HEALTH CARE - REGISTRATION FORM
(Please Print & Complete All Sections)

SORIANO MED

Today's Date ____/_____/_____ Auto Accident? ☐ Yes ☐ No

PATIENT INFORMATION

Patient's Last Name	First	Middle	Marital Status (Circle One) Single / Mar / Div / Sep / Wild
Is this your legal name?	If not, what is your legal name?		Birth Date / Sex
Street Address	City	State / ZIP Code	Social Security / Preferred Phone No.
Occupation	Employer		Employer Phone No.

How did you hear about us? (Please check one Box) □ Ins Plan □ Family/Friend □ Returning Patient

□ Internet Search (specify) _____ □ Other (specify) _____

May we contact you via email? □ Yes □ No If yes, email address: _____

INSURANCE INFORMATION

Is this patient covered by Insurance? □ Yes □ No	Name of Primary Insurance			
Subscriber's Name	Subscriber's S.S.#	Birth Date	Group #	Policy #

Patient's Relationship to Subscriber □ Self □ Spouse □ Child □ Other _____

Name of Secondary Insurance (if application)	Subscriber's Name	Group	Policy #

Person Responsible for Bill / Birth Date	Address (if different)	Home Phone No.
Is this person a patient her? □ Yes □ No		

Occupation	Employer	Employer Address	Employer Phone No.

Patient's Relationship to Subscriber □ Self □ Spouse □ Child □ Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative / Relationship to Patient / Home/Cell Phone No / Work Phone No

Pharmacy _____ Address/City _____Phone _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to paid directly to Soriano Physician Services, PLLC. I understand that I am financially responsible for any balances. I also authorize Soriano Physician Services, PLLC or insurance company to release any information required to process my claims.

× _____ _____

Patient/Guardian Signature / Date

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FINANCIAL POLICY STATEMENT

The policies listed herein have been approved by the management with the goal of providing the finest care and services to our patients at the least cost.

Care delivered by this office will be administered regardless of race, color, social status, national origin, handicap or gender.

We are committed to providing you with the best possible care. In order to accomplish this, we your assistance in reading and understanding financial responsibility and our payment policy.

RESPONSIBILITY FOR THE BILL

It is the expectation that all patients/guarantors receiving services are financially responsible for the timely payment of the charges incurred. While the office will file, verified insurance claims for payment of the bill(s) as a courtesy to the patient, the patient/guarantor is ultimately responsible for payment and agrees to pay the account(s) in accordance with the regular rates and terms of the practice in effect at the present time

POINT OF SERVICE COLLECTIONS

Payment for service is due at the time of service is rendered and non-emergency services may be declined until the necessary payment arrangements have been accomplished.

Payment will be accepted in checks and all major credit/debit cards. We will be happy to file verified insurance on your behalf. For your convenience if your check is dishonored or returned for any reason, we will be electronically debit your account the amount of he check plus a processing fee of $50.00.

Patients paying out of pocket for the services rendered are considered self payments. Payment is due at the time service, a$XX for Initial Consult and $XXX follow ups.

Patients unable to comply with the Point-of-Service payment policy will be re referred to the administrative office for necessary arrangements

PAYMENT ARRANGEMENTS

The practice will make a reasonable effort to assist patients in meeting their financial obligations. Financial arrangement for payments will be made at the office's discretion, based on the amount of the patient's liability and the patient's ability to pay based on completed credit application.

ACCEPTANCE OF INSURANCE

The practice will accept "Assignment of Benefits" on verified insurance policies and submit a bill to carrier on the patient's behalf. It is understood that insurance is filed as a courtesy to the patient and does not relieve the patient of financial responsibility. Claims filed will be held 45 days pending payment. The patient/guarantor will be responsible for payment in full on all the claims not paid within the allowed period of time.

VERIFICATION OF INSURANCE

Because of the wide range of insurance plans in effect, the clinic will verify insurance coverage, deductibles and other limits, prior to acceptance for payment of services

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REJECTED CLAIMS

Our staff is trained to assist you with insurance questions. COVERAGE ISSUES can only be addressed by your employer or group health administrator. Although our assistance is available, we cannot act as a mediator on your behalf.

RELEASE OF INFORMATION

By signing our release of information form, you provide us with the authority to release such information as is necessary to collect from insurance companies and other third party payers.

PATIENT RESPONSIBILITY

Balances after insurance are due within 30 days of the insurance payments, unless other satisfactory arrangements have been made with the practice.

Not all services are covered by all insurance companies. It should be understood that by accepting the service(s), the patient is responsible for payment regardless of the fact that insurance covers the service or not.

The practice cannot become involved with any third party liability matters and must always look to the patient/guarantor for payment of the bill.

OUTSTANDING BILLS

The clinic reserves the right to request deposits and payments for outstanding balances. Deposits will be based on the outstanding balance plus the patient's share of the bill for the new services to be performed.

HEALTHCARE LIENS

The clinic reserves the right to file healthcare liens against the patient and other responsible parties as is deemed appropriate to protect the practice interest.

BAD DEBTS/LEGAL ACTIONS

If the account is not paid in full or satisfactory arrangements made within the allowable time frame, the practices reserves the right to refer the account to an attorney and/or a collection agency for collections of the balance.

I agree to assume responsibility for all charges incurred should collections of this balance become necessary including court costs and attorney's fee.

The administrative and management welcomes the opportunity to discuss any aspect of the financial policy. We appreciate your confidence and strive to provide quality healthcare

I have read the *Financial Policy/Policy Statement* and understand regarding above.

_____ _____

Patient/Guarantor Date

_____ _____

Witness Date

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HIPAA ACKNOWLEDGEMENT/CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);

- Obtaining payment from third party payers (e.g. my insurance company);

- The day-to-day healthcare operations of your practice. I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA.

I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I, _____, give permission to my health care provider to disclose and/or release my health information to the following:

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Ph. Number: _____ Ph. Number: _____

Print Name _____

Signature _____Signature Date_____

Relationship to Patient (if patient unable to sign) _____

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Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No

Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

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Specialist Referral List

Date _____

Patient Name _____

MRN# _____

Physician First & Last Name	Seen for what service/condition?	Procedure/Surgeries Month/Year	When you were last seen? Month/Year

☐ **Entered into eCW** **Signed by Soriano Med Staff** _____ **Date** _____