Schneider MEDICAL GROUP

SCHNEIDER MEDICAL GROUP, PA
Registration Form Instructions
(Please Print)

Step 1: Download & Save to your computer

Either: Attach to email: info@SchneiderMedicalGroup.com

In order to make the most of your time with the Doctor, please complete the following forms prior to arrival for your initial appointment.

You have several options - STEP 1: download the document to your computer, then:

1. Once you've downloaded and saved the document to your computer; **THEN**:
2. You may **EITHER** print this PDF document by clicking the **RED** button on any page and fill out by hand, and bring it with you to your first appointment;
3. **OR**: You may complete the document online, then print it out by clicking the **RED** button on any page and bring it with you to your first appointment.
4. **OR**: You may complete the document online, save it and attach the completed forms to an email and send to: **info@SchneiderMedicalGroup.com** prior to your first appointment. *Please include your first and last name and appointment date* in both the subject line and the body of the email.

When completing by hand or online:

1. Please fill in as accurately and completely as possible.
2. Required fields are indicated with an "*"
3. If you need to un-select an option, click ***Edit, Undo*** in the main menu at the top of the screen.

If you have questions about the form you may call our office, or leave that question blank until your appointment.

We look forward to seeing you soon.

Schneider Medical Group, PA
(919) 301-8971
info@SchneiderMedicalGroup.com

SCHNEIDER MEDICAL GROUP, PA

Registration Form

(Please Print)

Step 1: Download & Save to your computer

Either: Attach to email: info@SchneiderMedicalGroup.com

PATIENT INFORMATION

LAST NAME*	FIRST NAME*	MIDDLE NAME

ADDRESS*	CITY*	STATE*	ZIP*

HOME PHONE*	WORK PHONE	CELL PHONE	EMAIL

DOB MM/DD/YYYY*	AGE	SOCIAL SECURITY #	MARITAL STATUS	GENDER

PATIENT EMPLOYMENT INFORMATION

CURRENT EMPLOYER	OCCUPATION	EMPLOYER PHONE #

ADDRESS	CITY	STATE	ZIP

PRIMARY CARE PHYSICIAN

NAME/PRACTICE/PHONE*	ADDRESS	CITY	STATE/ZIP

IN CASE OF EMERGENCY

NAME*	RELATIONSHIP*	HOME OR CELL #*	WORK #

ADDRESS	CITY	STATE	ZIP

REFERRAL INFORMATION

PLEASE SELECT ALL THAT APPLY		PLEASE PROVIDE NAME OR DETAIL
	FAMILY/FRIEND	
	PRIMARY CARE PHYSICIAN	
	WORK	
	OUR WEBSITE	
	FACEBOOK	
	ONLINE SEARCH	
	PRINT PUBLICATION	
	OTHER	

AUTHORIZATION SIGNATURE

The above information is true to the best of my knowledge. I understand that I am financially responsible for the fee. I also authorize Schneider Medical Group, PA information required to process my claims; when I submit it.

PATIENT/GUARDIAN SIGNATURE	DATE MM/DD/YYYY

HIPPA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, / 45 C.F.R. Parts 160 and 164)

Step 1: Download & Save to your computer

Either: Attach to email: info@ SchneiderMedicalGroup.com

1. Authorization

I authorize SCHNEIDER MEDICAL GROUP, PA to use and disclose the protected health information described below to

.

(Individual seeking the information)

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. period to (dates MM/DD/YYYY)

OR

b. all past, present, and future periods.

3. Extent of Authorization

a. I authorize the release of my complete health record (including records relation to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. I authorize the release of my complete health record with the exception of the following information:

Mental health records

Communicable diseases (including HIV and AIDS)

Alcohol/drug abuse treatment

Other (please specify):

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, i writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative

Printed name of patient or personal representative and is or her relationship to patient

Date

SCHNEIDER MEDICAL GROUP, PA
Reason for Visit and History
(Please Print)

Step 1: Download & Save to your computer

Either: Attach to email: info@SchneiderMedicalGroup.com

Briefly State the reason for the visit:

Physician Use Only - History and Present:

1. ______________________________

2. ______________________________

3. ______________________________

4. ______________________________

5. ______________________________

Step 1: Download & Save to your computer

Either: Attach to email: info@SchneiderMedicalGroup.com

SCHNEIDER MEDICAL GROUP, PA

Past Medical History

(Please Print)

HEAD	NO	YES	EXPLAIN
Eyes			
Blindness			
Cataracts			
Glaucoma			
Wear Glasses			
EARS	**NO**	**YES**	**EXPLAIN**
Hearing aids			
Nose Sinuses			
Allergic rhinitis			
Sinus infections			
MOUTH/THROAT/TEETH	**NO**	**YES**	**EXPLAIN**
Dentures			
CARDIOVASCULAR	**NO**	**YES**	**EXPLAIN**
Aneurysm			
Angina			
DVT			
Dysrhythmia/irregular heart rhythm			
Hypertension			
Murmur			
Myocardial infarction			
Other Heart disease			
RESPIRATORY	**NO**	**YES**	**EXPLAIN**
Asthma			
Bronchitis/emphysema			
Pleuritic			
Pneumonia			

Step 1: Download & Save to your computer

Either: Attach to email: info@SchneiderMedicalGroup.com

SCHNEIDER MEDICAL GROUP, PA
Past Medical History
(Please Print)

GASTROINTESTINAL	NO	YES	EXPLAIN
Cirrhosis			
GERD			
Gallbladder disease			
Heartburn			
Hemorrhoids			
Hepatitis			
Hiatal hernia			
Jaundice			
Ulcer			
GENITOURINARY	**NO**	**YES**	**EXPLAIN**
Hernia			
Incontinence			
Nephrolithiasis			
Other Kidney disease			
STDs			
UTIs			
MUSCULOSKELETAL	**NO**	**YES**	**EXPLAIN**
Arthritis			
Gout			
Musculoskeletal injury			
Fibromyalgia			
SKIN	**NO**	**YES**	**EXPLAIN**
Dermatitis			
Moles			
Other Skin Conditions			
Psoriasis			
Eczema			

Step 1: Download & Save to your computer

Either: Attach to email: info@SchneiderMedicalGroup.com

SCHNEIDER MEDICAL GROUP, PA
Past Medical History
(Please Print)

NEUROLOGICAL	NO	YES	EXPLAIN
Epilepsy			
Seizures			
Severe headaches, migraines			
Stroke			
TIA			
ENDOCRINE	**NO**	**YES**	**EXPLAIN**
Goiter			
Hyperlipidemia			
Hypothyroidism			
Thyroid disease			
Thyroiditis			
Diabetes mellitus type 1			
Diabetes mellitus type 2			
HEME/ONC	**NO**	**YES**	**EXPLAIN**
Anemia			
Cancer			
INFECTIOUS	**NO**	**YES**	**EXPLAIN**
HIV			
STDs			
Tuberculosis (diagnosis)			
Tuberculosis (expossure)			
CUSTOM ITEMS	**NO**	**YES**	**EXPLAIN**
Irritable bowel syndrome			
Obesity			
Skin cancer			
Colitis			
Colon polyps			
Rare cancer			
Other			

Step 1: Download & Save to your computer

Either: Attach to email: info@SchneiderMedicalGroup.com

SCHNEIDER MEDICAL GROUP, PA

Past Surgical History

(Please Print)

COMMON SURGERIES	NO	YES	EXPLAIN
Aneurysm repair			
Appendectomy			
Back surgery			
Bariatric surgery/gastric bypass			
Breast reduction/mastectomy			
CABG (cardio bypass)			
Carotid endarterectomy/stent			
Cesarean section			
Cholecystectomy/bile duct surgery			
D&C			
Hemorrhoid surgery			
Hiparthroplasty			
Hip replacement			
Hysterectomy Complete or partial			
Inguinal hernia repair			
Knee arthroplasty/knee replacement			
Lasik or other eye surgery			
Laminectomy			
Nasal surgery			
PTCA/PCI Cardio stent			
Pacemaker/defibrillator			
Prostrate surgery/biopsy			
TURP (prostate surgery)			
Rotator cuff surgery			
Sinus surgery			
Skin cancer excision/removal			
Spinal fusion			
TAH-BSO/complete hysterectomy			
Tonsillectomy/Adenoidectomy			
Vasectomy			

Step 1: Download & Save to your computer

Either: Attach to email: info@ SchneiderMedicalGroup.com

SCHNEIDER MEDICAL GROUP, PA
Lifestyle History
(Please Print)

ALCOHOL	NO	YES	TYPE/AMOUNT/HOW OFTEN/HOW MANY YEARS
Do not drink			
Drink daily			
Frequently drink			
History of alcoholism			
Occasional drink			
DRUG ABUSE	**NO**	**YES**	**TYPE/AMOUNT/HOW OFTEN/HOW MANY YEARS**
IV drug use			
Illicit drug use			
No illicit drug use			
CARDIOVASCULAR	**NO**	**YES**	**TYPE/AMOUNT/HOW OFTEN/HOW MANY YEARS**
Eat healthy meals			
Regular exercise			
Take daily aspirin			
SAFETY	**NO**	**YES**	**TYPE/AMOUNT/HOW OFTEN/HOW MANY YEARS**
Household smoke detector			
Keep firearms in the home			
Wear seat belts			
SEXUAL ACTIVITY	**NO**	**YES**	**TYPE/AMOUNT/HOW OFTEN/HOW MANY YEARS**
Exposure to STI			
Homosexual encounters			
Not sexually active			
Safe sex practices			
Sexually active			
TOBACCO/VAPOR NICOTINE	**NO**	**YES**	**PACK PER DAY/HOW MANY YEARS**
Current every day smoker			
Current occasional smoker			
Former smoker			
Heavy tobacco smoker			
Light tobacco smoker			
Never smoked			
Smoker, current status unknown			
Unknown if ever smoked			

Step 1: Download & Save to your computer

Either: Attach to email: info@ SchneiderMedicalGroup.com

SCHNEIDER MEDICAL GROUP, PA

Family History

(Please Print)

GENERAL	NO	YES	RELATIONSHIP	ALIVE (AGE)	DECEASED (AGE)
No health concerns					
Arthritis					
Asthma					
Bleeding disorder					
CAD less than age 55					
COPD					
Diabetes					
Heart attack					
Heart disease					
High cholesterol					
Hypertension					
Mental illness					
Osteoporosis					
Stroke					
CANCER			**RELATIONSHIP**	**ALIVE (AGE)**	**DECEASED (AGE)**
Breast cancer					
Colon cancer					
Ovarian cancer					
Uterine cancer					
Other cancer					

Step 1: Download & Save to your computer

Either: Attach to email: info@SchneiderMedicalGroup.com

Schneider MEDICAL GROUP

SCHNEIDER MEDICAL GROUP, PA

Hospitalization and Procedures History

(Please Print)

HOSPITALIZATION	REASON	APPROXIMATE Month/Day/Year
PROCEDURES	**REASON**	**APPROXIMATE Month/Day/Year**

Step 1: Download & Save to your computer

Either: Attach to email: info@SchneiderMedicalGroup.com

SCHNEIDER MEDICAL GROUP, PA

Preventive Test

(Please Print)

PHYSICAL EXAM	NO	YES	DATE TEST	LAST TEST
Physical exam				
Bone density				
Colonoscopy				
Cardiac stress test				
EKG				
Hem occult test or stool for blood				
Flu shot				
Pneumovax 23 pneumonia vaccine				
Prevnar 13 pneumonia vaccine				
Zostavax or shingles vaccine				
Hepatitis C screen				
HIV screen				
Mammogram				
Pelvic and Pap smear				
Rectal exam				
PSA				

Step 1: Download & Save to your computer

Either: Attach to email: info@SchneiderMedicalGroup.com

SCHNEIDER MEDICAL GROUP, PA
Medications History
(Please Print)

PRESCRIPTION MEDICATIONS	DOSE	TIMES PER DAY	STARTED
SUPPLEMENTS	**DOSE**	**TIMES PER DAY**	**STARTED**
OTC (OVER THE COUNTER)	**DOSE**	**TIMES PER DAY**	**STARTED**

SCHNEIDER MEDICAL GROUP, PA

Vaccines & Immunizations

(Please Print)

IMMUNIZATION	DATE
Tetanus-diphtheria; Tetanus-Diphtheria-Pertussis (TD/Tdap)	
Pneumococcal Vaccine - Pneumoax 23, Prevnar 13	
Influenza TIV LAIV	
Hepatitis A and B	
Measles/Mumps/Rubella (MMR)	
Varicella (Chickenpox)	
Homophiles Influenza Type B (Hib)	
Human Papillomavirus (HPV) Vaccine	
Tuberculosis (TB), TB skin test	
Typhoid	
Zostavax (Shingles Vaccine)	
YOUR BLOOD TYPE	