

REGISTRATION INFORMATION

Information requested due to Patient Protection and Affordable Care Act of 2010

PAULA PLUMMER, M.D.
SOUTHWEST FAMILY PHYSICIANS, P.A.

Name _____ Email address _____
Street _____ Cell/Home phone _____
_____ Work phone _____
City _____ State _____ Zip Code _____ Social Security _____
Date of Birth _____ Sex F M Driver's License _____
Pharmacy # _____

Race American Indian Asian Native Hawaiian Black or African American White Hispanic Other Unreport/Refused
Ethnicity Hispanic or Latino Not Hispanic Unreported/Refused
Language English Other Indian Spanish Chinese Vietnamese

Employed Yes No Marital Status: Single Married Widowed Divorced
Occupation _____

INSURANCE INFORMATION: Do you have Medical Insurance? No Yes
Insured _____ Insured's SS# _____
Name of Primary Insurance _____
Name of Secondary Insurance _____ None

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance named above and assign directly to Southwest Family Physicians, P.A. and Dr. Paula Plummer all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION: (If you have Medicare Insurance)

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Southwest Family Physicians, P.A. and Dr. Paula Plummer for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. If "other health insurance" is indicated item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature Date

POLICIES AND NOTICE OF PRIVACY PRACTICES

I, the undersigned, have received the Southwest Family Physicians, P.A. Notice of Privacy Policies and Practices.

Signature of Insured/Guardian Date

Emergency Contact Name _____ Phone Number _____

Who referred you to Dr. Paula Plummer? _____

Do you have any pertinent medical information needed to be requested from another physician or hospital? Yes No
If yes, please ask our office for a request of release of medical records to sign.

Do you have an Advanced Directive (directions on end of life care)? Yes No
If no, would you like an Advanced Directive? Yes No

We appreciate your confidence in us as your Primary Care Physician and take your medical care seriously. Repetitive no shows or cancellations may result in termination of this relationship.

PATIENT INFORMATION

CURRENT MEDICATION

Dosage

Frequency

MEDICAL HISTORY

ALLERGIES / INTOLERANCE

SURGICAL HISTORY

____ Month/Year _____

____ Month/Year _____

____ Month/Year _____

HOSPITALIZATION HISTORY

____ Month/Year _____

____ Month/Year _____

FAMILY HISTORY

DOB

Deceased

Diabetes

Hypertension

Heart

Cancer

Mother

Father

Sibling

Children

Children

SOCIAL HISTORY

Tobacco Use

Current Smoker

Former Smoker

Never Smoker

packs _____

Yrs. _____

Do you drink alcohol?

Yes No

Wine Beer Liquor

Socially

Daily

Rarely

If Yes, how many drinks a week on average? _____

Do you exercise?

Yes No

walking running swimming dancing hiking biking yoga pilates zumba

If Yes, how long and how frequently? _____

Caffeine intake?

Yes No

Coffee Tea Soft Drinks chocolate Energy Drinks

Amount _____

Use of recreational/street drugs?

Yes No Former User

PREVENTIVE CARE

Influenza (Flu Shot)

Yes

No

Date _____

Pneumonia Vaccine

Yes

No

Date _____

Tetanus/Diphtheria Booster

Yes

No

Date _____

Varicella/ Chicken Pox

Yes

No

Date _____

Zostavax/ Shingle Vaccine (Age 60+)

Yes

No

Date _____

Colonoscopy

Yes

No

Date _____

Bone Mineral Density (BMD)

Yes

No

Date _____

Mammogram (MMG)

Yes

No

Date _____

Pap Smear (PAP)

Yes

No

Date _____

Will you provide a current immunization record?

Yes

No

You will receive a Healthy Living pamphlet during the visit, please review it.

PATIENT NAME _____ DOB _____ DATE _____

Paula Plummer, MD