PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ DATE _____
First Middle Last

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME # _____ WORK# _____ CELL# _____

SS# _____ BIRTHDATE _____ MARITAL STATUS _____

PATIENT'S EMPLOYER _____

WORK ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE'S NAME _____ CELL# _____

EMPLOYER _____ WORK# _____

EMERGENCY CONTACT NAME & # _____

REFERRING PHYSICIAN _____ FAMILY PHYSICIAN _____

PREFERRED PHARMACY _____ ANY **DRUG** ALLERGIES? _____

LIST NAME AND PHONE # OF ANYONE THAT IS AUTHORIZED TO DISCUSS YOUR MEDICAL CONDITION(S)

_____

I understand that ETHOI will only release my protected healthcare information to the individuals that I have indicated on this form.

RESPONSIBLE PARTY(S)

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES.

SIGNATURE OF PATIENT _____

IN THE EVENT OF INCAPACITATION WHO, OTHER THAN THE PATIENT, WILL BE RESPONSIBLE FOR ALL CHARGES? _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME# _____

BIRTHDATE _____ SS# _____ CELL# _____

EMPLOYER _____ _____ WORK# _____

SIGNATURE OF 2ND RESPONSIBLE PARTY _____

Please note that if patient is married the spouse **MUST** sign as responsible party.

INSURANCE INFORMATION

PRIMARY INSURANCE RELATIONSHIP

NAME OF INSURED _____ TO PATIENT _____

BIRTHDATE _____ SS# _____ INS. EFFECTIVE DATE _____

NAME OF EMPLOYER _____ WORK # _____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURANCE CO _____ GROUP# _____ POLICY ID _____

DO YOU HAVE PRESCRIPTION COVERAGE? _____ WITH WHOM? _____

SECONDARY INSURANCE RELATIONSHIP

NAME OF INSURED _____ TO PATIENT _____

BIRTHDATE _____ SS# _____ INS. EFFECTIVE DATE _____

NAME OF EMPLOYER _____ WORK # _____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURANCE CO _____ GROUP# _____ POLICY ID _____

I authorize the release of any medical information necessary to process insurance claims and/or the release of medical records. I further authorize payment of medical benefits to the physician in the event they file for the insurance.

I UNDERSTAND AND AGREE THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE AND/OR MEDICARE/MEDICAID. I also agree that if my bills are not paid, all legal costs, interest, and collection fees will be my responsibility.

PATIENT SIGNATURE _____ DATE _____

EVANS 5007

REGISTRATION

What is your chief complaint today? _____

_____

PAST MEDICAL HISTORY

___ Aids/Hiv
___ Anemia
___ Angina
___ Arthritis
___ Aritificial Heart Valves
___ Artificial Joints
___ Asthma
___ Back Problems
___ Cancer
___ Chemical Dependency
___ Chest Pain
___ Chronic Diarrhea
___ Diabetes
___ Ear Problems
___ Epilepsy
___ Heart Attack
___ Heart Disease
___ Hepatitis
___ High Blood Pressure
___ High Cholestrol
___ Kidney Problems
___ Liver Disease
___ Low Blood Pressure
___ Lung Disease
___ Mental Illness
___ Phlebitis/Blood Clots
___ Radiation Therapy
___ Respiratory Disease
___ Rheumatic Fever
___ Shortness of Breath
___ Stroke/Mini Stroke
___ Tuberculosis
___ Ulcers
___ Varicose Veins
___ Venereal Disease
___ Weight Loss, Unexplained
___ Other: _____

Please list all surgeries that you have had: _____

_____

What perscriptions are you currently taking? _____

FAMILY HISTORY

Have your grandparents (G), parents (M or F), or siblings (B or S) been treated for any of the below:

Diabetes ___ Yes ___ No Who? ___ Cancer ___ Yes ___ No Who? ___
Heart Disease ___ Yes ___ No Who? ___ Vascular Disease ___ Yes ___ No Who? ___
Blood Clotting Problems ___ Yes ___ No Who? ___

ALLERGIES

Please indicate if you are allergic to any of the following:

___ Adhesive/Tape
___ Aspirin
___ Codeine
___ Demerol
___ General Anesthetic
___ Iodine
___ Local Anesthetic
___ Novocain
___ Penicillin
___ Seafood
___ Sulfa
___ None Known
___ Other (Please Specify)
_____
_____

MEDIGAP

If you have a supplemental policy and it is a MEDIGAP policy in which your Medicare carrier automatically "crosses over," we are required to keep a separate signature on file.

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

PATIENT SIGNATURE _____ DATE _____

(As it appears on Medicare Card)