PATIENT REGISTRATION FORM (eCW)

PATIENT INFORMATION

(Please print)

Patient's Name: (Last) _____ (First) _____ (MI) _____

Address: _____

City State Zip: _____

Home: _____ Cell: _____ Work: _____

E-Mail Address: _____ DOB: _____

Sex: ☐ Female ☐ Male ☐ Transgender

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander
☐ Black/African American ☐ White ☐ Hispanic ☐ Other ☐ Declined

Language: ☐ English ☐ Spanish ☐ Indian: Hindi, etc. ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Social Security Number: _____ - _____- _____

RESPONSIBLE PARTY INFORMATION (*If not self*)

(Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐

Responsible party name: (Last) _____ (First) _____ (MI) _____

Date of birth: MM ____/DD ____/YYYY_____ Sex: ☐ Female ☐ Male

Social Security Number: _____-_____-_____ Phone number: _____

Address: _____

City, State: _____ ZIP: _____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last) _____ (First) _____

Phone number: _____ Do you have a living will? ☐ Yes ☐ No

Emergency contact relationship to patient: _____ ☐ Guardian

Address _____

City, State: _____ ZIP: _____

Home phone: _____ Work home: _____ Ext. _____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative: _____ Date: _____

Printed name of patient or personal representative: _____ Relationship to patient: _____

HEALTH HISTORY

Name: _____ DOB: _____ Height: _____ Weight: _____

Please take a moment to answer the following questions to help us get to know you better.

Why are you seeing us today_____

Current Medications: Please list if you did not bring a list with you today._____

_____

_____

_____

_____

Do you have any Medication Allergies? _____

Medical History: Circle all current or if you have ever been diagnosed with any of the following medical conditions?

Aneurysm ☐	Cancer ☐ Type_____	Heart attack ☐ MI ☐	Hypertension ☐ high blood pressure ☐	Prostate problems ☐
Aortic Mitral valve disease ☐	Cystic Fibrosis ☐	Heart disease ☐	Irregular heart beat atrial fibrillation ☐	Sleep Apnea ☐
Artery blockages ☐ Peripheral vascular disease ☐	Depression ☐	Heart failure ☐	Kidney disease ☐	Stroke ☐ TIA ☐
Arthritis ☐	Diabetes ☐ high blood sugar ☐	Heartburn ☐ Indigestion reflux ☐	Liver disease ☐	Thyroid problems ☐
Asthma ☐	Emphysema ☐	Hepatitis ☐	Migraines ☐	Tuberculosis ☐
Blood clots ☐ pulmonary embolus ☐	High cholesterol ☐	HIV ☐	Pacemaker ☐	Ulcers ☐

Other not listed _____

What operations have you had? What year?

Have you been in the hospital other than for surgery?

Family History

Family Members	Alive	Deceased	Unknown	Age	Cause of Death
Mother					
Father					
Brother					
Sister					
Daughter(s)					
Son(s)					

Do any of the following conditions run in your family?

Asthma ☐	Cancer & Type ☐	Cystic Fibrosis ☐	Diabetes ☐
Emphysema ☐	Heart Disease ☐	High Blood Pressure ☐	

Social History

Social Info	**Details**		
Alcohol:	Type:	Frequency:	Years:
Caffeine	Type:	Frequency:	Years:
Smoking:	PPD:	Years:	When did you quit
	Current Smoker?		
Marital Status:			
Children:	Sons:	Daughters:	
Special Diet:			
Exercise:			
Occupation:		If retired what did you do?	
Fumes/dust Exposure			
Asbestos Exposure			
Pet/animals you have			
Any recent travels			

Date of last FLU vaccine _____ **Date of last PNEUMONIA vaccine** _____

Date of last Mammogram _____ **Date of last Colonoscopy** _____

Who is your Primary Care Physician? _____**Number** _____

Do you see any medical specialist? If yes who? (Physician, Specialty, Phone number).

1._____

2. _____

Pharmacy Name: _____**Pharmacy Phone Number:** _____

Please bring with you all of the medications that you are currently taking (including vitamins and herbs).

Centennial Thoracic Surgical Associates
Patient Consent for Financial Communications

Patient Name: _____
DOB: _____

Financial Agreement

- I acknowledge, that as a courtesy, CENTENNIAL THORACIC SURGICAL ASSOCIATES may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection. I acknowledge CENTENNIAL THORACIC SURGICAL ASSOCIATES may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to CENTENNIAL THORACIC SURGICAL ASSOCIATES any insurance or other third-party benefits available for health care services provided to me. I understand CENTENNIAL THORACIC SURGICAL ASSOCIATES has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to CENTENNIAL THORACIC SURGICAL ASSOCIATES, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to CENTENNIAL THORACIC SURGICAL ASSOCIATES by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for CENTENNIAL THORACIC SURGICAL ASSOCIATES, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that CENTENNIAL THORACIC SURGICAL ASSOCIATES or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or CENTENNIAL THORACIC SURGICAL ASSOCIATES or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Patient/patient representative signature: _____ **Date:** _____

If you are not the patient, please identify your relationship to the patient. Circle or mark relationship(s) from list below:

☐ Spouse
☐ Parent
☐ Legal Guardian
☐ Guarantor
☐ Healthcare Power of Attorney
☐ Other (please specify) _____