Sovereign Health
Medical Group

Full Name: _____
Last *First*

Address: _____

City: _____ State: _____ Zip Code:

Home #: _____ Cell #: _____ DOB: _____

SSN: _____ Gender: ☐ F ☐ M Marital Status: _____

Emergency Contact Name: _____

Relation: _____ Phone #: _____

Primary Provider (First & Last Name): _____

Referring Provider (First & Last Name): _____

If you were not referred by another provider, how did you hear about our office? _____

Insurance Information: IF WE COLLECTED YOUR CARD(S), ONLY FILL IN THE SUBSCRIBER DOB IF IT IS NOT SELF.

Primary Insurance: _____

Subscriber (if not self) : _____ Subscriber DOB: _____

Relation to Subscriber: _____

Subscriber ID: _____ Group #: _____

Secondary Insurance: _____

Subscriber (if not self) : _____ Subscriber DOB: _____

Relation to Subscriber: _____

Subscriber ID: _____ Group #: _____

E-RX Consent: Sovereign Medical Group implements ePrescribing at our office. ePrescribing is a federally mandated initiative that requires all p in this manner. ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, through the same technology companies. This helps protect the privacy of your personal information. ePrescribing software also lets your doctor see important information, like and prescription history. The benefits to you are reduced possibility of medical errors, less chance of adverse drug reactions, fewer trips to drop and a safer, faster, easier way to get your prescription filled. I agree that Sovereign Medical Group may request and use my prescription m from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

_____ _____
Patient Signature Date

Notice of Privacy Practices: *The Notice of Privacy Practices describes how Protected Health Information about you may be used and disclose*

Please circle your ethnicity, language, and race:

Ethnicity: Hispanic Non-Hispanic *Language:* English Spanish Italian Other: _____

Race: American Indian/Alaskan Native Asian Hawaiian Black/African American White

Additional Information:

Email Address: _____

Pharmacy: _____ City/State: _____

Please list anyone you authorize us to speak with regarding your medical information (results,refills,appts,etc.):

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

FINANCIAL RESPONSIBILITY: You are responsible to supply our staff with your insurance ID cards. It will automatically file the claim for you; h responsible for any deductible or co-pay due at the time of service as described by your insurance policy. If any of the procedures performed her under your plan, you will be financially responsible for full payment. You hereby guarantee payment in full to Sovereign Medical Group for all cha rendered and/or charges exceeding third party payments (except when prohibited by law or under contract). You also authorize Sovereign Medic to government agencies insurance carriers and others who may be financially liable for the services, all information necessary to pre-authorize s medical necessity and/or the extent or amount of liability and challenge denials of medical necessity. You hereby assign all amounts payable for Sovereign Medical Group. You understand that this constitutes a waiver of confidentiality under 42 C > F.R. part 2 (drug and alcohol records) an seq. (FTW and AIDS records) and that this authorization is revocable, except to the extent that action has been taken in reliance thereon and wil force indefinitely in order to effectuate the purpose for which it is given. It is your responsibility to understand which insurance plans SMG particip your responsibility. Your insurance policy is a contract between you and your insurance company. Our office is not a part of the contract. We are claim for you directly with you insurance company; however, the ultimate responsibility for payment is yours. You certify that the information give for payment under the Title XVIII of the Social Security Act is correct. You authorize any holder of medical or other information to release to the S Administration or its intermediaries or carries the information necessary for this or related to the Medicare claim. You request that payment of au made on your behalf; You hereby request and consent to, examination and treatment (including lab procedures, diagnostic and medical/surgical) Sovereign Medical Group and their associates. You also consent to the removal of specimens taken by lab or pathology examination. It is your r understand which lab your insurance company affiliates with. Our office will not be held liable for services rendered to you by a non-participating check, money order, and credit cards. There is a $25.00 fee for any returned check. Please be aware in the event your bill remains unpaid, we a collection agency and you will be responsible for all costs associated with the process. Do not hesitate to call our office with any billing questions (201) 703-5500. PLEASE NOTE: IF YOU DO NOT SHOW FOR YOUR SCHEDULED APPOINTMENT(S) WITHOUT CALLING THE OFFICE TO CANCEL/RESCHEDULE, YOU WILL BE CHARGED $25. **I certify that I have read this form and understand its contents. I also acknowled have been made to me as to the results of exams or treatment.**

_____ _____

Patient Signature Date

Medical History:

Reason for today's visit: _____

Height: _____ Weight: _____

Location of pain: _____ Duration of problem (pain): _____ Quality of pain: ☐ Sharp ☐ Burning ☐ Dull ☐ A

Please rate the severity of your pain: ☐ Mild ☐ Moderate ☐ Severe

Please list all current medications, vitamins, supplements you are taking:

_____

_____

_____

Do you have any allergies to medications/food: ◻ No ◻ Yes If yes , please list: _____

_____

Please list past surgeries/hospitalization(s):

_____

_____

Family History:

Mother: ◻ Alive ◻ Deceased ◻ Diabetes ◻ Hypertension ◻ Heart Disease ◻ Stroke ◻ Mental Illne:

Father: ◻ Alive ◻ Deceased ◻ Diabetes ◻ Hypertension ◻ Heart Disease ◻ Stroke ◻ Mental Illne:

Siblings: ◻ Alive ◻ Deceased ◻ N/A Children: ◻ Alive ◻ Deceased ◻ N/A

Do you smoke cigarettes, cigars, and/or chew tobacco? ◻ No ◻ Yes Quantity per day: _____

Did you used to smoke? ◻ No ◻ Yes If yes, how long ago did you quit: _____

Have you had an alcoholic beverage in the past year? ◻ No ◻ Yes

If yes, how often did you have an alcoholic beverage within the past year?

◻ Never ◻ Monthly or Less ◻ 2-4x a month ◻ 2-3x a wk ◻ 4 + times a week

If yes, how many drinks did you have on a typical day when you were drinking in the past year? ◻ 1-2 ◻ 3-4 ◻ 5-6

If yes, how often did you have 6 or more drinks on one occasion in the past year?

◻ Never ◻ Less than monthly ◻ Monthly ◻ Weekly ◻ Daily or almost daily

Have you ever received a pneumonia vaccine? ◻ No ◻ Yes Approximate date: _____

Have you recently received an influenza vaccine? ◻ No ◻ Yes Approximate date: _____

When was your last mammogram? ◻ N/A Approximate date: _____

When was your last colonoscopy? ◻ N/A Approximate date: _____

PATIENTS AGED 65+ :

Have you had any falls in the past year?

◻ No ◻ One fall with injury ◻ Two or more falls with injury ◻ One fall without injury ◻ Two or more falls without injury

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DIABETIC PATIENTS :

When was your last HGA1C lab test: _____ What was the result: _____

Please circle any of the following issues you've had or currently have:

Constitutional

Recent weight change

Fever

Fatigue

Headaches

Eyes

Eye Disease

Injury

Corrective Lens

Blurred/Double Vision

Glaucoma

Ear/Nose/Mouth/Throat

Hearing Loss/ Ringing in ears

Earaches or drainage

Rhinitis

Nose bleeds

Mouth sores

Bleeding gums

Bad breath /taste

Sore throat/ voice change

Cardiovascular

Angioplasty / Bypass

Palpitations / Arrhythmia

Swelling of extremities

Gastrointestinal

Blood in stool

Loss of appetite

Change in bowel movements

Nausea / Vomiting

Heartburn / Acid Reflux

Diarrhea, bloating, belching

Abdominal pain , peptic ulcer

Genitourinary

Erectile Dysfunction

Frequent urination

Respiratory

Asthma

Spitting up blood

Shortness of breath

Wheezing

Musculoskeletal

Difficulty walking

Joint Pain/Stiffness

Joint Swelling

Muscle Pain / Cramps

Back Pain

Disc Disease

Cold Extremities

Integumentary

Breast pain, lump, discharge

Rash/Itching

Change in skin color

Neurological

Stroke

Frequent headaches

Lightheaded / Dizzy

Seizures

Numbness/Tingling

Tremors

Psychiatric

Insomnia

Memory loss, confusion

Anxiety/Depression

Endocrine

Excessive thirst

Heat/Cold Intolerance

Hormone issues

Thyroid disease

Diabetes

Excessive thirst