



Dear Patient,

Welcome to our practice and thank you for choosing the Highland Medical, P.C., providers for your health care needs.

In order to expedite the registration process, please complete the new patient forms and bring with you to your first appointment. This will ensure that you are seen quickly and help us finalize the registration process efficiently and thoroughly. Also, please remember to bring the following items with you to your appointment:

- Your insurance card(s)
- Photo ID such as driver's license or passport
- Co-payment or deductible that your insurance requires (cash, check, or credit cards are accepted)
- List of all current medications, including dosage and frequency, and allergies
- Referrals that might be required prior to services rendered

We look forward to meeting and providing you with the quality healthcare services you deserve.

Sincerely,

The Staff at Highland Medical, P.C.

PATIENT INFORMATION:

last name	first name	middle initial	
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marital status	gender	
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street address	city/state/zip		
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home phone	cell	work	
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email address

date of birth	race	ethnicity	preferred language
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occupation	employer		
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INSURANCE INFORMATION:

cardholder's name	relationship		
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cardholder's date of birth

card holder's name	relationship		
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street address	city/state/zip		
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primary insurance	policy/ID number		
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secondary insurance	policy/ID number		
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Is this a work-related injury or illness? (please circle) YES NO

PATIENT NAME: _____ DOB: _____

REFERRING PHYSICIAN INFORMATION (if any):

referring physician

telephone

fax

referring physician street address

city/state/zip

PRIMARY CARE PHYSICIAN INFORMATION (if any):

primary care physician

telephone

fax

primary care physician street address

city/state/zip

OB/GYN PHYSICIAN INFORMATION (if any):

OB/GYN physician

telephone

fax

OB/GYN physician street address

city/state/zip

PHARMACY INFORMATION:

name

location

telephone

ASSIGNMENT OF BENEFITS:

I hereby authorize direct payment of medical benefits to Highland Medical, P.C., for services rendered. I understand that I am financially responsible for any charges not covered by my insurance carrier(s). This may include deductibles, co-payments, co-insurance, and denied (non-covered) services.

I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf. A photocopy of these assignments shall be valid as an original.

signature

date

name

date of birth

RELEASE OF INFORMATION:

I authorize Highland Medical, P.C., to release any necessary medical information to process my insurance claims.

signature

date

GUARANTEE OF PAYMENT:

In consideration of services rendered by Highland Medical, P.C., I, the undersigned, agree to pay Highland Medical, P.C., any co-payment, co-insurance or deductible mandated by my health insurance plan. In addition, I agree to pay for all services that are not covered by my health insurance plan provided that I am informed of same prior to rendering of said services.

signature

date

PATIENT COMMUNICATIONS:

In accordance with state and federal regulations, Highland Medical, P.C., wants to assure you that your personal medical information will be held in confidence and with the utmost respect. Please assist us in maintaining that confidence by completing this form. Please provide below the phone number(s) which we should use to contact you.

home phone

cell

work



PATIENT NAME: _____ DOB: _____

LEAVING A CONFIDENTIAL MESSAGE:

Please indicate at which number, if any, you authorize us to leave a confidential Voice message if we are unable to speak to you:

Phone Number for Confidential Message: _____

Initial Here: _____

USE OF EMAIL:

Please indicate whether we can send information to you by email: YES NO

email address

EMERGENCY CONTACT:

Is there any person that you want us to contact in the event of an emergency or if we are unable to reach you?

name relationship phone number

name relationship phone number

I understand that Highland Medical, P.C., will adhere to the regulations outlined by HIPAA and will follow the guidelines I have outlined above.

signature date



PATIENT NAME: _____ DOB: _____

Over the past few years, the number of different health insurance programs has increased at a significant rate. Even within one insurance company, there may be several programs with varying benefits and requirements. There is no way we can possibly know, or keep up to date with each insurance company's policies, programs, and provisions.

Some programs require a specific facility be used for your radiology and laboratory tests.

Some programs require pre-authorizations and notification of hospital and ER visits.

It is your responsibility to know:

1. Whether this office is participating with your insurance company and if they will cover physicals, immunizations, surgeries, etc.
2. To advise this office of your insurance requirements in advance, each and every time we provide a service. We will do our very best to comply with any responsible requirements your insurance company may have.

Please understand that if we have not been advised in advance of your insurance requirements or conditions and we provide a service or use a laboratory that is outside your insurance, you will be responsible for the appropriate fees. In addition, there may be times where we may not be able to obtain a consultant or laboratory that participates with your insurance. It is up to you to work this out with your insurance company.

Unless you carefully follow your insurance company's regulations, they may decline all or part of your claim. Your insurance carrier should have provided you with a phone number to use if you have any questions about your coverage.

I acknowledge receipt of this information.

patient signature

date

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE:

I have received a copy of the Highland Medical, P.C., Notice of Privacy Practices written in plain language. The notice provides in detail the use and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my health information.

I understand that Highland Medical, P.C., reserves the right to change terms of its Notice of Privacy Practices and make changes regarding all protected health information resident at, or controlled by, this practice. If changes occur, this practice will provide me with a revised Notice of Privacy Practices upon request. Furthermore, I understand that without my signed consent, medical information will not be released to any unauthorized individuals.

patient name	date of birth
patient signature	date
signature of parent of guardian (if minor)	date



Name: _____ Date: _____ Date of Birth: _____

Referring Physician: _____ Reason For Visit: _____

Sex: Male or Female Marital Status: M S D W

Occupation: _____

Medications and Vitamins	Dosage	How Often - By Mouth or Injection

Consent to check medication history? Yes ___ No ___

Medical Illnesses	Year of Diagnosis

Operations	Year	Hospital	Surgeon

Previous exposure to radiation? Yes ___ No ___ Age: ___

PATIENT NAME: _____ DOB: _____

Do you have, or have you ever had, any of the following? (Check all that apply.)

Diabetes	Asthma	Rectal Pain	Late Night Urination
Arthritis	Tuberculosis	Change in Bowel Habits	Urinary Frequency
Phlebitis/Blood Clots	Emphysema (COPD)	Blood/Mucus in Stool	Kidney Stones
High Blood Pressure	Chronic Cough	Black Tarry Stools	Abnormal Vaginal Bleeding
Heart Attack	Nausea/Vomiting	Weight Loss	Normal PAP in Last 2 Years
Chest Pain (Angina)	Diarrhea	Loss of Appetite	High Cholesterol
Shortness of Breath	Constipation	Jaundice	Depression
Stroke	Rectal Bleeding	Heartburn	Thyroid Problems

Have you ever had a colonoscopy? Yes ___ No ___ If so, when: _____

Drug Allergies

Reaction

Smoking

Alcohol Use

Current, Former, Never:	Yes No
Duration:	Duration:
Amount Per Day:	Amount Per Day:

Recreational Drug Exposure

Current, Former, Never:
Duration:
Type:



PATIENT NAME: _____ DOB: _____

FAMILY HISTORY OF CANCER:

II. Have any family members including children, siblings, parents, grandparents, aunts, uncles, cousins, had any of the following conditions? (If yes, please specify individuals and condition.)

1. Breast Cancer _____
2. Ovarian Cancer _____
3. Uterine Cancer _____
4. Male Breast Cancer _____
5. Stomach Cancer _____
6. Colon Cancer or Rectal Cancer _____
7. Liver and Biliary Cancer _____
8. Pancreatic Cancer _____
9. Prostate Cancer _____
10. Thyroid/Parathyroid Cancer _____
11. Kidney Cancer _____
12. Adrenal Gland Tumor _____
13. Leukemia/Other Blood Cancer _____
14. Bone Tumors or Cancer _____
15. Soft Tissue or Sarcoma (Muscle Cancer) _____
16. Brain/Pituitary Tumor _____
17. Melanoma/Lipoma/Other Skin Cancer _____
18. Face/Eye/Lip/Tongue/Oral Cancer _____



PATIENT NAME: _____ DOB: _____

FOR FEMALE PATIENTS ONLY:

Age of first menstrual period? _____ When was your last period (if applicable)? _____

Could you be pregnant? _____ At what age did you enter/complete menopause? _____

Any post-menopausal bleeding? _____ If yes, age of onset: _____

Are you currently or have you ever used oral contraceptives (birth control pills)? _____

Are you currently or have you ever used post-menopausal hormone replacement? _____

Have you had any pregnancies? _____ If yes, number of pregnancies: _____

Number of live births? _____ Age at the time of your first live birth: _____

Did you breastfeed, and if so, how many children and for how long? _____

Do you examine your breasts? _____ Date of last physician breast examination: _____

Date of last mammogram and where: _____ Age at first mammogram: _____

Have you had breast biopsies (specify which breasts and why)? _____

Date of breast biopsy and where: _____

Date of last PAP test: _____

Have you had a hysterectomy? Yes ___ No ___ Reason: _____

Have you had surgical removal of your uterus, ovaries or Fallopian tubes? Yes ___ No ___

Reason: _____



Dear Patient,

According to HIPAA Federal Regulations, each patient must be assured that his/her medical records are held in the strictest confidence. In order for Highland Medical, P.C., to comply with regulations, we ask that you take a moment to complete the following questionnaire.

Your signature is required where requested.

With what individuals may we discuss medical history, test, or lab results?

_____ name relationship to patient

_____ name relationship to patient

_____ name relationship to patient

Where may we contact you?: (please circle)

Home Phone: YES NO Phone Number: _____

Cell Phone: YES NO Phone Number: _____

Work Phone: YES NO Phone Number: _____

Email: YES NO Email Address: _____

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patient name date of birth

patient signature date

signature of parent/guardian (if minor) date

TO: _____

I hereby authorize and request that my medical records be released to Highland Medical, P.C., at the following practices:

practice name_____
practice name_____
address_____
address_____
city/state/zip_____
city/state/zip_____
phone number_____
phone number_____
practice name_____
practice name_____
address_____
address_____
city/state/zip_____
city/state/zip_____
phone number_____
phone number

Please send the medical records in your possession for the time period _____ concerning my treatment and/or illness.

*This authorization may include disclosures of information relating to alcohol and drug abuse, mental health treatment, and confidential HIV-related information ONLY if I initial below:

_____ Alcohol/Drug Treatment _____ Mental Health information _____ HIV-related information

patient name_____
address_____
city/state/zip_____
patient signature_____
date_____
witness_____
date