

**Patient Registration Form**

(Please Print)

**PATIENT INFORMATION**

Dr.  Mr.  Mrs.  Ms.  Jr.  Sr.  Other\_\_\_\_\_

Patient's Name (Last)\_\_\_\_\_ (First)\_\_\_\_\_ (Middle)\_\_\_\_\_

Also Known As Name (Last)\_\_\_\_\_ (First)\_\_\_\_\_

Marital Status  Married  Single  Divorced  Widowed  Legally Separated  Other

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  Female  Male Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

E-Mail Address\_\_\_\_\_

Phone Numbers Work\_\_\_\_\_  Day  Evening Home\_\_\_\_\_  Day  Evening  
Cellular\_\_\_\_\_ Pager\_\_\_\_\_

Address\_\_\_\_\_

City, State, ZIP (+4)\_\_\_\_\_

Employment Status  Employed  Full-Time Student  Part-Time Student  Retired  Self-Employed  Unemployed

Employer\_\_\_\_\_ Occupation\_\_\_\_\_

Emergency Contact Name\_\_\_\_\_ Phone Number\_\_\_\_\_

Emergency Contact Relationship to Patient\_\_\_\_\_

Referring Provider Name\_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

Responsible Party Name (Last)\_\_\_\_\_ (First)\_\_\_\_\_ (Middle)\_\_\_\_\_

Also Known As Name (Last)\_\_\_\_\_ (First)\_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  Female  Male Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

E-Mail Address\_\_\_\_\_

Phone Numbers Work\_\_\_\_\_  Day  Evening Home\_\_\_\_\_  Day  Evening

Address\_\_\_\_\_

City, State, ZIP (+4)\_\_\_\_\_

Employment Status  Employed  Full-Time Student  Part-Time Student  Retired  Self-Employed  Unemployed

Employer\_\_\_\_\_ Employer Phone Number\_\_\_\_\_

Patient Relationship to Responsible Party\_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**

(provide your insurance card to the front desk at check-in)

Name of Insured\_\_\_\_\_ Patient Relationship to Insured\_\_\_\_\_

Insured Employer Name\_\_\_\_\_

Insurance Company/Phone Number\_\_\_\_\_ (\_\_\_\_\_)\_\_\_\_\_

Subscriber ID (Policy Number)\_\_\_\_\_ Group ID\_\_\_\_\_ Copay Amount\_\_\_\_\_

Effective Date\_\_\_\_\_ Termination Date\_\_\_\_\_  Female  Male

Insured Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Insurance Company Address\_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

(provide your insurance card to the front desk at check-in)

Name of Insured\_\_\_\_\_ Patient Relationship to Insured\_\_\_\_\_

Insured Employer Name\_\_\_\_\_

Insurance Company/Phone Number\_\_\_\_\_ (\_\_\_\_\_)\_\_\_\_\_

Subscriber ID (Policy Number)\_\_\_\_\_ Group ID\_\_\_\_\_ Copay Amount\_\_\_\_\_

Effective Date\_\_\_\_\_ Termination Date\_\_\_\_\_  Female  Male

Insured Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Insurance Company Address\_\_\_\_\_

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

**Patient (or Responsible Party) Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**HCA Physician Services  
Center for Advanced Medical Care  
Patient Consent Form**

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient.
- Use of prescribed medication
- Performance of diagnostic procedures/test and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees.

I fully understand that this given in advanced of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that Center for Advanced Medical Care may include consent at satellite offices under common ownership.

I, the undersigned, authorize the Center for Advanced Medical Care to use and disclose my information for the purpose of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of consent shall be considered as valid as the original.

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. Therefore, we urge you, as the patient to please check with your insurance company regarding your coverage. It is your responsibility to know your individual coverage. Failure to comply could result in you, the patient, being responsible for all costs incurred. Please remember that your insurance policy is between you and your insurance company, not between your doctor and your insurance company. In the event my insurance does not pay for all costs incurred, I will assume full responsibility.

**MEDICARE PATIENTS:** I authorize to release medical information about me to the Social Security Administration, or its intermediaries for my Medicare claims. I assign the benefits payable for services to Center for Advanced Medical Care. I acknowledge that I have been given the Center for Advanced Medical Care Notice of Privacy Practices. I understand that if I have any questions or complaints that I should contact the Privacy Officials. Patient initials: \_\_\_\_\_

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

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**Patient (or Responsible Party) Signature**

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**Date**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Place of birth: \_\_\_\_\_ Gender: F M

Telephone number: \_\_\_\_\_ Cell phone: \_\_\_\_\_

e-mail address: \_\_\_\_\_

Address:

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What is the main purpose of your visit?

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How did you hear about me? \_\_\_\_\_

Health History:

Do you have any allergies or intolerances? Yes No

If yes, please specify: \_\_\_\_\_

Do you have any stomach problem such as colitis, gastritis, ulcer, reflux, diberticulosis, or other?

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Have you had any surgery procedures?

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Do you have any of the following conditions?

High Cholesterol ( )

Asthma ( )

Other :

High Triglycerides ( )

Renal dysfunction ( )

\_\_\_\_\_

Diabetes ( )

Hepatic dysfunction ( )

\_\_\_\_\_

High Blood Pressure ( )

Depression ( )

Heart Disease ( )

Gallbladder disease ( )

Do someone in your family has /had any of the following conditions?Who?

High Cholesterol ( )

Asthma ( )

Other :

High Triglycerides ( )

Renal dysfunction ( )

\_\_\_\_\_

Diabetes ( )

Hepatic dysfunction ( )

\_\_\_\_\_

High Blood Pressure ( )

Depression ( )

Heart Disease ( )

Gallbladder disease ( )

Are you usually constipated? Yes No

Are you taking any medications, drugs, vitamins, or herbs? Yes No

If yes, please specify:

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Have you ever been on a diet to lose weight? Yes No

If yes, please describe **what** kind of diet, **when** did you did it and **what happened**:

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Why did you decided to lose weight **now**?

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Smoking habits (Past and present) \_\_\_\_\_

Do you snore? \_\_\_\_\_

Do you have problems to sleep? \_\_\_\_\_

Do you wake up fatigued, or without energy? Yes No

How do you feel about the following aspects?

	Excellent	Very good	Good	Not very good	Bad
Your appearance					
Your Fitness					
Your weight					
Your eating habits					
Your exercise habits					

ONLY FOR WOMEN:

Have you been Pregnant? Yes No

How many kids do you have? 1 2 3 4 5 6 7 8 9

Did you breastfeed? Yes No

If yes, for how long? \_\_\_\_\_

Food that you most like:

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Food that you most dislike and/or can't eat

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Do you eat kosher: YES NO

Do you eat Vegetarian: YES NO

24 Hours recall

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Time	Food	Number of portions	Calories
Breakfast			
Snack			
Lunch			
Snack			
Dinner			

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