Patient Registration

Welcome to our office. We look forward to establishing a comfortable and secure relationship with you. You are important to us and we want you to feel special every time you call or walk into this office. Please take a few minutes to read and complete this form. This information is necessary to make sure you receive the best care during your visit and to minimize any misunderstanding which may occur due to incorrect or incomplete information.

PATIENT INFORMATION

First Name: _____ Last Name: _____ Today's Date: _____

Mailing Address: _____ City: _____ ST: _____ Zip: _____

Best Phone: _____ Secondary Phone: _____

email: _____

DOB: _____ Age: _____ Social Security #: _____ / _____ / _____ Sex ☐ M ☐ F Marital Status: ☐ M ☐ S ☐ W ☐ D

Primary Care Physician: _____ Referring Physician: _____

Employer: _____ Address: _____ Phone: _____

Reason For Today's Visit: _____

INSURANCE INFORMATION

Insurance And Responsible Party Information: ☐ SELF ☐ SPOUSE ☐ PARENT *If other than self please fill out the following information:*

Insurance Carrier: _____ Primary Card Holder: _____ DOB: _____

Social Security #: _____ / _____ / _____ Relation: _____

ETHNIC BACKGROUND INFORMATION (Required by Healthcare Legislation)

RACE: ☐ American Indian ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Indian ☐ African American ☐ Other

ETHNICITY: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name: _____ Relationship: _____ Phone: _____

PHARMACY

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____

Printed Legal Name: _____ **Signature:** _____

DELINQUENT ACCOUNTS: We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing.

If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If you fail to pay on time and we refer your account(s) to a third party for collection, a collection fee will be assessed and will be due at the time of the referral to the third party. The fee will be calculated at the maximum percentage permitted by applicable law, not to exceed 18 percent. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances.

CONSENT TO CONTACT: I grant permission and consent to AdvancedHEALTH and its agents, assignees, and contractors (which may include third party debt collectors for past due obligations): (1) to contact me by phone at any number associated with me, if provided by me or another person on my behalf; (2) to leave messages for me and include in any such messages amounts owed by me; (3) to send me text message or emails using any email address I provided or any phone number associated with me, if provided by me or another person on my behalf; and (4) to use prerecorded/artificial voice messages and/or an automated telephone dialing system (an auto dialer) as defined by the Telephone Consumer Protection Act in connection with any communications made to me as provided herein or any related scheduled services and my account. I understand that my refusal to provide the consent described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services.

NASHVILLE SURGICAL ASSOCIATES

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Ray HARGREAVES, MD ✦ Jonathan COHEN, MD ✦ Brian SHEA, MD

Name: _____ Age: _____ Today's Date: _____

REASON FOR TODAY'S VISIT: _____

Referring Doctor: _____ Primary Care Doctor (if different): _____

MEDICAL HISTORY (Please Check)

☐ Alcohol / Substance Abuse (Past or Present)
☐ Arthritis
☐ Asthma
☐ Blood Clots
☐ Cancer _____
☐ Cardiac Stenting / Angioplasty
☐ COPD / Emphysema
☐ Depression or Anxiety
☐ Diabetes
☐ Gout
☐ Heart Attack (MI)
☐ Heart Disease
☐ Heart Murmur
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV +
☐ Kidney Disease
☐ Liver Disease or Hepatitis
☐ Nervous Disorder
☐ Reflux / Heartburn
☐ Rheumatic Fever
☐ Seizures
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis

OPERATIONS	DATE	SURGEON/HOSPITAL

Have you ever had MRSA? ☐ No ☐ Yes If Yes, when: _____

Do you have any Food Allergies? ☐ No ☐ Yes: _____

Are you Allergic to any medication? ☐ No ☐ Yes: _____

Do you take any Medication on a regular basis? *Please include vitamins, supplements, and OTC medicine.* LIST DOSAGE.

1. _____ 5. _____ 9. _____
2. _____ 6. _____ 10. _____
3. _____ 7. _____ 11. _____
4. _____ 8. _____ 12. _____

Occupation: _____

Smoking: ☐ No ☐ Yes Amount: _____ *packs/day*

Alcohol: ☐ No ☐ Yes Amount: _____ */ week*

Family History of Cancer? ☐ No ☐ Yes

Type of Cancer: _____

Family relation *(example: Mother)* _____

FOR WOMEN:

Have you ever taken hormones? ☐ No ☐ Yes

Your age at menopause?: _____

How many times have you been pregnant?: _____

Number of deliveries?: _____

TO BE COMPLETED BY OFFICE MEDICAL ASSISTANT

Blood Pressure: _____ Weight: _____ Height: _____

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