



Welcome to our office! PLEASE ASSIST US BY PROVIDING THE FOLLOWING INFORMATION:

Patient Account: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Married: \_\_ YES \_\_ No Preferred Language: \_\_\_\_\_

Email Address: \_\_\_\_\_

Military Services: \_\_ YES \_\_ NO If yes, please provide your Social Security Number: \_\_\_\_\_

Emergency Contact Information

Contact Name: \_\_\_\_\_ Cell/Home Phone: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Insurance Information

Primary Insurance Co.: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_ CO-PAY: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Subscriber's Relationship to Patient: \_\_\_\_\_

Secondary Insurance Co.: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_ CO-PAY: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Subscriber's Relationship to Patient: \_\_\_\_\_

Assignment and Release:

I hereby assign my insurance benefits to be paid directly to Centennial Medical Group. This office may bill my insurance carrier as needed. I am financially responsible for Non-Covered services. As patient or legal guardian of minor patient, I agree to pay for all services rendered. I authorize the physician to release any information necessary to process this request. All Co-Pays, Deductibles, Coinsurance are to be paid at time of services rendered.

If you are unable to receive emailed statements, please check here to request a paper statement.

(Patient/Legal Representative Signature)

Date



Print Name \_\_\_\_\_

Date \_\_\_\_\_ DOB \_\_\_\_\_

## Health History for **NEW** Patients

Please completely answer all questions so we can provide you the best medical care. Thank you!

Main reason for today's visit: \_\_\_\_\_

Other concerns: \_\_\_\_\_

Where were you getting your care before? \_\_\_\_\_

**REVIEW OF SYMPTOMS:** Please mark the box and/or circle any **persistent** symptoms you have had in the **past few months**. Check no problems if you do not have any of the symptoms listed in each section. List other concerns above.

<b>General</b>	<b>Genitourinary</b>	<b>Psychiatric</b>
<input type="checkbox"/> Unexplained weight loss/gain	<input type="checkbox"/> Leaking urine	<input type="checkbox"/> Anxiety/stress/irritability
<input type="checkbox"/> Unexplained fatigue/weakness	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Sleep problem
<input type="checkbox"/> Fall asleep during the day when sitting	<input type="checkbox"/> Nighttime urination or increased frequency	<input type="checkbox"/> Lack of concentration
<input type="checkbox"/> Fever, chills	<input type="checkbox"/> Discharge: penis or vagina	<input type="checkbox"/> No problems
<input type="checkbox"/> No problems	<input type="checkbox"/> Concern with sexual function	
<b>Eyes</b>	<input type="checkbox"/> No problems	<b>Hematologic/Lymphatic</b>
<input type="checkbox"/> Change in vision/eye pain/redness		<input type="checkbox"/> Swollen glands
<input type="checkbox"/> No problems	<b>Breast</b>	<input type="checkbox"/> Easy bruising
	<input type="checkbox"/> Breast lump/pain/nipple discharge	<input type="checkbox"/> No problems
<b>Ears/Nose/Throat</b>	<input type="checkbox"/> No problems	
<input type="checkbox"/> Nosebleeds, trouble swallowing		<b>Endocrine</b>
<input type="checkbox"/> Frequent sore throat, hoarseness	<b>Skin</b>	<input type="checkbox"/> Heat or cold intolerance
<input type="checkbox"/> Hearing loss/ringing in ears	<input type="checkbox"/> New or a change in a mole	<input type="checkbox"/> Sudden change in weight
<input type="checkbox"/> No problems	<input type="checkbox"/> Rash/itching	<input type="checkbox"/> No problems
	<input type="checkbox"/> No problems	
<b>Respiratory</b>		<b>Infectious Disease</b>
<input type="checkbox"/> Cough/wheeze	<b>Musculoskeletal</b>	<input type="checkbox"/> COVID-19
<input type="checkbox"/> Loud snoring/altered breathing during sleep	<input type="checkbox"/> Neck pain	<input type="checkbox"/> Hepatitis C
<input type="checkbox"/> Short of breath with exertion	<input type="checkbox"/> Back pain	<input type="checkbox"/> HIV
<input type="checkbox"/> No problems	<input type="checkbox"/> Muscle/joint pain - Where?_	<input type="checkbox"/> No problems
	<input type="checkbox"/> No problems	
<b>Cardiovascular</b>		<b>Allergic/Immune</b>
<input type="checkbox"/> Chest pain/discomfort	<b>Neurological</b>	<input type="checkbox"/> Hay fever/allergies
<input type="checkbox"/> Palpitations (fast or irregular heartbeat)	<input type="checkbox"/> Headache	<input type="checkbox"/> Frequent infections
<input type="checkbox"/> No problems	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> No problems
	<input type="checkbox"/> Fainting	
<b>Gastrointestinal</b>	<input type="checkbox"/> Dizziness	<b>Women Only</b>
<input type="checkbox"/> Heartburn/reflux/indigestion	<input type="checkbox"/> Numbness/tingling	<input type="checkbox"/> Pre-menstrual symptoms (bloating, cramps, irritability)
<input type="checkbox"/> Blood or a change in bowel movement	<input type="checkbox"/> Unsteady gait	<input type="checkbox"/> Problem with menstrual periods
<input type="checkbox"/> Constipation	<input type="checkbox"/> Frequent falls	<input type="checkbox"/> Hot flashes/night sweats
<input type="checkbox"/> No problems	<input type="checkbox"/> No problems	<input type="checkbox"/> No problems



Print Name \_\_\_\_\_

Date \_\_\_\_\_ DOB \_\_\_\_\_

**IMMUNIZATIONS:** Check any vaccinations you have had. Add year, if known.

Check the box if you don't know the information.

Tetanus (Td) \_\_\_\_\_ With Pertussis (Tdap) \_\_\_\_\_ Varicella (Chicken Pox) shot or illness \_\_\_\_\_

HPV \_\_\_\_\_ Pneumovax (pneumonia) \_\_\_\_\_ Influenza (flu shot) \_\_\_\_\_ Hepatitis A \_\_\_\_\_

Hepatitis B \_\_\_\_\_ MMR \_\_\_\_\_ Meningitis \_\_\_\_\_ Zostavax (Shingles) \_\_\_\_\_

Medication	Dose	Times/Day

Medication	Dose	Times/Day

**PERSONAL MEDICAL HISTORY:** Please indicate whether you have had any of the following medical problems (with approximate date of illness or diagnosis):

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> High cholesterol _____
<input type="checkbox"/> Abnormal Pap smear	<input type="checkbox"/> Hypertension (high blood pressure)
<input type="checkbox"/> Cancer (malignancy)	<input type="checkbox"/> Last Tetanus shot _____
<input type="checkbox"/> Coagulation (bleeding/clotting disorder)	<input type="checkbox"/> Myocardial Infarction (heart attack)
<input type="checkbox"/> Congenital Heart Disease, specify type: _____	<input type="checkbox"/> If you have ever had a blood transfusion, specify date: _____
<input type="checkbox"/> Depression/suicide attempt	<input type="checkbox"/> Thyroid problem, specify type: _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Other problems _____

**SURGICAL HISTORY:** Please list all prior operations and dates:

Operation	Date

Operation	Date

**ALLERGIES OR REACTIONS** (to medication/foods/other agents):

Medication	Reaction or Side Effect



Print Name \_\_\_\_\_

Date \_\_\_\_\_ DOB \_\_\_\_\_

**FAMILY MEDICAL HISTORY:** Please indicate with a check (✓) family members who have had any of the following conditions:

Medical Condition	Mom	Dad	Sister	Brother	Daughter	Son	Other Close Relatives
Anemia							
Anesthesia Problem							
Asthma							
Bleeding Problem							
Cancer							
Diabetes							
Genetic Diseases							
Hay Fever							
Heart Attack							
High Blood Pressure							
High Cholesterol							
Kidney Diseases							
Stroke							
Thyroid Disorders							
Tuberculosis							

**OTHER HEALTH ISSUES:**

**Tobacco Use**

Smoke cigarettes:  Never  No  Yes

(If you never smoked please go to alcohol use question now)

Quit date: \_\_\_\_\_ How many years did you smoke? \_\_\_\_\_ Approximately how many packs a day did you smoke? \_\_\_\_\_

Current smoker: packs/day: \_\_\_\_\_ # of years: \_\_\_\_\_ Other tobacco:  Pipe  Cigar  Snuff  Chew

**Alcohol Use**

Do you drink alcohol?  No  Yes

# of drinks/week: \_\_\_\_\_  Beer  Wine  Liquor

**Drug Use**

Do you use marijuana or recreational drugs?  No  Yes

Have you ever used needles to inject drugs?  No  Yes

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



Patient Name: \_\_\_\_\_  
(Patient First and Last Name)

Date of Birth: \_\_\_\_\_

**HIPAA PRIVACY DISCLOSURES AND RESTRICTIONS**

I wish to be contacted in the following manner (check all that apply):

Cell Phone: \_\_\_\_\_

Alternate Phone: \_\_\_\_\_

- OK to leave message
- Leave message with call-back number only
- Do not Leave message
- Do not Call

- OK to leave message
- Leave message with call-back number only
- Do not leave message
- Do not Call

Written Communication:

Email: \_\_\_\_\_

- OK to mail to my home address
- Do not mail to my home address

- Ok to Email
- Do not Email

**PRIVACY PRACTICES DOCUMENTATION**

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under Federal and State laws, and outlining my rights regarding my health information.

\_\_\_\_\_  
(Patient/Legal Representative Signature)

\_\_\_\_\_  
Date



**AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Please Print First and Last Name)

**Information to be Disclosed**

I authorize the release of the following health information (check one box below):

- All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.
- Only the following records or types of health information:

\_\_\_\_\_  
\_\_\_\_\_

**Authorization for Use/Disclosure of Information**

I voluntarily consent to authorize Centennial Medical Group, Inc. to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

I authorize the release of my health information for the following specific purpose:

\_\_\_\_\_

**Terms**

I understand that this Authorization will remain in effect (Check one box below):

- From the date of this Authorization until the \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.
- Until the Provider fulfills this request.
- Until the following event occurs: \_\_\_\_\_

**Authorization Statements**

1. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the HIPAA Privacy Rule may no longer protect the information.
2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Centennial Medical Group staff member. I understand that the revocation will not apply to information that has already been released in response to this authorization.
3. I understand that Centennial Medical Group will not condition the provision of treatment or payment on the provision of this authorization.

\_\_\_\_\_  
(Patient/Legal Representative Signature)

\_\_\_\_\_  
Date



MISSED APPOINTMENT POLICY

We are glad you have chosen us to provide your medical care. If you miss your appointment, you compromise your care and prohibit other patients from receiving care during the time reserved for you. As a result, there is a No-Show fee for not showing up on time for your appointment or canceling with at least 24 hours work-day notice.

For all missed appointments, you will be charged the following fees:

Office Visits Charge: \$50.00

Procedure/Treatment Charge: \$75.00

Specialist Visit \$ 75.00

I have read and understand the Missed Appointment Fee Policy and agree to the terms.

\_\_\_\_\_  
(Patient/Legal Representative Signature)

\_\_\_\_\_  
Date

\*\*\*\*\*

MISCELLANEOUS FEES

Centennial Medical Group, Inc. charges a fee for the completion of any form which requires medical information and/or a physician's signature.

Short Forms \$10.00

- Sports Physical
- Pres-School Physical
- TB Skin Test

Long Forms \$20.00

- Disability
- DMV/AFLAC
- Kindergarten Physical
- Family Leave Act