PCP: Referred by:

Name: _____ Age: ___ D.O.B. _____ ___ Male ___ Female

What brings you into the office? _____

When did your symptoms start? _____

Were you injured? If yes, explain: _____

Where does it hurt? _____

On a scale of 1 to 10 with 10 being the most pain, what would you rate your pain? _____

When does it hurt (in example: when you wake up, after prolonged activities, sleeping, etc.)?

_____

Does anything make it better? _____

Have you seen another physician for this problem? _____

What have you tried to help resolve your problem (In example: medications, rest, ice, etc.)?

_____

Have you had x-rays obtained for this problem? ___ Yes ___ No If yes, where and when?

_____

Past Medical History: (please list) _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Past Surgical History: (please list) _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Medications: (list all current medications with dosages)

Medication	Dosage	Frequency	What are you taking it for?

Allergies: (please list) _____ _____ _____

PREMIER
PHYSICIANS CENTERS

***PLEASE PRESENT THIS FORM ALONG WITH YOUR INSURANCE CARD AND COPAYMENT TO THE FRONT DESK**

*Information Required

Last* _____ First* _____ Middle* _____

Gender* _____ SSN _____ Marital Status _____ Date of Birth* _____

Race* _____ Ethnic Group* _____ Language* _____ Primary Provider _____

If you elect not to give information to any of the above questions, please write "decline" and initial.

Address _____ City _____ State _____ Zip _____

❒ Phone (H) _____ ❒ Phone (Cell) _____ ❒ Phone (Work) _____ ❒ Email _____

Check box for preferred contact method.

Relationship to Insured* Self _____ Spouse _____ Child _____ Other _____

Employer _____ Work Phone ( ) _____

Name of Referring Physician _____

Contact in Case of Emergency _____ Phone ( ) _____

Responsible Party Information: Complete if responsible party is someone other than patient

First Name _____ MI _____ Last Name _____

Address _____ City, State, Zip _____

Birth Date _____ Social Security Number _____

Employer _____ Work Phone ( ) _____

If Covered by Medicare, Complete this Section: Is Medicare Primary? Yes No

Medicare Number (include letter) _____ Are you employed? Yes No

---

Insured Party Information:

Primary Insurance Policy Holder _____ DOB* _____

Address _____ Phone ( ) _____

Insurance Company _____ SS# _____

Policy Number _____ Group Number _____

Secondary Insurance Policy Holder* _____ DOB* _____

Address _____ Phone ( ) _____

Insurance Company _____

I UNDERSTAND THAT I AM RESPONSIBLE FOR FULL PAYMENT OF MY BILL, IN A TIMELY FASHION.
I authorize the release of my medical information necessary to process this claim: AND
I authorize payment of medical benefits to the providing physician directly for services rendered:

_____

PATIENT'S SIGNATURE DATE

PLEASE PRESENT THIS FORM ALONG WITH YOUR INSURANCE CARD AND COPAYMENT TO THE FRONT DESK

Social History:

Have you ever smoked tobacco? ___ Yes ___ No

If you answered "yes", do you currently smoke? ___ Yes ___ No

How many packs per day? _____ If you quit smoking, when did you quit?

Do you drink alcohol? ___ Yes ___No If yes, how often? ___ Occasional ___ Daily

Are you currently using recreational drugs? ___ Yes ___ No

Are you currently employed? ___ Yes ___ No If yes, where? _____

Family History: (please check mark below and list any pertinent illnesses)

Mother ___ Living ___ Deceased Illnesses _____

Father ___ Living ___ Deceased Illnesses _____

Sibling(s) ___ Living ___ Deceased Illnesses _____

Sibling(s) ___ Living ___ Deceased Illnesses _____

Review of Systems: (please check mark all that applies)

General	Skin	HEENT	Lungs	Heart	GI
___ weakness	___ rashes	___ headaches	___ cough	___ Murmur	___ Abd pain
___ fatigue	___ color changes	___ blurred vision	___ SOB	___ Chest Pain	___ Nausea
___ fever	___ itching	___ loss of balance	___ Pain	___ Blood clots	___ Vomitting
___ chills	___ dryness	___ dizziness	___ phlegm	___ Cold Extremity	___ Heartburn
___ night sweats	___ sores	___ hard of hearing	___ blood	___ Swelling	___ Constipation

Neuro	MSK
___ numbness	___ jt pain
___ loss of memory	___ cramps
___ gait shuffling	___ back pain
___ seizures	___ hip pain
___ Tingling/Burning	___ jt swelling

BP _____

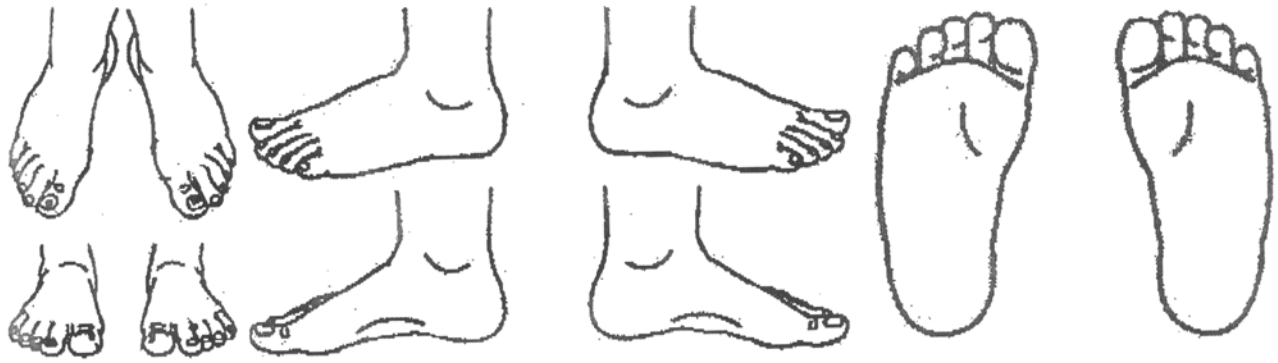
Shoe Size _____

Vitals: Height _____ Weight _____

Most recent Blood Sugar (only if you have Diabetes) _____

Most recent Hemoglobin A1c (only if you have Diabetes _____

Please Mark on diagram below where your pain is located.



PREMIER PHYSICIANS CENTERS

CONSENT FORM

I consent to treatment by my attending physician and/or such physicians and assistants as may be selected by him/her to diagnose and treat the condition or conditions from which I am suffering by such means including diagnostic exam/testing and in-office procedures as he/she believes indicated by his/her studies in my case.

I authorize Premier Physicians Centers to submit any and all health care information, which may include drug and alcohol history and HIV status to my health insurance program for their review and payment. I understand that it is my responsibility to know the benefits of my insurance plan. I also understand that some services, tests or consultations may not be covered by my insurance plan and that I am financially responsible for any services that are not covered by my benefit plan, including denials for failure to obtain prior authorization or referral.

I understand that co-payments are due at the time of service.

By signing below, I am also verifying that I have legal authority to authorize medical treatment as well as authorize payment to be made to Premier Physicians Centers by my insurance carriet.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Printed Patient's Name

_____

Witness

PREMIER PHYSICIANS CENTERS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that Premier Physicians Centers is a multi-specialty healthcare organization and that these providers may share my health information for treatment, billing and healthcare operations. I have been given a copy of the organization's Notice of Privacy Practices that describes how my health information is used and shared. I understand that Premier Physicians Centers has the right to change this notice at any time. I may obtain a current copy by contacting the Privacy Officer or the doctor's office.

My signature below constitutes my acknowledgement that I have been provided a copy of the "Notice of Privacy Practices".

_____ _____

Signature of Patient or Legal Representative Date

_____

Relationship to Patient

FOR OFFICE USE ONLY:

Print Patient Name: _____

Name and Location of Office: _____

_____

Patient Refused to Sign:

_____ _____

Witness Date

Reason(s) for Refusal:

_____

_____

_____