# Mondragon & McGrinder Medical Associates, PLLC

Name: _____
Former Name (s): _____

Address: _____
_____
_____

Telephone: (Home) _____
(Work) _____
(Cell) _____

DOB: _____
Email: _____

| | |
|---|---|
| Date: | |
| Update: | |
| Initial | |
| Update: | |
| Initial | |

Primary Care Physician or Family Doctor: _____

Allergies: _____

OPTIONAL

Race: _____
Ethnicity: _____
Language: _____

MEDICAL HISTORY

Cancer-Patient: _____
Cancer-Family: _____
Abnormal Paps: _____

Surgeries: _____
Other Illnesses: _____
_____

CURRENT PROBLEMS _____
_____
_____

MEDICATIONS-PHARMACY NAME & PHONE NUMBER

_____
_____
_____
_____

EMERGENCY CONTACT INFORMATION

Emergency contact name: _____
Relationship to patient: _____ Phone #: _____

# PATIENT REGISTRATION FORM

PATIENT NAME: _____ Date of Birth: _____

Street Address: _____ City: _____ Zip: _____

Telephone Home: _____ Work: _____ SS#: _____

Referring Doctor: _____ Primary Doctor: _____

Responsible Party (if above named patient is under 18 years of age):

_____

**PLEASE NOTE THAT THE FOLLOWING INSURANCE INFORMATION MUST BE COMPLETELY FILLED OUT IN ORDER FOR US TO BILL YOUR INSURANCE CARRIER.**

Primary Insurance: _____ Policy #: _____

Address: _____ Group #: _____

_____

Patient Relationship to Policy Holder (please circle one): **WIFE CHILD PARENT SELF OTHER**

Policy Holder's Name: _____ SS#: _____

Policy Holder's Date of Birth: _____ Policy Holder's Employer: _____

COPAY Amount (please circle one): **$5 $8 $10 $15 $20 $25 $30**

Secondary Insurance: _____ Policy #: _____

Address: _____ Group #: _____

_____

Policy Holder's Name: _____ SS#: _____

Policy Holder's Date of Birth: _____ Policy Holder's Employer: _____

COPAY Amount (please circle one): **$5 $8 $10 $15 $20 $25 $30**

Purpose of Visit: _____

_____

List any medical conditions for which you are being treated: _____

_____

**Are you allergic to any medication?** YES NO **If yes, please list:** _____

_____

_____

**STATEMENT TO AUTHORIZE PAYMENT OF INSURANCE BENEFITS: I certify that the information given by me on this form is correct. I authorize any holder of medical information about me to release to my insurance carriers or companies any information required to process my medical insurance claims. I request that payment under medical insurance problems be made to the medical provider for the services provided to me.**

_____ _____

Patient Signature (Parent's Signature if patient is a minor) Date

TODAY'S DATE_____

NAME:_____AGE:_____DOB:_____MARITAL STATUS: S M D S W P

ADDRESS:_____HOME PHONE:_____SS#:_____

_____

OCCUPATION:_____WHERE EMPLOYED:_____WORK PHONE:_____

HUSBAND'S NAME:_____OCCUPATION:_____WHERE EMPLOYED:_____

INSURANCE – PATIENT'S:_____HUSBANDS:_____PCP:_____

NAME & ADDRESS OF NEAREST RELATIVE:_____

NAME OF PERSON WHO REFERRED YOU TO THIS OFFICE:_____

MAIN PROBLEM: THE REASON YOU'RE HERE, I.E. YEARLY EXAM, PREGNANCY, MENSTRUAL PROBLEMS, ETC.

_____

_____

_____

_____

DO YOU SMOKE?_____ IF YES, HOW MANY PACKS A DAY?_____FOR HOW MANY YEARS?_____

HISTORY OF PREGNANCIES: BEGIN WITH FIRST PREGNANCY AND CONTINUE THROUGH TO THE MOST RECENT:

| YEAR | TERM OR PREM | BIRTH WEIGHT | SEX | HRS. OF LABOR | PERSON WT GAIN | COMPLICATIONS |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

DATE OF LAST MENSES:_____PREVIOUS MENSES:_____AGE OF ONSET OF MENSES:_____

HOW OFTEN DO YOUR PERIODS OCCUR:_____HOW MANY DAYS DO YOUR PERIODS LAST:_____

LAST MAMMO:_____ LAST PAP:_____ LAST DEXA SCAN:_____

**DO YOU EXPERIENCE ANY OF THE FOLLOWING? (YES OR NO)**

BLEEDING BETWEEN PERIODS: Y N EXCESSIVE DISCHARGE: Y N COLOR_____ VAGINAL ITCHING: Y N

HEAVY PERIODS: Y N # OF PADS SATURATED PER HOUR_____ PAINFUL PERIODS: Y N

PAINFUL SEXUAL INTERCOURSE: Y N SPOTTING AFTER INTERCOURSE: Y N

LOSS OF URINE WITH COUGHING OR SNEEZING: Y N PAIN WITH URINATION: Y N

DO YOU HAVE A NEED FOR BIRTH CONTROL: Y N IF SO, WHAT METHOD_____

| LIST ANY DRUG ALLERGIES: | LIST ANY DRUGS YOU ARE CURRENTLY TAKING: |
|---|---|
| | |
| | |
| | |
| | |

NAME_____

HAVE ANY MEMBERS OF YOUR FAMILY HAD THE FOLLOWING DISEASES?

| DISEASE | YES | NO | WHICH RELATIVE (S) | COMMENTS |
|---|---|---|---|---|
| CANCER | | | | WHAT TYPE: |
| DIABETES | | | | |
| TUBERCULOSIS | | | | |
| HEART DISEASE | | | | |
| KIDNEY DISEASE | | | | |
| HIGH BLOOD PRESSURE | | | | |
| ASTHMA | | | | |
| EPILEPSY | | | | |
| OTHER, INCLUDING INFECTIOUS DISEASES | | | | |

HAVE YOU HAD ANY OF THE FOLLOWING?

| | | | | |
|---|---|---|---|---|
| MEASLES | | | | |
| MUMPS | | | | |
| CHICKEN POX | | | | |
| POLIO | | | | |
| RHEUMATIC FEVER | | | | |
| SCARLET FEVER | | | | |
| TUBERCULOSIS | | | | |
| BLOOD DISEASE | | | | |
| HEART DISEASE | | | | |
| KIDNEY DISEASE | | | | |
| EPILEPSY | | | | |
| MENTAL DISORDER | | | | |
| VENEREAL DISEASE | | | | |
| DIABETES | | | | |
| THYROID DISEASE | | | | |
| BLOOD TRANSFUSION | | | | |
| HIGH BLOOD PRESSURE | | | | |
| VARICOSE VEINS | | | | |
| OTHER | | | | |

LIST ANY OPERATIONS WHICH YOU HAVE HAD:

| OPERATION | YEAR | REASON FOR |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5 | | |

# ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I, _____, understand that as part of my health care, Mondragon McGrinder Medical Associates PLLC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, as well as plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means to facilitate communication among the many healthcare professionals who contribute to my care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided; and
- A tool for healthcare operations of Mondragon McGrinder Medical Associates PLLC such as assessing quality of care and reviewing the competence of healthcare professionals

I understand that as part of Mondragon McGrinder Medical Associates PLLC's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity for the purposes stated above.

I understand and have been provided with a ***Notice of Privacy Practices*** that provides a more complete description of how Mondragon McGrinder Medical Associates PLLC may use and disclosure my protected healthcare information. I further understand that Mondragon McGrinder Medical Associates PLLC reserves the right to change its ***Notice of Privacy Practices.*** Should Mondragon McGrinder Medical Associates PLLC change its ***Notice of Privacy Practices***, an amended copy will be posted in a prominent location in the practice site, or, upon my request, an amended copy will be sent to the address I have provided.

I agree that the Practice may do the following unless I specifically give direction prohibiting such activity:

- I agree that Mondragon McGrinder Medical Associates PLLC may do the following unless I specifically give direction prohibiting such activity:
- Send visit reminders and test results to the address I have provided.
- Send routine correspondence, such as billing statements, to the address I have provided.
- Leave messages on an answering machine or voice mail associated with the telephone numbers I have provided to either confirm appointments or to request that I call the Practice on medical or billing matters.
- I agree that the Practice may share billing information with my spouse and/or the person holding the insurance to secure payment.. Other persons with whom the Practice may discuss billing information include_____.
- I give the Practice permission to share medical information with the following relatives or friends involved in my care_____.

_____ **DOB**_____

Patient's Signature or Signature of Personal Representative

_____

Date

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FOR OFFICE USE ONLY

[ ] Receipt received by _____ on _____.

[ ] Patient refused to sign receipt. _____(Signature of Practice Representative)

*Mondragon McGrinder Medical Associates P.L.L.C.*
***Patient authorization for medical release***

Patient Name_____Date_____

I consent to examination and treatment by the physicians and nursing staff of Mondragon McGrinder Medical Associates P.L.L.C.

I authorize my physician to release any and all of my medical records including but not limited to: records of my office visits and treatment rendered, clinical laboratory reports, diagnostic test results, photos and x-ray reports.

Such records may be released to my attorney, another requesting physician, or any other health care professional or facility for the purposes of discussing my condition, consulting on my case, or reviewing my medical records.

These records in their entirety regardless of dates of coverage may also be released to any governmental agencies insurance companies, employees of insurance companies, and the physicians health organizations which contract with my insurer for the purpose of pursuing payment, insurance reimbursement, submitting claims for services rendered or to be rendered to me, or performing quality assurance reviews as required by law.

Patient Signature Date

**Patient's reauthorization**

Patient signature Date

Patient signature Date

Patient signature Date

Patient signature Date

Patient signature Date

Although authority to revoke permission to release records must be obtained in writing from the patient, it is still advisable to ask the patient to authorize record release at least once a year. This document must be made part of the patients' records.