Thompson Medical Group
New Patient Registration Form

PLEASE PRINT

Last Name:_____ First Name: _____ MI:_____

Sex: Male / Female Date of Birth:_____ Age:_____

Race (i.e. Caucasian/Hispanic/Asian):_____Ethnicity (i.e. American/Mexican/German):_____
Marital Status:_____

Primary Language:_____

Address: _____City: _____Zip:_____

(H) Phone:_____ (C) Phone_____(W) Phone:_____

Preferred number to reach you? **Home Cell Work** OK to leave message at this number? **Yes / No**

In Case Of Emergency Contact:
Contact name: _____ Relationship: _____ Number: _____

Contact name: _____ Relationship: _____ Number: _____

E-mail:_____

Referred By:_____

***Local Pharmacy Name:**_____ **Phone:**_____

Address or Cross-Streets:_____ **Phone:**_____

***Mail Order Pharmacy Name:**_____

Primary Insurance Name:_____

Primary Holder Name:_____ Date of Birth:_____

Secondary Insurance Name:_____

Primary Holder Name: _____ Date of Birth:_____

ASSIGNMENT OF BENEFITS

I hereby authorize my benefits to be paid directly to Thompson Medical Group and I am financially responsible for non-covered services and/or balances not paid by the insurance carrier. I also authorize release of my information required to process these claims. I authorize you to give me my medical care, including diagnosis and/or treatment.

_____ _____ _____

Signature of the Patient or the Patient's Legal Representative Date Relationship to Patient

Patient Name: _____DOB:_____ Date: _____

CHIEF COMPLAINT: Please provide the main reason for your visit today? (describe your problem in detail)

_____

_____

MEDICATION ALLERGIES: ☐ NONE

LIST ALLERGIES TO MEDICATION AND REACTION:

CURRENT MEDICATIONS AND VITAMINS: ☐ NONE

Name of Drug	Strength of Drug (mg)	How Often (# times per day)	Name of Drug	Strength of Drug (mg)	How Often (# times per day)

Patient Name: _____ **DOB:** _____ **Date:** _____

Thompson Medical Group

Consents Form

Would you like a copy of the Notice of Privacy Practices? Declined ☐ Accepted ☐

Acknowledgement of Notice of Privacy Practices:

I have been offered a copy of the Notice of Privacy Practices. I understand that Thompson Medical Group has the right to change its Notice of Privacy Practices from time to time and that I may contact Thompson Medical Group at any time to obtain a current copy.

**Signature:_____ Date:_____

Authorization of Release of Health Information:

I authorize the following individual(s) to have access to my personal health information.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

**Signature:_____ Date:_____

Notice of Limited English Proficiency:

I have been offered a copy of the Notice of Limited English Proficiency. I understand that if I have Limited English Proficiency, I must provide a reliable, competent and proficient translator. If I cannot provide this translator, I must notify Thompson Medical Group in writing.

**Signature: _____Date: _____

Consent to Obtain Electronic Medication History:

To optimize the use of electronic prescribing of medications and coordinate care between my providers, I hereby authorize Thompson Medical Group to access my medication history without limitation or exclusion as is reasonably necessary to disclose, retrieve, and view medications issued by a provider.

**Signature:_____ Date:_____

Assignment of Benefits

I hereby assign medical and or surgical benefits, private insurance, and any other health plan benefits to Thompson Medical Group. A copy of this assignment is considered as valid as the original.

Authorization to Treat

I, and/or the undersigned on behalf of the patient ,voluntarily consent to allow Thompson Medical Group physicians and staff to provide such evaluation and/or care and treatments as an outpatient on a continuing basis and as an inpatient as necessary, as Thompson Medical Group physicians and staff may decide is advisable and necessary

I understand that although care is reviewed and supervised by Thompson Medical Group physicians, actual care may be rendered by physician extenders, i.e.: physician assistants and nurse practitioners.
I understand that such treatment may include physical examination, x-ray examination, laboratory procedures, other office procedures, as well as inpatient procedures as required. **I understand** that should I execute a Durable Power of Attorney for Health Care or other Advance Directive, I will provide and execute a copy to my physician. **I understand** that I will notify my physician of any changes in the Directive. **I understand** that I will be informed about the course of my treatment. **I understand** that I am free to terminate my treatment with my Thompson Medical Group physician at any time

Authorization to Release Information:

I hereby authorize Thompson Medical to release any medical information necessary to my insurance company or it's agents in order to secure payments.

Financial Responsibly:

Please be advised that ultimately, **YOU, the PATIENT, are responsible for your bill.** Thompson Medical Group will bill your insurance on your behalf as a *courtesy*. Should your insurance not pay the charges within 60 days, the balance due will be transferred to YOU, the PATIENT. It will be your responsibility to follow up on your claim and remit payment to Thompson Medical Group. Please be advised that billing statements are sent one time at no charge to you, however, if payment is not received within 30 days, a $20.00 service charge will be applied for the second, and each additional, statement.

I certify that I have read the foregoing and as the patient, the patient's guardian, conservator, or general agent, I agree to accept the above terms. I acknowledge receipt of a copy of Thompson Medical Group's Notice of Privacy Practices which outlines the use, disclosure, certain restrictions, and rights I may have regarding my protected health information under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that THOMPSON MEDICAL GROUP has the right to change its Notice of Privacy Practices at any time and that I may contact you at any time to obtain a current copy.

**Signature:_____ Date:_____

Guardian/Conservator/General Agent Signature: _____Date:_____

Witness Signature: _____Date:_____

Financial Agreement

Completion of Forms:

Due to the extensive nature of some forms that require completion by your physician and his/her staff, it has become necessary for our office to implement a fee for their completion. Forms that are 3 pages or longer such as FMLA or Short Term Disability will require a payment of **$25.00** to be paid at time of pick-up or prior to send-off. Forms will **NOT** be released until payment is made. Please allow **72 hours** for completion of all forms.

Please Initial and Sign

_____I understand that there will be a charge for the completion of forms in the amount of $25.00 due at the time of pick-up by patient. In the event my forms need to be faxed or mailed I will pay the fee at drop-off or over the phone prior to send-off.

Missed Appointment Policy: It has become necessary for us to enforce the following missed appointment policy. Notifying our office if you are unable to keep a scheduled appointment will allow other patients to be seen as needed.

_____I understand that I am responsible for keeping ALL scheduled appointments. If I fail to follow the previous statement I will be responsible for a $30.00 charge. I understand that this charge is not billable to my insurance company.

_____I understand that I am responsible for notifying the office 24 hours in advance if the appointment needs to be canceled or re-scheduled. **(Messages can also be left with our answering service if calling after 4 p.m.)**

**Signature:_____Date:_____

Authorization to Obtain Healthcare Information

Patient's Name_____

Date of Birth_____ Social Security # _____

Previous Name/ Nickname _____

I request and authorize to Release:

- All Healthcare Information
- Healthcare Information Relating to _____
  _____
- Other _____

YES ☐ NO☐ STD results/ HIV/AIDS testing, whether negative or positive

STD Definition: Sexually Transmitted disease (STD) as defined by law, RCW 70.24 et seq, includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV, AIDS, and ghonorhea

YES ☐ ☐ NO Records regarding Drug, Alcohol, or Mental Health Treatment

FROM: (list medical office below)

Name_____

Address_____

Phone #_____Fax #_____

TO: THOMPSON MEDICAL GROUP @ ***fax # (623) 583-7410***, phone # (623) 583-7400

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER IT IS SIGNED

****Signature:**_____Date:_____

Refusal of Advanced Directives

This form is to acknowledge that I have been offered a **Durable Health Care Power of Attorney and a Living Will**. My signature on this form will serve as my refusal to fill these forms out at this time. I understand that I can still turn in these forms whenever I want after signing this form.

Print Name_____

Date of Birth_____

Signature:_____Date:_____

This form serves as proof that the above patient has been offered a Living Will and Durable Healthcare Power Of Attorney.

Patient Name: _____**DOB:**_____ **Date:** _____

MEDICAL HISTORY:

Have you experienced any of the following?

Alcoholism	Gout	Osteoporosis
Allergies	Head injury	Pneumonia
Anemia/Blood Clots	Hearing trouble	Polio
Appendectomy	Heart Attack/Stroke	Prostate Problems
Arthritis	Heart murmur/disease	Psoriasis
Asthma/Emphysema	Hemorrhoids	Rheumatoid Arthritis
Cancer:_____	Hernia/Ulcer	STDs/Mono
Chicken Pox/Shingles	High Blood Pressure	Stomach Problems
Deep Venous Thrombosis	High Cholesterol	Thyroid Problems
Depression/Anxiety	Kidney Stones	Tonsillectomy
Diabetes	Liver Problems	Tuberculosis
Drug addiction	Memory trouble	Valley Fever
Epilepsy/Seizures	Mental illness	Vasectomy
Gallstones	Migraines	Vision trouble
Glaucoma	Mitral Valve Prolapse	

Other:

ALLERGIES:

Do you have allergies? □Yes □No

If yes, please indicate what type:

□Food □Sinus/Eyes □Insect □Animal □Plant □Other:_____

Medications taken (over-the-counter or prescription): _____

sinus infections during year:_____ Have you been tested for allergies? □Yes □No

SURGICAL HISTORY:

☐**NONE**(if necessary, please use the back of this sheet)

Procedure	Month/Year
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

FAMILY MEDICAL HISTORY:

FAMILY MEMBER	DETAILS	AGE	DISEASE(S)	IF DECEASED, CAUSE
Father				
Mother				
Sibling	□ M □ F			
Sibling	□ M □ F			
Sibling	□ M □ F			
Sibling	□ M □ F			

OTHER DISEASES IN FAMILY:_____

Patient Name: _____ **DOB:** _____ **Date:** _____

SOCIAL HISTORY:

1) Occupation: _____

2) Marital Status (please circle): Single Married Divorced Widowed

3) Do you have children/step-children? □Yes □No
   If yes, how many? _____ Age(s): _____

4) Do you exercise? ☐ Yes ☐ No
   If yes, what type? How often? _____

TOBACCO/ ALCOHOL/ ETC:

1) Do you now or have you ever smoked? □ Yes □ No Year quit?_____
   If yes, what type?_____ How often?_____ How many?_____

2) Do you consume alcohol? □ Yes □ No
   If yes, what kind?_____ How often?_____ How much?_____

3) Do you consume caffeine? □ Yes □ No
   If yes, what kind?_____ How often?_____ How much?_____

4) Do you use illegal drugs? □ Yes □ No
   If yes, what kind?_____ How often?_____ How much?_____

5) Do you wear seatbelts? □ Yes □ No

6) Do you wear sunscreen? □ Yes □ No

MEDICAL HEALTH HISTORY:

When was your last:

Blood test:	HIV test:	Heart Attack:
Chest x-ray:	TB test:	Stroke:
Chicken Pox vaccine:	Tetanus shot:	Pneumovax:
Colonoscopy:	Flu shot:	Sigmoidoscopy:
EKG:	Rectal exam:	Other:

Female Only:

Last pap smear:	Hysterectomy:
Experienced menopause: Total # of pregnancies/children:	Last mammogram: Last menstrual period:

Patient Name: _____ **DOB:** _____ **Date:** _____

Review of Symptoms. Do you have any of the following? (Please mark an (X) in the spaces provided)

Constitutional Symptoms	X	Genitourinary	X	Cardiovascular	X
Weight Change		Change in Stream		Chest pain	
Chills		Nocturia (getting up at night)		Tightness/heaviness in chest	
Fever		Urinary frequency > 8times/day		Irregular heartbeat	
Itching		Burning with urination		Swelling in ankles	
Night Sweats		Blood in urine		High blood pressure	
Other:		Urinary leakage		Shortness of breath	
		Trouble starting urine flow		Heart enlarged	
		Dribbling at end of urine flow		Feel skipped beats	
		Other:		Heart pounds fast	
				Low blood pressure	
				Do you have a murmur?	
				Do you feel palpitations?	
				Other:	
Musculoskeletal	**X**	**EYES**	**X**	**Neurological**	**X**
Muscle weakness		Glaucoma		Tremors	
Joint pain (swelling)		Cataracts		Dizzy spells	
Sciatica		Wear glasses		Numbness/tingling	
Muscle pains		Blurred vision/Pain in your eyes		Stroke	
Muscle cramps stiffness		**Other:**		Seizures	
Other:				Insomnia	
				Other:	
ENT	**X**	**Gastrointestinal**	**X**	**Respiratory**	**X**
Pain in ears		Abdominal pain		Wheezing	
Discharge from ears		Nausea/vomiting		Frequent cough	
Motion sickness		Indigestion/heartburn		Shortness of breath	
Difficulty hearing		Constipation		Are you on oxygen?	
Trouble with teeth		Diarrhea		**Other:**	
Trouble with gums		**Other:**			
Nose bleeds					
Other:					
Endocrine	**X**	**Hematological/Lymphatic**	**X**	**Psychological**	**X**
Excessive thirst		Swollen glands		Do you feel depression?	
Too hot/cold		Blood clotting problems		Do you feel anxious?	
Other:		Bruising		Seeing a psychiatrist	
		Other:		Any psychiatric diagnosis?	
				Other:	
Sexual History	**X**	**(WOMEN ONLY)**	**X**	**(MEN ONLY)**	**X**
Change in sex drive?		Pelvic Pain		Pain or swelling of testicles	
Sexual performance Satisfactory?		Breast Problems		Discharge from penis	
Other:		Infertility		Blood in Semen	
		Other:		**Other:**	