# PATIENT REGISTRATION

## PATIENT INFORMATION

**Last Name** _____ **First Name** _____ **Middle** _____

**SSN** _____ **Date of Birth** _____/_____/_____ **Gender M / F**

**Home Address** _____

**City** _____ **State** _____ **ZIP**_____

**Race (Select One)** White / Black / Native American / Asian / Pacific Islander / Other / Unknown

**Language** _____ **Ethnicity (Select One)** Hispanic/ Non- Hispanic / Unknown

**Marital Status S M W D** _____ **E-Mail** _____

**Home #**_____ **Work #**_____ **Cell #**_____

**Employer** _____ **Occupation** _____

**Spouse's Name** _____ **Date of Birth** _____/_____/_____

**Work #** _____ **Cell #** _____

**Emergency Contact** _____ **Relationship** _____

**Home #**_____ **Cell #**_____ **Work #** _____

## INSURANCE INFORMATION

**Primary**
**Subscriber's Name** _____ **Relationship to Patient** _____
**(If different from patient)**

**SSN** _____ **Date of Birth** _____/_____/_____ **Employer** _____

**Secondary**
**Subscriber's Name** _____ **Relationship to Patient** _____
**(If different from patient)**

**SSN** _____ **Date of Birth** _____/_____ /_____ **Employer** _____

**Primary Care Physician** _____ **Phone #** _____

**Referring Physician** _____ **Phone #** _____

## Financial Policy and Assignment Agreement for BASS MEDICAL GROUP

Office copayments and coinsurance will be collected at the time of your appointment. Our practice accepts cash, personal checks, VISA and MasterCard**.** You will be charged $25.00 for returned checks or credit card. *Estimated Prepayment or credit card information will be required at the time of service if you have not met your deductible and out of pocket*.

**Insurance**
We bill participating insurance companies as a courtesy to you. If we do not receive payment from your insurance company you will be responsible to pay the balance in full.

**Assignment Agreement**
I request that payment of authorized benefits be made to Bass Medical Group for any medical services rendered. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay a claim.

**Missed Appointments/Late Cancellations**
Broken appointments represent a cost to us, to you and inconvenience to other patients who could have been seen in the time set aside for you. *We require a 24 hour notification for cancellation or reschedule of an office appointment or there will be a $50 charge*. Excessive abuse of scheduled appointments may result in discharge from the practice. *We require a 5 business day notification to cancel or reschedule procedures or there will be a $100 charge per procedure. For missed procedures without notification there will be a $200 charge*.

**Consent for Treatment of Minor**
This will authorize F. Anderson Rowe, M.D., and Julia DeRenzi, PA-C to perform any necessary or routine medical treatment including examination and diagnostic procedures.

**Collections**
Patients with an outstanding balance of 60 days overdue must make payment arrangements prior to scheduling appointments. For accounts 90 days overdue, patients will receive a final call from our billing office and payment arrangements must be made within 10 business days. *Accounts will be sent to Collections and a 25% collection fee will be assessed, if no patient response.*

_____

Patient's Name (please print) Signature Date

**If Minor or Responsible Party is other than patient, please fill out below:**

_____

Parent/Responsible Party's Name Signature Date

Address Home # Alternate#

**Name**: _____
**Date of Birth**: _____
**Reason for visit**: _____

**Primary Care Provider:**
**Other doctors/providers you see and their speciality** (example: Dr. Smith, cardiology):

- ❑ _____
- ❑ _____

**Allergies to Medication** (and reaction):

- ❑ No Known Drug Allergies
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____

**Current Medications**:

_____
_____
_____
_____

**Smoking History:** Have you ever smoked (pls circle)? NO YES How many packs per day? _____
**Alcohol Consumption** (pls circle): NO YES. How many drinks per day? _____ per week?: _____

**Past Medical Problems**

- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroid
- ❑ Heart problems
- ❑ Murmur
- ❑ Arrhythmia
- ❑ Pulmonary embolism
- ❑ DVT (deep vein thrombosis)
- ❑ Enlarged prostate
- ❑ Acid reflux/Heartburn
- ❑ Esophageal cancer
- ❑ Celiac disease
- ❑ Hepatitis
- ❑ Liver problem: _____
- ❑ Colon polyps
- ❑ Blood in stool/rectal bleeding
- ❑ Diverticulosis
- ❑ Diverticulitis
- ❑ Hemorrhoids
- ❑ OTHER:_____
  _____
  _____

**Past Surgeries**

- ❑ Appendix
- ❑ Gallbladder
- ❑ C section
- ❑ Hysterectomy
- ❑ Stomach surgery/Gastric bypass
- ❑ Nissen Fundoplication
- ❑ Endoscopy
- ❑ ERCP
- ❑ Colonoscopy
- ❑ Hemorrhoid surgery

**Family History** (if marked yes, please list Family Member with problem)

- ❑ Colon Cancer:
- ❑ Esophageal Cancer:
- ❑ Stomach Cancer
- ❑ Breast cancer:
- ❑ Ovarian cancer:
- ❑ Uterine cancer:
- ❑ Lung cancer:
- ❑ Heart problems:
- ❑ Ulcerative Colitis/Crohns
- ❑ Celiac Disease
- ❑ Liver problems