REGISTRATION FORM

(Please Print)

Date:					
Patient Name:	First	MI	Last		Date of Birth:
Social Security No.		Sex: ☐ M ☐ F		Age:	
Race:			Preferred Language		
Mailing Address:			City, State, Zip		
Home Phone No.			Cell No.		
Employer			Work Phone		
Spouse's Name			Spouse's Employer		
Emergency Contact			Phone No.		
Name of Pharmacy			Email		

INSURANCE INFORMATION

Primary Insurance				
Insured's Name:	First	MI	Last	Insured's SSN
Insured's Date of Birth				
Patient's Relationship to Insured				
Secondary Insurance				
Insured's Name:	First	MI	Last	Insured's SSN
Insured's Date of Birth				
Patient's Relationship to Insured				

PLEASE READ AND SIGN BELOW

I understand that by completing this form, I certify that all information furnished is correct. I understand that even though I have insurance, I am ultimately responsible for payment of services and for all collection costs that may become necessary. Medicare recipients are responsible for deductibles, co-insurance and any non-covered service. I also authorize Somerset Internal Medicine to release any medical information necessary to process my claim and authorize payment of medical benefits to the physician.

Patient Signature _____ Date _____

SOMERSET INTERNAL MEDICINE

MEDICATION LIST

Medication	Dosage	Frequency

MEDICATION ALLERGIES

Medication	Reaction

NON DRUG ALLERGIES: _____

Personal Medical History

Name:_____ DOB:_____ Date: _____

Check all that apply. Use Comment area for additional details or other disorders

- ❑ Abnormal EKG
- ❑ Abnormal Mammogram
- ❑ Allergies (seasonal/environmental)
- ❑ Arthritis
- ❑ Asthma
- ❑ Anemia
- ❑ Anxiety
- ❑ Back Pain
- ❑ BCG (TB immunization)
- ❑ Brain Hemorrhages
- ❑ Brain Surgery
- ❑ Broken Bones
- ❑ Bronchitis
- ❑ Breast Cancer
- ❑ Cataracts
- ❑ Chest Pain
- ❑ Chrons Disease
- ❑ Colon Cancer
- ❑ Colitis
- ❑ Concussions
- ❑ Constipation
- ❑ Depression
- ❑ Deep Vein Thrombosis/Blood Clots
- ❑ Dental Problems
- ❑ Diabetes (juvenile; Type 1)
- ❑ Diabetes (adult; Type 2)
- ❑ Diverticulosis/Diverticulitis
- ❑ Diarrhea (chronic)
- ❑ Emphysema (COPD)
- ❑ Family History of Tuberculosis (TB)
- ❑ Falling
- ❑ Gallbladder Problems/Stones
- ❑ Glaucoma (pressure in the eye)
- ❑ Gum Disease
- ❑ Head Injury
- ❑ Hearing Loss
- ❑ Headaches (migraine)
- ❑ Headaches (tension)
- ❑ Heart Attack
- ❑ Heart Failure
- ❑ Heart Murmurs
- ❑ Hepatitis
- ❑ HIV/AIDS
- ❑ Hiatal (high) Hernia
- ❑ High Cholesterol
- ❑ High Blood Pressure
- ❑ Kidney Stones
- ❑ Leg Swelling
- ❑ Liver Disease
- ❑ Murmur (heart)
- ❑ Pneumonia
- ❑ Positive TB Skin Test
- ❑ Rheumatic Fever
- ❑ Seizures
- ❑ Sinus Problems/Sinusitis
- ❑ Stroke
- ❑ Transfusions (blood)
- ❑ Transient Ischemic Attack (TIA)
- ❑ Thyroid (hypoactive; low)
- ❑ Thyroid (hyperactive; high)
- ❑ Ulcerative Colitis
- ❑ Ulcers (stomach)
- ❑ Ulcers (legs and feet)
- ❑ Urinary Tract Infections

Other Conditions / Past Surgeries:

Social / Occpational History

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Living Together ❑ Separated ❑ Widowed

Number of Children?_____

Ages? _____

Who lives at home besides yourself? _____

Do any family members have significant healthcare or emotional needs? _____

What is your level of education?_____

Please list any hobbies or recreational activities? _____

Employment: ❑ Retired ❑ Employed (❑ full-time ❑ part-time ❑ self-employed ❑ home maker) ❑ Unemployed

Current Occupations: _____

Previous Occupations: _____

Have you had on the job exposure to any of the following:

- ❑ Asbestos
- ❑ Lead
- ❑ Dust
- ❑ Chemicals
- ❑ Solvents
- ❑ Radiation
- ❑ Other - Specify: _____

Tobacco Use? ❑ Y ❑ N
If Yes, Ammount: _____

Alcohol Use? ❑ Y ❑ N
If Yes, Ammount: _____

Caffeine Use? ❑ Y ❑ N
If Yes, Ammount: _____

I have reviewed and confirmed this information: _____ DO/MD/ARNP Date: _____

New/Interval Physical Visit

Name: _____ DOB: _____ Date: _____

Health Maintenance

Please indicate whether you have had or received any of the following screening tests or immunizations and the date if known.

	Tests	Yes	No	Unsure	Date
Women Only	Breast Self Exams				
	Pap Smear				
	Mammogram				
	Rubella Blood Test (for child bearing years only)				
Men and Women	Cholesterol or Lipid Profile				
	Colonoscopy				
	Sigmoidoscopy				
	Stool Blood Test				
Men Only	Prostate Cancer				
	Immunizations	**Yes**	**No**	**Unsure**	**Date**
Men and Women	Hepatitis A Vaccine				
	Hepatitis B Vaccine				
	Influenza Vaccine				
	Measles/Mumps/Rubella (MMR)				
	Pneumonia Vaccine (Pneumovax)				
	Tetanus Booster				
	Tuberculosis Skin Test (PPD; TB Skin Test)				
	Other (Describe)				
	Other (Describe)				

Family Medical History

Please indicate if any blood relative has ever had any of the following. Check box and indicate which relative(s):

Yes No

- ☐ ☐ Kidney Disease _____
- ☐ ☐ Bleeding Problems _____
- ☐ ☐ Breast Cancer _____
- ☐ ☐ Colon Cancer _____
- ☐ ☐ Diabetes _____
- ☐ ☐ Migraine Headaches _____
- ☐ ☐ Heart Attacks _____
- ☐ ☐ High Blood Pressure _____
- ☐ ☐ Stroke _____
- ☐ ☐ Tuberculosis _____
- ☐ ☐ Liver Disease _____
- ☐ ☐ Other _____

Please indicate the ages and whether living or deceased for each of the following:

Family Member	Age	Living/Deceased
Mother	____	_____
Father	____	_____
Brother/Sister	____	_____
Brother/Sister	____	_____
Brother/Sister	____	_____
Brother/Sister	____	_____
_____	____	_____
_____	____	_____

Other: _____

SOMERSET MEDICAL GROUP, PLLC
HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

- **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes stepparents, grandparents and any caretakers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ Email Confirmation
- ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ Email Confirmation
- ☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

- ☐ Phone Message
- ☐ Text Message
- ☐ Email
- ☐ **Any of the Above**
- ☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

_____

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- It was emergency treatment ___
- I could not communicate with the patient ___
- The patient refused to sign ___
- The patient was unable to sign because ___
- Other (please describe) ___

_____
Signature of Privacy Officer