CENTENNIAL
MEDICAL GROUP

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

CENTENNIAL MEDICAL GROUP

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.

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

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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):

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

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MEDICAL GROUP

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:** _____

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Patient Name:_____ Date of Birth:_____
(Patient First and Last Name)

HIPAA PRIVACY DISCLOSURES AND RESTRICTIONS

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

Cell Phone:_____

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

Alternate Phone: _____

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

Written Communication:

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

Email: _____

- ☐ 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

CENTENNIAL
MEDICAL GROUP

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

CENTENNIAL
MEDICAL GROUP

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 to 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: $25.00

Procedure/Treatment Charge: $50.00

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