PATIENT REGISTRATION FORM

GRAND BLANC SURGICAL SPECIALIST

You must bring your driver's license and insurance card to your appointment. This has been implemented in order to reduce medical identity theft.

PATIENT INFORMATION			
Last Name: First: Middle:			Sex: ☐ Male ☐ Female
DOB: _____/_____/_____	SSN:	Marital Status: ☐ M ☐ S ☐ D ☐ W	Language:
Race:		Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic Latino ☐ Refuse to Report	
Address:		City/St:	Zip:
Home Phone:	Cell Phone:	Work Phone:	
What is your preferred method of communication? ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Other:_____			
May we leave messages about your care or treatment appointments using: ☐ Home Phone ☐ Cell Phone ☐ Work Phone			
Email Address:		Use the email provided to register for your patient portal? ☐ Yes ☐ No	
Occupation:		Employer:	Phone:
Employer Address:		City/St:	Zip:

PRIMARY CARE PHYSICIAN INFORMATION	
Primary Care Physician:	City:
I authorize the release of any medical information necessary to my referring doctor.	Patient Initials:

SPOUSE/GUARDIAN INFORMATION			
Last Name: First: Middle:			Relation:
DOB: _____/_____/_____	SSN:	Home Phone:	Cell Phone:
Address:		City/St:	Zip:
Home Phone:	Cell Phone:	Work Phone:	

EMERGENCY CONTACT (NOT LIVING AT THE SAME ADDRESS)		
Name:		Relation:
Home Phone:	Cell Phone:	Work Phone:

INSURANCE INFORMATION		
Primary Insurance Name:	Policy Number:	Group Number:
Subscriber Name:	Subscriber DOB: _____/_____/_____	
Relationship to Subscriber:	Employer Name:	
Secondary Insurance Name:	Policy Number:	Group Number:
Subscriber Name:	Subscriber DOB: _____/_____/_____	
Relationship to Subscriber:	Employer Name:	

PHARMACY INFORMATION		
Pharmacy Name:	Address:	Phone:

CHIEF COMPLAINT

What are you being seen for today? How long have you had this issue?

Was this the result of a work injury or auto accident? ☐ Yes ☐ No	If yes, which: ☐ Worker's Comp. ☐ Auto ☐ Other

If you answered yes, please complete the Worker's Compensation or Auto Accident Patient Form.

CURRENT MEDICATIONS

List any medication and vitamins/minerals/herbs that you are currently taking. ☐ Not currently taking any medications

NAME	DOSE	FREQUENCY	REASON FOR TAKING?

MEDICAL HISTORY

Please check all that apply

☐ Abnormal Bleeding	☐ Acid Reflux	☐ Anemia	☐ Alcoholism	☐ Anxiety
☐ Arthritis	☐ Asthma	☐ Back Trouble/Pain	☐ Balance Problems	☐ Bladder Infections
☐ Blood Clots	☐ Blood Transfusions	☐ Bronchitis/Emphysema	☐ Broken Bones	☐ Bursitis
☐ Cancer	☐ Cramps or Numbness	☐ Diabetes	☐ Epilepsy	☐ Eye Problems
☐ Fibromyalgia	☐ Gout	☐ Heart Attack	☐ Heart Disease/Failure	☐ Hepatitis A, B or C
☐ HIV+/AIDS	☐ High Blood Pressure	☐ Irregular Heartbeats	☐ Kidney Disease	☐ Liver Disease
☐ Low Blood Pressure	☐ Migraines/Headaches	☐ Mitral Valve Prolapse	☐ Neuropathy	☐ Open Sores
☐ Osteoarthritis	☐ Osteoporosis	☐ Pacemakers	☐ Parkinson's Disease	☐ Pneumonia
☐ Rheumatic Fever	☐ Rheumatoid Arthritis	☐ Skin Disorder	☐ Sickle Cell Disease	☐ Sleep Apnea
☐ Spinal Stenosis	☐ Stomach Ulcers	☐ Stroke	☐ Substance Abuse	☐ Thyroid Condition
☐ Tuberculosis				

ALLERGIES

Type:	Allergy to:	Reaction:
☐ **Drug** ☐ **Food** ☐ **Environmental**		
☐ **Drug** ☐ **Food** ☐ **Environmental**		
☐ **Drug** ☐ **Food** ☐ **Environmental**		
☐ **Drug** ☐ **Food** ☐ **Environmental**		
☐ **Drug** ☐ **Food** ☐ **Environmental**		
☐ **Drug** ☐ **Food** ☐ **Environmental**		

SURGICAL HISTORY		☐ N/A: No prior surgeries	
Date (Mo/Yr.)	**Surgery:**	**Date (Mo/Yr.)**	**Surgery:**

RECENT HOSPITALIZATIONS		☐ N/A: No prior hospitalizations	
Date (Mo/Yr.)	**Reason:**	**Date (Mo/Yr.)**	**Reason:**

FAMILY HISTORY		
Are you adopted: ☐ Yes ☐ No	Number of Siblings: ____ Brothers ____ Sisters	Number of Children: ____ Sons ____ Daughters
Father living: ☐ Yes ☐ No	Current Age (or age at death):	List cause of death:
Mother living: ☐ Yes ☐ No	Current Age (or age at death):	List cause of death:

	Diabetes	High Blood Pressure	Heart Disease	Mental Illness	Cancer	Bleeding Disorders
Father	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐
Siblings	☐	☐	☐	☐	☐	☐
Son(s)	☐	☐	☐	☐	☐	☐
Daughter(s)	☐	☐	☐	☐	☐	☐
Paternal Grandfather	☐	☐	☐	☐	☐	☐
Paternal Grandmother	☐	☐	☐	☐	☐	☐
Maternal Grandfather	☐	☐	☐	☐	☐	☐
Maternal Grandmother	☐	☐	☐	☐	☐	☐

DIAGNOSTIC EXAMS	
Date of Last Colonoscopy:	

GYNECOLOGICAL REVIEW (WOMEN ONLY)			
Are you or could you be pregnant: ☐ Yes ☐ No	My periods occur every _____ days		My periods last every _____ days
First day of last period:	Age periods started:	Have you had or are you experiencing menopause: ☐ Yes ☐ No	
Abnormal vaginal bleeding: ☐ Yes ☐ No	Late period: ☐ Yes ☐ No		Irregular cycles: ☐ Yes ☐ No
Number of pregnancies:	Number of miscarriages:		
Date and result of last mammogram:			
Date and result of last cancer smear:			

SOCIAL HISTORY

Do you live alone? ☐ Yes ☐ No	Do you have children? ☐ Yes ☐ No	If so, how many children?

Education: ☐ Some High School ☐ High School Degree ☐ GED ☐ Some College ☐ Associates ☐ Certification ☐ Bachelors ☐ Masters ☐ PhD

Occupation:	How often do you exercise?

Please describe your caffeine intake: ☐ Coffee ☐ Tea ☐ Soft Drinks ☐ Energy Drinks

☐ None	☐ 1-2 cups per day	☐ 2-3 cups per day	☐ 3-4 cups per day	☐ more than 4 cups per day

Did you have a drink containing alcohol in the past year? ☐ Yes ☐ No

How often did you have a drink containing alcohol in the past year?

☐ Monthly or less ☐ 2 to 4 times a month ☐ 2 to 3 times a week ☐ 4 or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?

☐ 1 or 2 drinks ☐ 3 or 4 drinks ☐ 5 or 6 drinks ☐ 7 to 9 drinks ☐ 10 or more drink

How often did you have 6 or more drinks on one occasion in the past year?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

	Have you ever smoked:	**Do you currently smoke? If yes, for how many years?**	**Frequency:**
Cigarettes	☐ Yes ☐ No	☐ Yes ☐ No _____ years	
Cigars	☐ Yes ☐ No	☐ Yes ☐ No _____ years	
Chewing Tobacco	☐ Yes ☐ No	☐ Yes ☐ No _____ years	
Marijuana	☐ Yes ☐ No	☐ Yes ☐ No _____ years	

CURRENT SYMPTOMS

Are you currently experience any of the following?

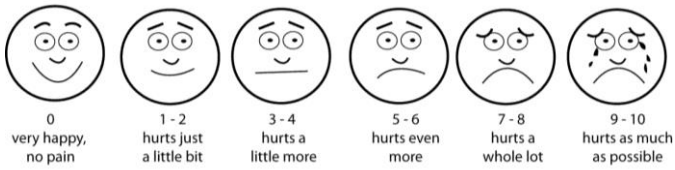
☐ Change in Appetite	☐ Change in Diet	☐ Fever or Shaking Chills	☐ Night Sweats
☐ Severe Sweating	☐ Problems in Sleep	☐ Weakness	☐ Fatigue/Excessive Tiredness
☐ Swollen Glands/Lymph Nodes	☐ Changes in Body Hair	☐ Hot Flashes	☐ More Cold Natured
☐ Hypoglycemic/Low Sugar	☐ Increased Thirst	☐ Bleeding (gums, etc.)	☐ Bruising

Are you currently experiencing any pain: ☐ **Yes** ☐ **No**

Where are you experiencing pain:

How long have you been experiencing pain:

If so, please circle your pain:



MEDICAL RELEASE INFORMATION

Name:	Relationship:	Phone Number:
Name:	Relationship:	Phone Number:
Name:	Relationship:	Phone Number:

I authorize the office of Grand Blanc Surgical Specialist to discuss my care or treatment with the above listed individual(s).	Signature:
	Date:

CONSENT FOR TREATMENT

1. **GENERAL CONSENT FOR TREATMENT**. I hereby authorize employees and agents of Grand Blanc Surgical Specialist (GBSS) including physicians, physician assistants, nurse practitioners, nursing and other staff members to render medical evaluations and care to the patient indicated below.

   I consent to the testing and disposal of specimens of my blood, urine and other bodily fluids, tissues and products. I understand that an HIV (human immunodeficiency virus) test may be done upon me without further consent if a doctor, health professional or employee sustains a percutaneous, mucous membrane or open wound exposure to my blood or other bodily fluid.

2. **ADDITIONAL CONSENT FORMS**. I understand that for certain procedures deemed necessary by my physicians(s), I will be required to sign a special consent form. Further, if I do not fully understand a procedure or its risks, consequences and alternative methods of treatment, I have the right to question the appropriate health care professionals.

3. **OTHER CONSENTS.** GBSS participates in an affiliated teaching program; residents and/or medical students may assist physicians in patient care. I understand I have the right to refuse residents or medical students' involvement in my care and will notify my care provider(s) of any such decision.

4. **E- PRESCRIBING CONSENT**. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in any ePrescribe program. These include:
   a. **Formulary and benefit transactions** – Gives the prescriber information about which drugs are covered by the drug benefit plan.
   b. **Medication history transactions** – Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

   By signing this consent form you are agreeing that this office can request and use your prescription medication history via eClinicalWorks EHR system from other healthcare providers, insurance companies and/or third party pharmacy benefit payors for treatment purposes

5. **NO GUARANTEE**. I understand that the practice of medicine is not an exact science and that the doctors or assistants have made no guarantees or promises to me as a result of treatments or examinations.

FINANCIAL AGREEMENT

6. **SELF-PAY PATIENTS**. Patients who do not have health insurance are considered self-pay and will be expected to pay for office visits on the date of service. If you are in need of surgery or a procedure, you will be expected to pay prior to the date of service.

7. **INSURANCE PATIENTS**. You must make all co-payments and outstanding balances at the time of your visit, as well as payments for any deductibles, coinsurance, or non-covered services. Our office will submit insurance claims for you as a courtesy. **You are responsible for charges that your insurance does not pay, including any deductible amount, co-insurance, or any other balance not paid by insurance.**

8. By signing below, you authorize GBSS to release to any third party payer (such as an insurance company or government agency, ex: HAP or Medicare) any medical conditions and records concerning diagnosis and treatment when requested by such third party payer for is use in connection with determining a claim for payment for such treatment or diagnosis.

9. **REFERRALS**. We ask that patients obtain any required referrals from their primary care physician prior to their scheduled appointment and bring a copy to their appointment. For those patients who are required to obtain a referral and/or a prior authorization to see us and do not obtain that authorization prior to their appointment, the balance incurred may transfer to the patient's responsibility.

10. **CANCELLATIONS / 'NO-SHOWS'** – You are expected at your scheduled appointment time because that time slot has been reserved for you to see the Doctor. Not showing up for a scheduled appointment interrupts the scheduled patient flow, does not allow the Doctor to see other patients in need, and does not allow GBSS staff to use our time effectively. Accordingly, we handle "no-shows" as follows:

    a. **APPOINTMENTS**: If you do not call us to cancel or reschedule at least 24 hours in advance of your scheduled appointment, this may be considered a "no-show". The first time there is a "no show," the patient will be sent a letter alerting them to the fact that they have failed to show up for an appointment and did not cancel the appointment. If there is a second "no show," within 1 year, a fee of **$25.00** will be billed to the patient, not the insurance company and this fee is required to be paid prior to scheduling the patients next appointment. Three "no shows," in 1 year, may result in the termination from our practice.

    b. **OFFICE PROCEDURES.** If you do not call us to cancel or reschedule at least 24 hours in advance of your scheduled procedure/surgery, this may be considered a "no-show" and a fee of **$50.00** will be billed to the patient, not the insurance company.

11. **PAYMENT METHODS ACCEPTED**. For your convenience, we accept Visa, MasterCard, American Express, Discover, money orders, cash or personal checks with proper ID.

12. **INSUFFICIENT FUNDS**. If your check is returned due to insufficient funds, you will be charged a **$30.00** fee by us in addition to whatever your bank charges you. You will receive a statement for amounts due in this case. Also, you will not be allowed to pay us by check for the next 6 months following the returned check.

13. **PATIENTS IN COLLECTIONS.** Patients with unpaid balances in collections will not be scheduled for appointments unless approved by the Billing Dept. Generally "Collections" balances must be paid in full before you can be seen here again.

Signature:	Date: Time:

PATIENT PORTAL CONSENT FORM

PURPOSE OF THIS FORM. Grand Blanc Surgical Specialist (GBSS) offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

HOW THE SECURE PATIENT PORTAL WORKS: A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Someone who knows the right password or pass-phrase to log in to the portal site can only read secure messages and information.

PROTECTING YOUR PRIVATE HEALTH INFORMATION AND RISKS: This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors:

1. The secure message must reach the correct email address, and
2. Only the correct individual (or someone authorized by that individual) must be able to have access to the message.

Only you can make sure these two factors are present. **It is imperative that our practice has your correct e-mail address and that you inform us of any changes to your e-mail address.** You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us.

You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

TYPES OF ONLINE COMMUNICATION/MESSAGING:

Online communications should never be used for emergency communications or urgent requests. If you have an emergency or an urgent request, please call our office or go to the nearest emergency room.

If there is information that you don't want transmitted via online communication, please inform our office.

PATIENT PORTAL CONSENT FORM - ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand the *Patient Portal Consent Form* and the Policies and Procedures regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, including the Policies and Procedures set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. I understand and agree with the information that I have been provided.

☐ No, I do not want to participate ☐ Yes, I wish to participate	Patient Signature:	Date:

ACKNOWLEDGMENT OF PRIVACY PRACTICES NOTICE

I understand that:

- In general, any information that is about your health and the care you receive or payment for that care is considered confidential and protected by our practice consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) with regard to Protected Health Information (PHI).
- GBSS needs to use your protected health information to carry out treatment, payment, health care operations, and/or other purposes. My signature below authorizes the release of pertinent medical records and information – on paper, in electronic form, or verbally.
- GBSS Notice of Privacy Practices provides a more complete description of permitted uses and disclosures. *A copy of GBSS Notice of Privacy Practices has been made available to me.*

PATIENT SIGNATURE:	**DATE:**