

**SPRING MEDICAL ASSOCIATES  
PATIENT REGISTRATION FORM (eCW)**

**PATIENT INFORMATION**

(Please print)

Patient's Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ DOB: \_\_\_\_\_

Sex:  Female  Male  Transgender

Race:  American Indian/Alaska Native  Asian  Native Hawaiian/Pacific Islander  
 Black/African American  White  Hispanic  Other  Declined

Language:  English  Spanish  Indian: Hindi, etc.  Japanese  Chinese  Korean  French  German  Russian  Other

Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Declined

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION (If not self)**

(Information used for patient balance statements)

Responsible party:  Another patient  Guarantor  Self Check here if address and telephone information is same as patient

Responsible party name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Date of birth: MM \_\_\_\_/DD \_\_\_\_/YYYY \_\_\_\_ Sex:  Female  Male

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Phone number: \_\_\_\_\_

Address: \_\_\_\_\_

City, State: \_\_\_\_\_ ZIP: \_\_\_\_\_

**INSURANCE INFORMATION:** Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

**EMERGENCY CONTACT INFORMATION**

Emergency contact name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_

Phone number: \_\_\_\_\_ Do you have a living will?  Yes  No

Emergency contact relationship to patient: \_\_\_\_\_  Guardian

Address \_\_\_\_\_

City, State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work home: \_\_\_\_\_ Ext. \_\_\_\_\_

**GENERAL CONSENT FOR CARE AND TREATMENT CONSENT**

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative: \_\_\_\_\_ Date: \_\_\_\_\_

Printed name of patient or personal representative: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

## Health History

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Reason for visit today: \_\_\_\_\_

Do you smoke?  Yes  No If yes, how many packs per day? \_\_\_\_\_

Have you ever smoked?  Yes  No If yes, when did you quit? \_\_\_\_\_

Do you use alcohol?  Yes  No If yes, how many drinks per week? \_\_\_\_\_

Do you or have you used the following in the last three months?  Marijuana  Cocaine  Heroin  Crack  Methamphetamine

### Are you allergic to any medications? Yes or No (If yes, please list.)

Current Medications	Dosage

Previous Surgery	Date

**Have you ever had any of the following? Circle all that apply:** Asthma Stomach Problems Bladder problems Jaundice-Liver Gout Alcoholism Kidney Disease Prostate Skin Disease Joint Disease Stroke Epilepsy-Seizures Depression-Anxiety Thyroid Blood Clot High Blood Pressure Tuberculosis Diabetes Cancer Lung Disease Heart Disease Psychiatric Disorder

**Do any of these conditions run in your family? Circle all that apply:** Alcoholism Addiction Joint Disease Stroke Blood Clots Diabetes Psychiatric Disorder Heart Disease

### Primary care physician information:

Name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Address: \_\_\_\_\_

### Pharmacy information:

Name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Address: \_\_\_\_\_

### How did you hear about us? Circle any that apply:

Website      Family/Friend      Internet Search

Former or current patient (please provide name so we can thank them!) \_\_\_\_\_

Physician (please specify): \_\_\_\_\_

Other Healthcare facility (please specify): \_\_\_\_\_

Insurance Network (please specify): \_\_\_\_\_

Other (specify): \_\_\_\_\_

**SPRING MEDICAL ASSOCIATES**

Patient name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

**Patient Consent for Financial Communications**

**Financial Agreement**

- I acknowledge, that as a courtesy, SPRING MEDICAL ASSOCIATES may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

**Third Party Collection.** I acknowledge SPRING MEDICAL ASSOCIATES may use the services of a third-party business associate or affiliated entity as an extended business office (“EBO Servicer”) for medical account billing and servicing.

**Assignment of Benefits.** I hereby assign to SPRING MEDICAL ASSOCIATES any insurance or other third-party benefits available for health care services provided to me. I understand SPRING MEDICAL ASSOCIATES has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to SPRING MEDICAL ASSOCIATES, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

**Medicare Patient Certification and Assignment of Benefit.** I certify that any information I provide, if any, in applying for payment under Title XVIII (“Medicare”) or Title XIX (“Medicaid”) of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to SPRING MEDICAL ASSOCIATES by the Medicare or Medicaid program.

**Consent to Telephone Calls for Financial Communications.** I agree that, in order for SPRING MEDICAL ASSOCIATES, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that SPRING MEDICAL ASSOCIATES or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or SPRING MEDICAL ASSOCIATES or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

**Patient/patient representative signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If you are not the patient, please identify your relationship to the patient. Circle or mark relationship(s) from list below:

- |                |                              |
|----------------|------------------------------|
| Spouse         | Guarantor                    |
| Parent         | Healthcare Power of Attorney |
| Legal Guardian | Other (please specify) _____ |