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
- Copayment 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

marital status | gender

street address | city/state/zip

home phone | cell | work

email address

date of birth | race | ethnicity | preferred language

occupation | employer

EMERGENCY CONTACT:

name | relationship

phone number | additional phone number

street address | city/state/zip

INSURANCE INFORMATION:

cardholder's name | relationship

cardholder's date of birth

card holder's name | relationship

street address | city/state/zip

primary insurance | policy/ID number

secondary insurance | policy/ID number

Is this a work-related injury or illness? (please circle) YES NO

REFERRING PHYSICIAN INFORMATION (if any):

referring physician

telephone | fax

referring physician street address | city/state/zip

ASSIGNMENT OF BENEFITS:

I hereby authorize direct payment of medical benefits to Highland Medical, PC 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

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

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

HEALTH HISTORY:

I. Have you had any prior hospitalizations, surgeries, cancer or chronic health problems including Diabetes? If yes, please explain. _____

_____

_____

At what age was your first menstrual period? _____

At what age did you enter/complete menopause? _____

Are you currently or have you ever used oral contraceptives? _____

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

Previous exposure to radiation? _____ Do you/have you smoked cigarettes? _____

Recreational Drug Exposure? _____ Do you consume alcoholic beverages? (Daily/Weekly/Rarely) _____

When was your last mammogram? _____

How old were you when you started having mammograms? _____

Did you have any breast biopsies, specify which breast and when?

Did you have colonscopy? _____ When? _____

Did you have any thyroid problems? _____

Did you have Hysterectomy? _____

Did you have surgical removal of your ovaries and Fallopian tubes? _____

Have you had any previous pregnancies? Please describe the outcome and number of children, as well as your age at your first pregnancy? Did you breastfeed? For how long?

_____

_____

_____

FAMILY HISTORY:

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. Thryroid/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 _____

Name:_____ Date: _____ Date of Birth:_____

Referring Physician: _____ Reason For Visit: _____

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

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

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
	Phylebitis/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

Family history of cancer, heart disease, and diabetes.

Who	What Type

FOR FEMALE PATIENTS:

Last normal period: _____ Any post menopausal bleeding?: _____

Do you examine your breasts?_____ Last mammogram and where? _____

Last PAP test: _____ Do you take birth control pills?_____ Could you be pregnant? _____

Drug Allergies	Reaction

Smoking	Alcohol Use
Current, Former, Never:	Yes No
Duration:	Duration:
Amount Per Day:	Amount Per Day:

FOR OFFICE USE ONLY:

Height: _____

Weight: _____

Blood Pressure: _____

Highland Medical, P.C.
BREAST SURGERY

MEDICATION LIST

name _____ date of birth _____

pharmacy _____ pharmacy phone number _____

Please include all prescriptions, as well as all over the counter (OTC) medications, and vitamins/supplements taken on a regular basis.

Medication Name	Dose	Frequency

I do not take any medications consistently. (check here) _____

Highland Medical, P.C.

RECORDS RELEASE AUTHORIZATION

TO: _____

_____

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

_____
practice name

_____
address

_____
city/state/zip

_____
phone number

_____
practice name

_____
address

_____
city/state/zip

_____
phone number

_____
practice name

_____
address

_____
city/state/zip

_____
phone number

_____
practice name

_____
address

_____
city/state/zip

_____
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