Patient Registration Information

Please PRINT AND complete ALL sections below!

PATIENT'S PERSONAL INFORMATION

Name: _____ _____ _____
last name first name initial

Gender: Male __ Female __ Social Security #_____Marital Status_____ _Date of Birth_____

Race: Declined__ American Indian or Alaska Native___ Asian___ Black or African American___ Native Hawaiian or other Pacific Islander___ White___ Other Race___

Ethnic Group: Declined___ Hispanic or Latino___ Not Hispanic or Latino___

Address: _____

Line 2 _____

Zip_____ **City**_____**State**_____**Country**_____

Phone: **Home**_____**Cell**_____**Work** _____**Ext**_____

E-Mail_____

Preferred Method of Contact : Phone___ Text Message___ Mail___ E-Mail___ Secure E-Mail___(not yet available) Patient Portal ___(not yet available)

Preferred Reminder Method: Phone- Cell___ Home___ Work___ Mail___ E-Mail___

PATIENT 'S EMPLOYER

Name: _____ Occupation: _____

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

PATIENT 'S / RESPONSIBLE PARTY INFORMATION

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Name: _____ _____ _____
last name first name initial

Date of Birth: _____ / _____ / _____ Social Security #: _____ - _____ - _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Address: _____ Apt. #: _____ City: _____ State: ____ Zip: _____

PATIENT'S INSURANCE INFORMATION

Please present insurance cards to receptionist.

PRIMARY Insurance Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Name of insured: _____ Date of Birth: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: _____ Group #: _____ Copay: $ _____

SECONDARY Insurance Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Name of insured: _____ Date of Birth: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: _____ Group #: _____ Copay: $ _____

PATIENT'S REFERRAL INFORMATION

Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: (_____) _____ Fax: (_____) _____

PHARMACY INFORMATION PLEASE NOTE WE SEND MOST PRESCRIPTIONS ELECTRONICALLY

Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: (_____) _____ Fax: (_____) _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Assignment of Benefits • Financial Agreement

I herby give authorization for payment of insurance benefits to be made directly to Sislen & Associates, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.
I further agree that a photocopy of this agreement shall be as valid as the original.

Date: _____ Your Signature: _____

GENERAL INTERNAL MEDICINE — MEDICAL HISTORY FORM

Name | Date of Birth | Date:

MEDICAL REVIEW — Check off any symptoms or illness you have or have had in the past

- ☐ Decreased Hearing
- ☐ Ringing in ears
- ☐ Frequent ear infections
- ☐ Ear perforation
- ☐ Double/blurred vision
- ☐ Eye pain
- ☐ Glaucoma
- ☐ Eye infections
- ☐ Nose bleeds-recurrent
- ☐ Sinus trouble
- ☐ Hay fever
- ☐ Tonsilitis-recurrent
- ☐ Hoarseness
- ☐ Pneumonia
- ☐ Pleurisy
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic cough
- ☐ Coughing up blood
- ☐ Tuberculosis
- ☐ Shortness of breath
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Palpitations/irreguiar pulse
- ☐ Swollen ankles
- ☐ Recurrent fainting
- ☐ Chest pain
- ☐ Leg pain when walking
- ☐ Varicose veins
- ☐ Phlebitis/blood clots
- ☐ Recent loss of appetite
- ☐ Stomach ulcer
- ☐ Difficulty swallowing
- ☐ Indigestion/heartburn
- ☐ Persistant nausea/vomiting
- ☐ Recurrent Abdominal pain
- ☐ Recent changes in bowel habits
- ☐ Diarrhea
- ☐ Consitpation
- ☐ Colitis
- ☐ Diverticulosis
- ☐ Bloody or tarry stools
- ☐ Hemorrhoids
- ☐ Gallbladder trouble
- ☐ Jaundice/Hepatitis
- ☐ Hernia
- ☐ Urine infections
- ☐ Painful urination
- ☐ Protein/sugar/blood in urine
- ☐ Frequent overnight urination
- ☐ Problems with control of urination
- ☐ Decrease in force of urination
- ☐ Urethral discharge
- ☐ Venereal disease
- ☐ Sexual problems
- ☐ DES Exposure
- ☐ Ongoing fatigue
- ☐ Recent weight loss
- ☐ Anemia
- ☐ Bruise easily
- ☐ Cancer
- ☐ Thyroid disease/goiter
- ☐ Diabetes
- ☐ Convulsions/seizures
- ☐ Stroke
- ☐ Tremor/shakiness
- ☐ Muscle weakness
- ☐ Numbness/tingling
- ☐ Frequent headaches
- ☐ Arthritis/rheumatism
- ☐ Recurrent back pain
- ☐ Gout
- ☐ Skin rash
- ☐ Hives
- ☐ Psoriasis
- ☐ Trouble sleeping
- ☐ Nervousness
- ☐ Depression
- ☐ Memory loss
- ☐ Moodiness
- ☐ Mental illness
- ☐ Suicide attempt
- ☐ Radiation exposure
- ☐ Chicken Pox
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ German Measles
- ☐ Measles
- ☐ Mumps
- ☐ Mononucleosis
- ☐ Other medical problems (please elaborate on back)

FEMALES

- ☐ Breast Disease
- ☐ Severe pain with periods
- ☐ Irregular periods
- ☐ Pain/bleeding after sex

Date of last period _____
No. of pregnancies _____
No. of live births _____
Birth Control _____

MALES

- ☐ Testicular mass or pain
- ☐ Varicocoele
- ☐ Prostate problems

Approximate date of last:
Chest xray _____
EKG _____
Tuberculosis skin test _____
Pap Smear _____
Tetanus Vaccination _____

MEDICATIONS

Please list all that you are taking including non-prescription drugs

ALLERGIES

HOSPITALIZATIONS — Please list past hospitalizations

Year	Illness or Operation	Year	Illness or Operation

FAMILY HISTORY — If any blood relative has suffered any of the following — please check box and indicate which relative

- ☐ Tuberculosis _____
- ☐ Stroke _____
- ☐ Migraine _____
- ☐ Mental Illness _____
- ☐ Epilepsy _____
- ☐ Diabetes _____
- ☐ Arthritis _____
- ☐ Gout _____
- ☐ Allergy _____
- ☐ Glaucoma _____
- ☐ Kidney Disease _____
- ☐ Intestinal Cancer _____
- ☐ Lung Cancer _____
- ☐ Breast Cancer _____
- ☐ Other Cancer _____
- ☐ High Blood Pressure _____
- ☐ Heart Attack _____

SOCIAL HISTORY

With whom do you live? _____

Do you (have you) smoke(d)?	☐ Yes	☐ No	If yes, how much and for how long? _____
Do you drink alcohol?	☐ Yes	☐ No	If yes, how much and for how long? _____
Do you exercise regularly?	☐ Yes	☐ No	If yes, describe _____
Do you currently work?	☐ Yes	☐ No	List present and past occupations. _____
Have you travelled outside the U.S. lately?	☐ Yes	☐ No	If yes, where? _____

Safeguard Business Systems
FORM NO. CS 8111/1266F

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Telephone

202-296-0670

Fax

202-331-8924

FINANCIAL POLICY

We are committed to providing you with the best possible care. We are more than willing to submit Insurance claims for those companies we participate with, in order to help you receive your maximum allowable benefits in accordance with your insurance policy. For those individuals with insurance plans we do not participate with, we will provide you with the necessary documents so that you may submit your claim. The payment from your Insurance plan will be mailed directly to you. In order to achieve these goals, we need your assistance and your understanding or our payment policy.

If your Insurance plan requires a referral to see a specialist, and you are seeing one of our doctors as a specialist, you **must** present that referral to the receptionist when you check in. If you do not have a referral, you must call your Primary Care physician and have one faxed immediately or you may be forced to reschedule your appointment. Primary Care Physician visits do not require a referral.

Due to the ever-changing health insurance laws and regulations, we cannot guarantee that all provided services are covered by your insurance policy. In the event that your Insurance does not cover our services, you will be responsible for payment. Payments of these non-covered services as well as any co-payments are due at the time service is rendered. We accept cash, checks, Visa, MasterCard, American Express and Discover.

Our office is not a preferred provider with the CareFirst network. If you have the Basic plan with CareFirst, you must agree to pay in full for all services rendered. If you have Blue Choice with an Opt Out component, you must agree to pay our entire charge for all labs, x-rays and other services performed in our office for which your plan will not pay. If you have BlueCross HMO and you are seeing a physician who is not your PCP, you must agree to pay in full for all services performed in our office.

A fee of $35.00 will be charged for any returned checks.

A cancellation fee will also be charged for any appointments that are missed or cancelled without a 24-hour notice.

An additional fee will be charged for patients requesting copies of their medical records for purpose other than medical consults.

Signing below indicates that you have read and understand our Financial Policy.

_____ _____

Signature Date

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RECEIPT OF NOTICE OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have reviewed / received a copy of Sislen & Associates' Notice of Privacy Practices.

_____ _____

Signature of Patient Date