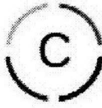

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PATIENT REGISTRATION FORM

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss

Name (first) ____________________ (middle)____________________ (last)____________________ ❑ male ❑ female
Address ____ Apt# __________
City ______________________________ State ______________________ Zip __________
Birth Date______________________ Age ________ Social Security # ________-________-________
Home Phone ______________________________ Work Phone ______________________________
E-Mail ______________________________ Cellular Phone______________________________
Employed: ❑ yes ❑ no Employer Name ______________________________
Marital Status: ❑ single ❑ married ❑ divorced ❑ widowed

May we leave messages at home with other residents ❑ yes ❑ no
May we leave personal health information on your answering machine/voicemail ❑ yes ❑ no
May we contact you via e-mail or cellphone ❑ yes ❑ no
Appointment reminders will be left on voicemail.
Who may we contact in case of Emergency? Name ______________________________
Relationship ______________________________ Phone #1 ____________ #2 ____________
Please list below all individuals with whom we may talk to about your medical concerns:
Please Note: We will not release any personal health information to anyone unless they are listed below
Name______________________________________Relationship______________
Name______________________________________Relationship______________
Name ______________________________________ Relationship______________

INSURANCE INFORMATION

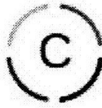
Note: We require that your card be presented at every visit ~ OR~ if card is not available you must verify eligibility, and provide ID#, group #, mailing address & provider services #. If not, you will be responsible for the cost of the office visit.

Primary Insurance Company______________________________ Co-payment $__________
Card Holder Name______________________________ Birth Date ______________
Address ______________________________Social Security # ________-________-________
Is your insurance through employer: ❑ yes ❑ no If yes, employer
____

Relationship to card holder: ❑ self ❑ mother ❑ father ❑ other

Secondary Insurance ______________________________
Card Holder Name ______________________________ Birth Date ______________
Address ______________________________Social Security # ________-________-________
Relationship to Card Holder: ❑ self ❑ mother ❑ father ❑ other
Card(s) Copied: Primary: ❑ yes ❑ no Secondary: ❑ yes ❑ no

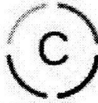
I assign directly to Cerium Medical Group all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid for by my insurance company. I authorize the use of my signature on all insurance submissions. The above-named facility may use my health care information and



Cerium Medical Group

may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. Should my account be referred for collection procedures, I also agree to pay collection expenses and any attorney fees. I understand I have read and understand the above, and as the patient, guarantor, or patient responsible party, I agree to and accept these terms

Signature ____ Today's Date ___________________



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Health History Questionnaire

Patient Name: ______________________________ DOB: ______________

Great healthcare is the result of great communication. At Cerium Medical Group, we want to understand everything we can about your ideas on healthcare, your concerns, and your goals. Keeping you well means knowing you well. Thank you for beginning our conversation before your visit by completing this information.

Main reason for today's visit:

____

Other concerns:

____

____

____

ALLERGIES

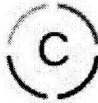
Please list all allergies (medications, food, bee stings, etc.) and reactions to each.

ALLERGY	REACTION
1.	
2.	
3.	
4.	

MEDICATIONS

Please list all the medications you are currently taking. Include prescribed drugs and over-the-counter drugs, as well as vitamins and supplements.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		



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PAST MEDICAL HISTORY

Please circle all that apply:

Anxiety Disorder	Diverticulitis	Kidney Disease
Arthritis	Fibromyalgia	Kidney Stones
Asthma	Gout	Leg/Foot Ulcers
Bleeding Disorder	Pacemaker	Liver Disease
Blood Clots (or DVT)	Heart Attack	Osteoporosis
Cancer	Heart Murmur	Polio
Coronary Artery Disease	Hiatal Hernia or Reflux Disease	Pulmonary Embolism
Claustrophobic	HIV or AIDS	Reflux or Ulcers
Diabetes - Insulin	High Cholesterol	Stroke
Diabetes - Non-Insulin	High Blood Pressure	Tuberculosis
Dialysis	Overactive Thyroid	Other ______________________

(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY

Date of last pap smear ________ Normal Abnormal

Date of last mammogram ________ Normal Abnormal

Age of first menstrual period ________

Date of last menstrual period ________

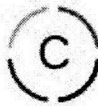
Age at menopause ________

Number of pregnancies: ________ Number of births: ________ Number of abortions: ________

Number of miscarriages: ________ Number of cesarean sections: ________

FAMILY HISTORY

Grandmother (maternal)	Alcoholism Diabetes Osteoporosis	Arthritis Genetic Disease Stroke	Depression Heart Disease Other	Cancer Hypertension
Grandfather (maternal)	Alcoholism Diabetes Osteoporosis	Arthritis Genetic Disease Stroke	Depression Heart Disease Other	Cancer Hypertension
Grandmother (paternal)	Alcoholism Diabetes Osteoporosis	Arthritis Genetic Disease Stroke	Depression Heart Disease Other	Cancer Hypertension
Grandfather (paternal)	Alcoholism Diabetes Osteoporosis	Arthritis Genetic Disease Stroke	Depression Heart Disease Other	Cancer Hypertension



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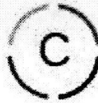
Father	Alcoholism Diabetes Osteoporosis	Arthritis Genetic Disease Stroke	Depression Heart Disease Other	Cancer Hypertension
Mother	Alcoholism Diabetes Osteoporosis	Arthritis Genetic Disease Stroke	Depression Heart Disease Other	Cancer Hypertension
Brother	Alcoholism Diabetes Osteoporosis	Arthritis Genetic Disease Stroke	Depression Heart Disease Other	Cancer Hypertension
Sister	Alcoholism Diabetes Osteoporosis	Arthritis Genetic Disease Stroke	Depression Heart Disease Other	Cancer Hypertension
Other	Alcoholism Diabetes Osteoporosis	Arthritis Genetic Disease Stroke	Depression Heart Disease Other	Cancer Hypertension

SOCIAL HISTORY

Education	Less than 8th grade High school graduate 2 year college 4 year college Post graduate	**Marital Status**	Married Single Divorced Separated Widowed Domestic Partner	
Exercise Level	None Occasional Moderate Heavy	**Caffeine**	None Occasional Moderate Heavy	Cups/cans daily? ____________
Drugs	Do you use illicit drugs?		Yes No	If yes please list:
Alcohol	Do you drink alcohol?	Yes No	If so how often? Occasionally Less than 3 times a week More than 3 times a week	
Tobacco	Do you use tobacco?	Yes No	If not currently, did you ever use? Cigarettes- _________ packs per day Chew- _________ packs per day Cigars-__________ each per day Number of years used: __________ Year quit: __________	



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PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL

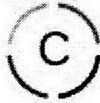
REVIEW OF SYSTEMS

Constitutional:	Eyes:	Ears and Nose:	Mouth and Throat:
☐ Fever ☐ Night sweats ☐ Weight gain ☐ Weight loss ☐ Exercise intolerance	☐ Dry eyes ☐ Vision change ☐ Irritation	☐ Difficulty hearing ☐ Ear pain ☐ Frequent nosebleeds ☐ Nose problems ☐ Sinus problems	☐ Sore throat ☐ Bleeding gums ☐ Snoring ☐ Dry mouth ☐ Mouth ulcer ☐ Oral abnormalities ☐ Teeth problems
Cardiovascular:	**Respiratory:**	**Gastrointestinal:**	**Genitourinary:**
☐ Chest pain ☐ Arm pain on exertion ☐ Shortness of breath when walking ☐ Shortness of breath when lying down ☐ Palpitations ☐ Known heart murmur	☐ Cough ☐ Wheezing ☐ Shortness of breath ☐ Coughing up blood ☐ Sleep apnea	☐ Abdominal pain ☐ Vomiting ☐ Change in appetite ☐ Diarrhea ☐ Vomiting blood ☐ Indigestion ☐ GERD	☐ Incontinence ☐ Difficulty urinating ☐ Blood in urine ☐ Increased frequency
Musculoskeletal:	**Integumentary:**	**Neurologic:**	**Psychiatric:**
☐ Muscle aches ☐ Muscle weakness ☐ Joint pain ☐ Back pain ☐ Swelling in extremities	☐ Abnormal mole ☐ Jaundice ☐ Rash ☐ Laceration	☐ Loss of consciousness ☐ Weakness ☐ Numbness ☐ Seizures ☐ Dizziness ☐ Migraines ☐ Headaches ☐ Tremors	☐ Depression ☐ Sleep disturbances ☐ Unsafe relationship ☐ Alcohol abuse ☐ Anxiety ☐ Hallucinations ☐ Suicidal thoughts
Endocrine:	**Hematologic/Lymphatic:**	**Allergic/Immunologic:**	**Other/not listed:**
☐ Fatigue	☐ Swollen glands ☐ Bruising ☐ Excessive bleeding	☐ Runny nose ☐ Sinus pressure ☐ Itching ☐ Hives ☐ Frequent Sneezing	

Please add any additional health information here:

____

____



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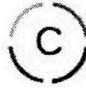
Patient, Parent, Guardian, or Signature **Date**



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PATIENT CONSENT

1. CONSENT TO MEDICAL CARE AND TREATMENT

I am being treated at Cerium Medical Group and I consent to all medical and surgical care, examinations and tests determined by my Physician that are necessary for me. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. I also understand that if I do not follow my Physician's recommendations as they may relate to my health that the Physician and this Office will not be responsible for any injuries or damages that are the result of my non-compliance. I understand that if an employee or any individual associated with Physician Office is exposed to my blood or body fluids, I will be tested for the hepatitis viruses and the Human Immunodeficiency Virus (HIV). I also understand that I will receive education related to this testing and that I will not be charged for testing and education related to the exposure.

2. CONSENT TO USE OF INFORMATION

Electronic Health Records. I understand that Cerium Medical Group may collaborate with other health care providers to coordinate, manage and provide health care to me and I consent to Cerium Medical Group's sharing my health information and records electronically for the purposes of treatment, payment or operations, including improving the overall quality of health care services provided to me (e.g., avoiding unnecessary or duplicate testing, etc.). I consent to the inclusion in the electronic health records of sensitive diagnoses and related information such as HIV/AIDS status, sexually transmitted diseases, genetic information, and mental health and substance abuse, etc. The electronic health records (EHR) will be accessible by Trinity Health credentialed physicians/practitioners as well as other individuals approved to access the EHR for purposes related to treatment, payment, health care operations and/or other purposes permitted by federal and state laws, including the Health Insurance Portability and Accountability Act ("HIPAA"). Cerium Medical Group has implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality and integrity of my medical information as required by HIPAA.

Use and Disclosure of Information. In addition to the above consent to use and share my health information with the Aprima EHR system, I agree that the Cerium Medical Group may use and disclose my health information for a range of purposes including: treatment, eligibility verification, and/or payment to private and public payers or their agents including insurance companies, managed care organizations, my employer (if I am injured at work), state and federal government programs, Workers' Compensation programs, obtaining pre-admission or continued length of stay certification, quality of care assessment and improvement activities, evaluating the performance of qualifications of physicians and health care workers, conducting medical and nursing training and education programs, conducting or arranging for medical review, audit services, ensuring compliance with legal, regulatory and accreditation requirements and public health and health oversight services.

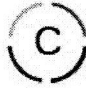
Request for Information from Others. I consent to Cerium Medical Group's request of my health information from other providers of care to me, receipt of and release of my health information, whether written, verbal, or electronic, for the uses described above as well as Cerium Medical Group's participation in any health information exchange.

3. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received or been offered a copy of Physician Office's Notice of Privacy Practices which provides information on how the
Cerium Medical Group may use or disclose PHI for purposes of treatment, payment, or health care operations.
Please Initial ________

4. ASSIGNMENT OF BENEFITS

I hereby assign to and authorize payment of all insurance and health care benefits available to me directly to the Physician Office for services provided to me. I understand that benefits may be payable to me directly if I do not provide this authorization.



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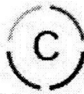
5. **FINANCIAL RESPONSIBILITY**

I understand and agree that I am financially responsible for payment of all charges incurred which are not paid by insurance or health care benefits, including any and all products provided or services rendered to me which are not eligible for payment (non-covered) under health care plans, Medicare, Medicaid or other insurance or payers (e.g., services rendered by health care providers who do not participate with my insurance plan). Non-covered services also may include those services my physician determines to be medically necessary, but are later determined unnecessary by the payer.

6. PERSONAL VALUABLES. I understand that the Physician Office does not accept responsibility for any lost, stolen or damaged personal items while I am at Cerium Medical Group.

Patient Signature: ____ Patient Date of Birth: _________________



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Authorization to Release Lab Information

This release grants permission for Cerium Medical Group to leave my lab results by:

(Check all that apply)

- ☐ Home/Telephone/Answering Machine Phone #:______________________
- ☐ Cell Phone/Leave Message on Cell Phone Phone #: ______________________
- ☐ Email ____
- ☐ Mail Message

____

Patient Name – Print

____ _______________

Patient's Signature Date

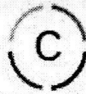
I authorize the following persons to receive my lab results and discuss the results with CMG personnel

1. Designated Party:_____________________________ Telephone:____________________

   Relationship: _________________________________

2. Designated Party:_____________________________ Telephone:____________________

   Relationship: _________________________________



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HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted on our website.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

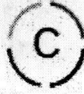
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.



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8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, ______________________________________ acknowledge I have read and understand the terms set forth in the HIPAA INFORMATION FORM and that this consent shall remain in force from this time forward.