

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, RELATIONSHIP
WILL BE RESPONSIBLE FOR ALL CHARGES? _____ 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 _____

REGISTRATION

What is your chief complaint today? _____

PAST MEDICAL HISTORY

- | | | |
|--|--|---|
| <input type="checkbox"/> Aids/Hiv | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Ear Problems | <input type="checkbox"/> Phlebitis/Blood Clots |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke/Mini Stroke |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chronic Diarrhea | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Weight Loss, Unexplained |
| <input type="checkbox"/> 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:

- | | | |
|---|---|---|
| <input type="checkbox"/> Adhesive/Tape | <input type="checkbox"/> Iodine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> None Known |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Novocain | <input type="checkbox"/> Other (Please Specify) |
| <input type="checkbox"/> Demerol | <input type="checkbox"/> Penicillin | _____ |
| <input type="checkbox"/> General Anesthetic | <input type="checkbox"/> Seafood | _____ |

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)