PRIVIA MEDICAL GROUP NORTH TEXAS

PHYSICIAN: _____ BEING SEEN TODAY

LOCATION: _____ DATE: _____

PATIENT REGISTRATION INFORMATION

If Patient cannot be billed for these services (for example, minor children), please complete RESPONSIBLE PARTY SECTION below as well as this patient registration information section.

Social Security #: _____ Driver's License # _____ State: _____

Name: _____ ___ ___ ___/___/___ ___ S M D W O
LAST FIRST MI SEX DATE OF BIRTH (MM DD YY) AGE MARITAL STATUS

Address: _____ _____ ___ _____ (____) _____
MAILING ADDRESS APARTMENT CITY ST ZIP HOME PHONE

Alt/Cell Phone: (____)_____ Day Phone: (____)_____ Email: _____

Race_____ Language_____ Ethnicity ❒ Hispanic/Latin ❒ Non Hispanic/Latin

Full-Time Part-Time Retired Unemployed Student Employer's Name: _____
EMPLOYMENT STATUS (PLEASE CIRCLE ONE) or School

Employer's Address: _____ _____ _____ _____
MAILING ADDRESS CITY ST ZIP

Occupation: _____

Emergency Contact: *(Please indicate a friend or relative not living at the same address.)*

_____ _____ (____) _____
NAME RELATIONSHIP EMERGENCY CONTACT #

RESPONSIBLE PARTY AND BILLING INFORMATION

Patient is responsible unless a minor child or guardian. RESPONSIBLE PARTY SECTION must be completed.

Patient Relationship to Responsible Party: Child ____ Other _____ Resp. Party SS #: _____
SPECIFY

Name: _____ ___ ___ ___/___/___ ___ S M D W O
LAST FIRST MI SEX DATE OF BIRTH (MM DD YY) AGE MARITAL STATUS

Address: _____ _____ ___ _____ (____) _____
MAILING ADDRESS APARTMENT CITY ST ZIP HOME PHONE

Full-Time Part-Time Retired Unemployed Student Employer's Name: _____
EMPLOYMENT STATUS (PLEASE CIRCLE ONE) or School

Employer's Address: _____ _____ _____ _____
MAILING ADDRESS CITY ST ZIP

Occupation: _____ (____) _____ (____)
WORK PHONE EXT

OTHER PATIENT INFORMATION

Spouse's Name: _____ Employer: _____

___/___/___ Spouse's Work Phone: (____) _____ (_____) Occupation: _____
DATE OF BIRTH EXT

PRIMARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

Insurance Company: _____ Address: _____ (____) _____
STREET or P.O. BOX PHONE

Co-Pay Amount: (if applicable) _____ _____ _____ _____
CITY ST ZIP

Primary Care Physician: _____

Policy Holder: _____ ___ ___ ___/___/___ _____
LAST FIRST MI SEX DATE OF BIRTH SS #

Patient Relationship to Insured Party: Self___ Spouse___ Child___ Other_____
(SPECIFY)

Employer's Name: _____ _____ _____
INSUREDS ID GROUP NAME AND/OR NUMBER

Address: _____ _____ _____ _____
STREET CITY ST ZIP

SECONDARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

Insurance Company: _____ Address: _____ (____) _____
STREET or P.O. BOX PHONE

Co-Pay Amount: (if applicable) _____ _____ _____ _____
CITY ST ZIP

Primary Care Physician: _____

Policy Holder: _____ ___ ____ ____/____/____ _____
LAST FIRST MI SEX DATE OF BIRTH SS #

Patient Relationship to Insured Party: Self___ Spouse___ Child___ Other_____
(SPECIFY)

Employer's Name: _____ _____ _____
INSUREDS ID GROUP NAME AND/OR NUMBER

Employer's Address: _____ _____ _____ _____
STREET CITY ST ZIP

WORKER'S COMPENSATION

Worker's Compensation Insurance Name: _____ Adj. _____

Address: _____ City: _____ State _____ Zip _____ Phone _____

Claim #: _____ DOI _____

What Employer: _____

ACCIDENT INFORMATION

Was this the result of an accident? ___Yes ___No Where did it occur? ___At Work ___Auto Accident ___Other

Date of Accident_____Have you reported this injury to your employer? ___Yes ___No When _____

Describe accident briefly: _____

Do you have an attorney representing you? ___Yes ___No Who is the attorney? _____

REFERRAL INFORMATION

Who referred you? _____ Address: _____ Phone: _____

Family Physician _____ Address: _____ Phone: _____

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/NOTICE OF PRIVACY PRACTICES/APPOINTMENT OF AUTHORIZED REPRESENTATIVE

PLEASE READ

Privia Medical Group North Texas (PMG), and its physicians are committed to securing the privacy of your health information. Accordingly, we have posted our "Notice of Privacy Practices" in the reception area. You are not required to read this notice. However, we would like your acknowledgement that you have been advised that PMG has such a Notice of Privacy Practices.

I hereby assign, transfer and set over to PMG, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits, including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that this order does not relieve me of my obligation to pay such bills if not paid/covered/found medically necessary by my commercial/third party/government plan or insurance company. I am also financially responsible for any balances due after payments by my insurance company.

I appoint PMG to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

All charges are due at the time of service. If surgery is indicated, I am responsible for furnishing insurance claim forms to the office prior to surgery.

_____ _____ _____ _____
PATIENT SIGNATURE DATE WITNESS SIGNATURE DATE

Patient Name: _____ DOB: ____/____/____

PHARMACY INFORMATION

Preferred Pharmacy: _____ Phone: _____

Address: _____

Do you use a mail order pharmacy? If yes, please indicate: _____

MEDICATION LIST

Medication Name	Dosage	Frequency

MEDICATION AND FOOD ALLERGIES

Food or Medication	Reaction(s)	Severity

PREVENTATIVE TESTING

Test	Date	Abnormal? Write Y or N
None		
Cardiac Stress Test		
Colonoscopy		
Cologuard		
DEXA Scan/Bone Density Test		
Echocardiogram		
Annual Physical Exam		
Pulmonary Function Test		
Mammogram		
PAP Smear		
Eye Exam		
EKG		
Bloodwork		

Have you had your FLU shot? Y / N If so, when _____/_____/_____, **where?** _____

Patient Name: _____ DOB: ____/____/____

MEDICAL HISTORY

CONDITION	YEAR	CONDITION	YEAR
None		Liver Disease	
Allergies		Migraine Headaches	
Anemia		Myocardial Infarction (Heart Attack)	
Angina		Obesity	
Anxiety		Osteoarthritis	
Arthritis		Osteoporosis	
Asthma		Peptic Ulcer Disease	
Atrial Fibrillation		Pneumonia/TB	
Benign Prostatic Hypertrophy		Renal (Kidney) Disease	
Cancer- Type		Seizure Disorder	
Stroke/ TA		Stomach Ulcer	
Coronary Artery Disease/ CHF		Thyroid Disease	
COPD		Other:	
Crohn's Disease			
Dementia/Alzheimer's			
Depression			
Diabetes: Type 1 or Type 2			
Gallbladder Disease			
GERD (Reflux)			
Glaucoma/Cataracts			
Hepatitis C			
Hyperlipidemia (High Cholesterol)			
Hypertension (High Blood Pressure)			
Insomnia			
Irritable Bowel Disease			

SURGICAL HISTORY

Have you had any surgeries? Y / N If yes, please list surgery name and date of surgery below

Surgical Procedure	Date

PATIENT'S 65 YEARS OF AGE AND OLDER

Have you had your Pneumonia shot? Y / N If so, when ____/____/____, where? _____

Have you had your Zostavax shot? Y / N If so, when ____/____/____, where? _____

Have you fallen in the last 12 months? Y / N If so, when ____/____/____ How many times? _____

As a result, from the fall, were you hurt? Y / N If yes, what was your injury? _____

Do you have any Advance Directive? Y / N Power of Attorney ☐ DNR ☐ Living Will ☐

Other: _____

Patient Name: _____ DOB: ____/____/____

FAMILY HISTORY

Diagnosis	Mother	Father	Brother	Sister	Other
Alive and Well					
Deceased- Age					
No pertinent info known					
Alcoholism					
Alzheimer's Disease					
Asthma					
Blood Disease					
CAD (Heart Attack)					
Cancer- Type:					
CVA (Stroke)					
Depression					
Developmental Delay					
Diabetes					
Hearing Deficiency					
Hyperlipidemia (High Cholesterol)					
Hypertension (High Blood Pressure)					
Irritable Bowel Syndrome					
Learning Disability					
Mental Illness					
Tuberculosis					
Obesity					
Osteoarthritis					
Osteoporosis					
PVD (Peripheral Vascular Disease)					
Renal Disease					
Other					

SOCIAL HISTORY (Circle that which applies)

Tobacco Use Have you ever used tobacco? NO/NEVER YES PAST CURRENTLY

Cigarettes ☐ _____ Packs per day Cigar ☐ Pipe ☐ Chewing Tobacco ☐

Alcohol Use Do you drink alcohol? NO/NEVER YES PAST CURRENTLY

Type of Alcohol: _____ How often: _____ Amount: _____ Last Drink: _____

Caffeine Use- Do you drink caffeine? NO/NEVER YES PAST CURRENTLY

Type of Caffeine: Soda Coffee Energy Drinks Caffeine per day: _____

Exercise Activity- Do you exercise on a regular basis? NO/NEVER YES PAST CURRENTLY