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
Employer _____ 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 my signature requests that payment be made and authorized release of medical information necessary to pay the claim. 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 cased, 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/Diptheria 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