281-412-6606
Fax: 281-489-0233

Appointment Policies:

Welcome to our office! We are pleased that you have chosen us to take care of your medical needs. To make our time together most efficient and enjoyable, we have listed several office policies. Please read them carefully.

1. **YOUR APPOINTMENT**: Be on time for your appointments, preferably 10-15 minutes early. If you are late, you risk cancellation of your appointment.

2. **CANCEL OR RESCHEDULE POLICY**: We require a minimum of 24 hour notice to cancel or reschedule your appointment. All no show, cancellation or reschedules less than 24 hours will have a $25 charge applied to their account.

3. **BROKEN APPOINTMENT POLICY**: If a confirmed appointment is missed without proper cancellation or rescheduling you are provided a one-time notice and reminder of the policy. Any appointment missed without proper cancellation or rescheduling thereafter could result in a dismissal from the office as well as the **$25 charge**. Our answering service is available 24 hours a day.

4. **PROOF OF INSURANCE**: Bring your Insurance card to every appointment. We cannot file a claim without a current Insurance or Medicaid card on file.

I acknowledge that I am fully responsible for making and keeping my appointments as well as providing proof of insurance at every appointment.

I have read and completely understand my obligations to the office policies.

Signature: _____ Date: _____

Relationship to patient if not self: _____

PRESTIGE MEDICAL, P. A. /SAI PRIMARY CARE

MEDICAL HISTORY PAGE 1

Name _____ DOB:____/____/_____

Phone number: _____

ALLERGIES:_____

Pharmacy _____ Phone (____)_____

Occupation: _____ Marital Status: Married / Single / Widow/Divorced

IMMUNIZATIONS/ YEAR

(Please provide us with a copy of your most recent Immunization/shot records to keep on file)

Tetanus Vaccine_____ Measles Mumps Rubella (MMR) Vaccine _____

Pneumonia Vaccine_____ Influenza/Flu Vaccine_____Hepatitis B Vaccine _____

Shingles Vaccine _____

SCREENINGS

Last Pap smear _____ Last Colonoscopy_____ Last Mammogram _____

Last Prostate Screening_____ Last Dexa Scan _____ Last Physical _____

Last Eye Exam

Do you have a Living Will? ☐YES ☐NO

If no, do you wish to receive a copy of Advanced Directives today? ☐YES ☐NO

Medical Problems:

☐Vision problems	☐Hearing problems	☐bleeding from the nose	☐Pain – tooth
☐Chest pain	☐Shortness of breath	☐Diabetes	☐High Blood Pressure
☐Heartburn	☐Abdominal Pain	☐Constipation	☐Tobacco Use
☐Alcohol Use	☐Fractures	☐Blood transfusion	☐Hepatitis B/C
☐Chickenpox	☐Pain in the joints	☐Tingling/numbness	☐Headaches
☐Seizures	☐Fatigue	☐Trouble sleeping	☐Urinary Incontinence
☐Depression	☐Anxiety/Panic attacks	☐Sexually Transmitted Diseases	
☐Other			

• List of surgeries / Year / Reason

1._____
2._____
3._____
4._____
5._____

• Hospitalizations other than for surgeries /Year/Reason

1._____
2._____
3._____

MEDICAL HISTORY PAGE 2

Name: _____Date of Birth: _____/_____/_____

• **Current List of medications/ Strength/ Number of times a day (*Please keep an updated copy of your medications for every office visit)***

Name of medication *strength* *how often*

1._____

2._____

3._____

4._____

5._____

6._____

7._____

Herbal Supplements

_____

_____

Females Only:

Obstetric History

Number of pregnancies: _____ Number of live births: _____

Gestational Diabetes: ☐Yes ☐No High Blood Pressure: ☐Yes ☐No

Contraception Barrier: ☐ Yes ☐No ☐Oral Contraceptives ☐Depo Provera ☐Other_____

☐IUD _____ Year of IUD Insertion: _____

☐Natural Methods

☐Other_____ ☐☐None

Menstrual History: Age of first menstrual cycle: _____ Regular ☐Yes ☐No

Last Menstrual Cycle: _____

Family History: Y / N Relation

- Asthma:_____
- Cancer:_____
- Heart disease:_____
- Stroke:_____
- Diabetes:_____
- High Blood Pressure:_____
- Seizures:_____
- Mental Illness:_____

Please list any specific concerns you wish to discuss with your health care provider:

_____

_____

_____