New Patient Registration and Questionnaire SECTION 1

Patient Information			
Name:			MRN:
AKA:			Sex: ☐ M ☐ F
Birth Date:	Marital Status:		Preferred Method of Contact: ☐ Email ☐ Mail ☐ Text ☐ Phone
Email Address:			
Address 1:		Home Phone:	
Address 2:		Mobile:	
City, State:		Zip:	

Guarantor Information (Person Responsible for Bill)	
Guarantor Name:	
Relation to Guarantor: ☐ Parent ☐ Sibling ☐ Child ☐ Aunt/Uncle ☐ Legal Guardian ☐ Other	
Address:	Telephone #:
City, State:	Zip:

Patient Employer Information		Guarantor Employer Information	
Employer:		Employer:	
Address 1:		Address 1:	
Address 2:	Telephone #	Address 2:	Telephone #:
City, State:	Zip:	City, State:	Zip:

Emergency Contact Information	
Name:	Relation:
Address:	
City, State:	Zip:
Home Telephone #:	Mobile #:

Insurance Information		
Primary Insurance:	Subscriber Name:	DOB:
	ID Number:	
Secondary Insurance:	Subscriber Name:	DOB:
	ID Number:	
Tertiary Insurance:	Subscriber Name:	DOB:
	ID Number:	

New Patient Registration and Questionnaire SECTION 2

1. Demographic

Race	Ethnicity
☐ White ☐ African American/Black ☐ American Indian ☐ Pacific Islander ☐ Other ☐ Decline ☐ Unknown	☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Other ☐ Unknown
Do you need a translator? ☐ Y ☐ N	Primary spoken language:
Do you have an Advance Directive? : ☐ Y ☐ N	Are you hearing impaired? ☐ Y ☐N

2. Health Maintenance

a. When was the last time you had the following tests performed? (please check all that apply)

	Past Year	2 Years	10 years	Never
Colonoscopy				
Routine Physical				
Eye Exam				
Breathing Test				
Bone Density				
Cholesterol Check				
Flu Shot				
Pneumonia Vaccine				
Women's Health				
Mammogram				
PAP Smear				

3. Past Medical History

a. Do you have or have you ever been diagnosed with: (If yes, please specify how long ago)

	Yes	No	0 – 12 months	1 – 3 years	3 - 5 years	5 – 10 years	10+ years
Diabetes							
High Blood Pressure							
Heart Disease							
High Cholesterol							
Cancer							
Stroke							
Seizures							
Lung Disease (Asthma, COPD, etc.)							
Glaucoma							
HIV							
Other(s):							

New Patient Registration and Questionnaire SECTION 2

b. Have you been hospitalized in the past year? ☐ Y ☐ N (If yes, please specify below)

Date	Hospital	Reason

For additional space, please use page 5 addendum 3b

c. Do you see any specialists? ☐ Y ☐ N If yes, please provide the name and reason:

Specialist Name	Reason

For additional space, please use page 5 addendum 3c

4. Past Surgical History

Have you ever had surgery? ☐ Y ☐ N If Yes, please explain:

Date	Procedure	Reason

For additional space, please use page 5 addendum 4

5. Family History

	Yes	No	Relation (e.g. father)
Diabetes			
High Blood Pressure (Hypertension)			
Heart Disease			
High Cholesterol			
Cancer			
Stroke			
Seizures			
Lung Disease (Asthma, COPD, etc.)			
Other(s):			

6. Social History

a. What is your smoking status? Never_____Past Smoker_____Current Smoker_____

How many packs per day?_____How many years of smoking history? _____

b. Do you drink alcoholic beverages? ☐ Y ☐ N If yes, approx. # drinks per week: _____

c. Have you or do you use any drugs for recreational use (confidential): ☐ Y ☐ N

If yes, please explain: _____

New Patient Registration and Questionnaire SECTION 2

d. Have you been exposed to any conditions/events that could potentially be damaging to your health (i.e. military combat, occupational hazards, etc.)? If yes, please explain: _____

_____

_____

7. Allergies

Do you have any food or drug allergies? ☐ Y ☐ N If yes, please list and describe:

Food or Drug	Reaction

For additional space, please use page 5 addendum 7

8. Medications

Please list all medications, including over the counter "OTC" medications and herbal supplements that you are currently taking or have taken in the last 12 months:

Drug, OTC, or Herbal Supplement	Currently Taking?		Dose	Treatment Purpose
	Yes	No		

For additional space, please use page 5 addendum 8

9. Pharmacy Information

Please provide us with the name and location of your preferred pharmacy:

Name:_____ Phone:_____

Location:_____

10. Patient/Provider Review

Please sign below to confirm that the information above is accurate and has been reviewed.

Patient Signature:_____ Date:_____

Provider Signature:_____ Date: _____

New Patient Registration and Questionnaire SECTION 2

Addendum

3.b Past Hospitalizations

Date	Hospital	Reason

3.c Current Specialists

Specialist Name	Reason

4. Past Surgical History

Date	Procedure	Reason

7. Allergies

Food or Drug	Reaction

8. Medications

Drug, OTC, or Herbal Supplement	Currently Taking?		Dose	Treatment Purpose
	Yes	No		

DIGNITY PRIMARY CARE

ADULT PATIENT CONSENT FORM

Thank you for allowing Dignity Primary Care to serve you. Please complete this consent form and provide proper documentation of insurance in order to receive services.

CONSENT FOR TREATMENT

I hereby give my consent to receive comprehensive health services at Dignity Primary Care. I further authorize any health professional working for Dignity Primary Care to provide medical tests, procedures, and treatments that are necessary or advisable for the medical evaluation and management of my health care. This includes examinations, blood tests laboratory and imaging procedures, medications, infusions, nursing care and other services or treatments rendered by my physician, consulting physicians and their associates and assistants, or rendered by Dignity Primary Care personnel under the instructions, orders or direction of such physician(s).

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign and authorize payment of all of my insurance benefits, sick benefits, Medicare benefits and injury benefits due because of liability of a third-party, payable by any party or organization directly to Dignity Primary Care or any Dignity Primary Care-based physician, unless the account for the facility, outpatient visit or series of outpatient visits is paid in full upon discharge or upon completion of the outpatient series. If eligible for Medicare, I request Medicare services and benefits. I understand that I am responsible for any charges not covered by my insurance company.

PROMISE TO PAY

I understand that I am obligated to pay in full for any services received in accordance with the regular rates and terms of Dignity Primary Care. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above Dignity Primary Care visit may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Dignity Primary Care's Notice of Privacy Practices that provides information about how the Dignity Primary Care may use and disclose my protected health information.

I have read and understand the above information and give permission for my care as described. *I understand that I have the right to OPT-OUT of any medical testing or treatment.* I also understand that I may obtain further information regarding the health services offered by Dignity Primary Care by contacting (404) 588-0101.

_____

Patient Name

_____ _____/_____/_____

Patient/Legal Representative Signature **Date**

_____ _____/_____/_____

Witness Signature **Date**