Robert J Bloomberg, MD * Joshua Bloomberg, DO * Sami Zamani, DO
Bradley Gonik, MD * Shu Hsieh, NP * Brittany West, PA-C

New Patient Registration Form

First Legal Name: ___________________________ Middle Initial: _____ Last Name: ___________________

Date of Birth: ____/____/_______ Gender: ________ SSN: _______-_____-________

Home Phone: (______) ______-_________ Cell Phone: (_______) _______-_________

**Email: _____________________________________ Address: _____________________________________

Apt: ____________ City: __________________ State: __________ Zip: _______________

Primary Language spoken: _____________________ **Emergency Contact**: ___________________________

Relation: ______________________________ Phone: (______) ________-__________

Race: ____ African American/Black _____ American Indian/Alaska Native ____ Asian _____ Caucasian/White

_____ Hispanic/Latino _____ Middle Eastern ______ Pacific Islander/Hawaiian _____ Other _____ Declined

Ethnicity: _____ Hispanic/Latino ______ Non-Hispanic/Latino _____ Unknown _____ Declined

Financial Policies

1. Patient insurance responsibility: I understand that as a patient, I am responsible for fully understanding my health insurance policy, including co-pay, deductible, benefits and coinsurance related costs. I understand that any applicable co-pay or deductible amount will be due upon check-in. We strive to be as accurate as possible when calculating your responsibility but with so many variations in policies and fee schedules, we are not always exact. **Initials _______**
2. Financial policy: I understand that I am financially responsible for any co-pay, deductible, coinsurance, and charges which are not covered by my insurance. I understand that verification of coverage is not guarantee of payment of benefits. My insurance company determines benefit payments. **Initials ______**
3. Forms: I understand there will be an additional $85 charge for forms deemed appropriate (FMLA, Disability, etc.) that need to be filled out by a provider without an appointment. **Initials _______**
4. Non-sufficient funds: I understand there will be a $35 charge for any check returned due to non-sufficient funds. **Initials _____**
5. Collection policy: I understand that I may be turned over to collections for further processing if a payment has not been made on my account in 90 days. **No additional appointments will be made on delinquent accounts until they are current**. In the event that my account is transferred to a licensed collection agency, I agree to pay the fees of the collection agency equal to a maximum of 50% of the outstanding balance at the time the account is placed with the collection agency; interest of 10% per

year will be accrued on the principal balance. Should legal action be necessary to collect the account, I agree to pay attorney fees and court costs incurred for collection. **Initials _____**

6. Specimen handling: Any specimens collected in-house will be sent to a contracted lab based on the health insurance provided by you at time of service. Specimens may be split and sent to different facilities as needed. Specimens are collected and tested to determine diagnosis and treatment, which are considered medically necessary, we cannot guarantee that your health plan will cover the service. While we make every effort to use the proper medical coding, coverage is ultimately determined by your health plan. **Initials _______**
7. No-show/Late Cancellation Appointments: I understand there will be a $50 no-show charge for any appointment not kept, including same day cancellations without rescheduling. **Initials _____**

I acknowledge that this office makes every attempt to verify your insurance is active and that the provider you are seeing is in-network, but ultimately, it is my responsibility as a patient to confirm my insurance status. I am responsible for determining my own benefits and coverage for all services. I am responsible for all medical charges that are not covered by insurance. By signing below, I authorize appropriate examination and treatment for problems identified on this and subsequent visits. A copy of our Notice of Privacy Practices is available for you at the front desk if you would like one. By signing below, I acknowledge it has been made available to me.

Print Full Name: ____ DOB: __________________

Signature: ____ Date: ___________________

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Health Information Exchange

Your healthcare provider participates in a non-profit, non-governmental health information exchange (HIE) called Health Current. It will not cost you anything and it can help your doctor, healthcare providers, and health plans better coordinate your care. It allows your providers to securely access your health records.

The following types of health information may be available:

- Hospital records
- Medical History
- Medications
- Allergies
- Lab test results
- Radiology reports
- Clinic and doctor visit information
- Health plan enrollment and eligibility
- Other Information helpful for your treatment

By signing below, I acknowledge I have received, read, and understand the Notice of the Health Information Practices regarding my provider's participation in the statewide Health Information Exchange (HIE), or that I have previously received this information and decline another copy.

My signature here provides consent to share my information on the HIE.

Full Name: ____ DOB: _______________

Signature: ____ Date: _______________

If you would like to opt-out of the HIE, please ask the front desk for a specific opt-out form.

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Medical Information Release Form

Full Name: ______________________________________ Date of Birth: _____/_____/_______

Release of Information

_____ I authorize the release of information including all medical diagnoses, records, visit notes and claim information. This information may be released to:

Name: ___________________________ Relationship: _______________ Phone: __________________

Name: ___________________________ Relationship: _______________ Phone: __________________

Name: ___________________________ Relationship: _______________ Phone: __________________

Name: ___________________________ Relationship: _______________ Phone: __________________

Name: ___________________________ Relationship: _______________ Phone: __________________

Name: ___________________________ Relationship: _______________ Phone: __________________

______ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Signed: ____ Date: ____/_____/______

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Medical History Intake Form

Please complete all sections to help us provide you and your family with the best healthcare.

Last Name:	First Name:	MI:	DOB:	Visit Date:

Medications:

Please list all medications you take. Prescription and non-prescription and their dosage information.

____ No Medications

Medication: Ex. Lisinopril	Dosage: 30mg	SIG: Take 1 tab orally daily
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		

Medication/Food/Environmental Allergies

Please list all allergies

Allergy	Severity	Reaction
1.		
2.		
3.		
4.		
5.		
6.		
7.		

PREMIER MEDICAL GROUP

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Pharmacy

1. Pharmacy Name ________________________________ Phone: ____________________

   Address ____

2. Pharmacy Name ________________________________ Phone: ____________________

   Address ____

Past Medical History

Please indicate any medical conditions and date of experience.

Condition	Date of experience

Past Surgical History

Surgery Type	Date/Year

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Family History

Please check if any family member has had any of the following conditions or select adopted/unknown.
____ Adopted or Unknown

Condition	Mother	Father	Brother	Sister	Maternal Grandma	Maternal Grandpa	Paternal Grandmother	Paternal Grandfather	Cause of Death
ADD/ADHD									
Alcoholism									
Allergies									
Alzheimer's									
Asthma									
Blood disease									
Heart disease									
Cancer Type:									
Depression									
Developmental delay									
Diabetes Type:									
Eczema									
Hearing loss									
High cholesterol									
Hypertension									
Inflammatory bowel disease									
Kidney disease									
Learning disability									
Migraines									
Obesity									
Osteoporosis									
Peripheral vascular disease									
Seizure/Epilepsy									
Stroke									
Heart Attack									
Other:									

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Social History

1. Do you use tobacco?

   ______ Yes, type of tobacco used: ____________________

   ______ No

   ______ Former

   Packs per day? _________ Years smoked? ________ Year quit: _________

2. Do you drink caffeine:
   ______ Yes, Amount daily? ________________________
   ______ No
3. Do you drink alcohol?
   ______ No
   ______ Yes, Amount: _______________________ Frequency: ____________________
   How much per week? ______________________ Last Drink: ______________________
   Year quit: ___________

4. Do you give permission to receive blood transfusion if medically necessary? ______ (Y/N)

Health Maintenance

Test Name	**Yes/No**	**Date of Last**
Lipid panel		
Stool card/IFOBT		
Last physical		
Colonoscopy		
Sigmoidoscopy		
Influenza vaccine		
Pneumococcal vaccine		
Covid-19 vaccine		
RSV vaccine		
Tetanus vaccine		
Dexa bone density scan		
GYN exam		
Pap		
Mammogram		
Breast exam		

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Other Providers/Past Primary Care Provider

Provider Name	Specialty	Phone

Print name: ____ DOB: __________________

Signature: ____ Date: __________________