



**Southwest General  
Medical Group, Inc.**  
Family Practice

# Southwest General Medical Group, Inc.

## Patient Registration Form

Patient Acct #M: \_\_\_\_\_

PATIENT	Patient's Name: Last			First (legal):			Middle Initial:		
	Address:								
	City:			State:			Zip:		
	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female			Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed					
	SSN#:			Birthdate:			Age:		
	Home Phone #:			Cellular #:			Work #:		
	Ext:			Employer:			Email Address:		
	Can a message be left at your home? <input type="checkbox"/> Yes <input type="checkbox"/> No Left on your answering machine? <input type="checkbox"/> Yes <input type="checkbox"/> No								
	<b>Race</b> <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Alaskan Native-American Indian <input type="checkbox"/> More than one race <input type="checkbox"/> Unreported/Refused			<b>Ethnicity</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non Hispanic <input type="checkbox"/> Unreported / Refused			<b>Student:</b> <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Not Attending		
				<b>Preferred Language :</b>			<b>How would you like to get notification of preventative reminders</b> <input type="checkbox"/> US Mail <input type="checkbox"/> Phone		
	Preferred Local Pharmacy:								
	Preferred Mail Order Pharmacy:								
	Emergency Contact:								
	Relationship to Patient:			Home Phone: ( )			Cell Phone: ( )		
	<b>* Please present your insurance card to the receptionist so that a copy can be made for our records*</b>								
INSURANCE	Primary Insurance: _____ ID# _____ Group # _____								
	Subscriber's Name: _____ DOB _____ SSN _____								
	Relation to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Guardian <input type="checkbox"/> Other								
	Employer Name: _____								
	Secondary Insurance _____ ID # _____ Group # _____								
	Subscriber's Name: _____ DOB: _____ SSN: _____								
Relation to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Guardian <input type="checkbox"/> Other									
FINANCE	Insured / Responsible Party (who is responsible for payment)								
	Name Last:			First (legal)			Middle Initial:		
	Address ( if different than patient)								
	City:			State:			Zip:		
	SSN#:			Birth date:					
	Phone #:			Relation to patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Guardian <input type="checkbox"/> Other					

### Authorization for Treatment and Financial Disclosure

I authorize SGMG, INC physicians to release any information that may be necessary to comply with subpoenas, governmental regulations and laws. I also authorized this physician to release the following parties, any information they request from the physician: Medicare and/or insurer. For physician services provided to me, I assign to the physician all insurance or other payments made by other for my physician services. I request that payment of authorized benefits be made either to me or on my behalf to the above provider for services furnished by that physician. I authorize release to the indicated insurance carrier any medical information about me needed to determine these payments for related services.

I understand that I am responsible for payment of all bills for any services provided by an SGMG physician. If I do not provide the name of an insurance company or other party obligated to pay my bills, I will provide the physician with personal credit information and cooperate with physicians in establishing plan for payment of my physician services.

\_\_\_\_\_  
Patient or Responsible Party Signature

\_\_\_\_\_  
Date

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Last Physical Exam date: \_\_\_\_\_  
 Previous Physician: \_\_\_\_\_

Below are a number of questions concerning possible present symptoms and / or past medical history. Please answer the questions as accurately as possible. This will enable us to become completely familiar with your medical history as well as enable us to expedite proper medical services to you. This is a confidential record of your medical history and will not be released to anyone without your prior consent.

<b>List all past medical conditions:</b> _____ _____ _____	SOCIAL HISTORY			
	Do you:	Yes	No	Daily consumption
	Use tobacco			packs
	Drink coffee			cups

Alcohol			servings
Hard liquor / wine consumption			servings

Operations / Hospitalization	Yes	No	Date
Tonsils			
Appendix			
Gall Bladder			
Stomach			
Kidney			
Colon			
Thyroid			
Hernia			
Uterus (women)			
Ovaries (women)			
Prostate (man)			
Joint Replacement			
Pregnancy / C-Section			
Other:			

Other information:  
 Have you received a blood or plasma transfusion  Y  N  
 Substance abuse:  Y  N

**IMMUNIZATION (check those you have had and please note year):**  
 Tetanus  Pneumonia  Hepatitis B  
 Chicken Pox  Childhood Immunization(s)  
 Other: \_\_\_\_\_

FAMILY HISTORY						
Living			Health Problems			
Age	Health			Age at death	Health Problems Cause of Death	
	Good	Fair	Poor			
	Father					
	Mother					
	Brother(s)					
	Sister(s)					

<b>Female Only Menstrual History:</b> Onset at age: _____ Days of flow: _____ Length of cycle: _____ Number of pregnancies: _____ Last mammogram (date): _____ Last Pap / Pelvic / Breast exam (date): _____	<b>Please ✓ box below and list blood relative next to illness:</b> <input type="checkbox"/> Anemia _____ <input type="checkbox"/> Heart Disease _____ <input type="checkbox"/> Arthritis _____ <input type="checkbox"/> High Blood Pressure _____ <input type="checkbox"/> Asthma _____ <input type="checkbox"/> Stroke _____ <input type="checkbox"/> Cancers _____ <input type="checkbox"/> Thyroid Disease _____ <input type="checkbox"/> Depression / Suicidal _____ <input type="checkbox"/> Tuberculosis _____ <input type="checkbox"/> Uncontrolled Bleeding _____ <input type="checkbox"/> Diabetes _____ <input type="checkbox"/> Ulcer _____ <input type="checkbox"/> Epilepsy _____ <input type="checkbox"/> Other: _____
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<b>List below all medications you are presently taking (including birth control and diet pills).</b> _____ _____ _____	<b>Doctor's Use Only – Summary:</b> _____ _____ _____
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<b>List all allergies to medications:</b> _____ _____ _____	
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Have you had problems with any of the following within the **PAST** year?

<p><b>General</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Weight Loss or Gain</li><li><input type="checkbox"/> Fever</li><li><input type="checkbox"/> Trouble Sleeping</li><li><input type="checkbox"/> Chronic Fatigue</li><li><input type="checkbox"/> Excessive Bleeding</li><li><input type="checkbox"/> Easy Bruising</li><li><input type="checkbox"/> Abnormal Thirst</li></ul> <p><b>Eyes</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Itchy, Red eyes</li><li><input type="checkbox"/> Vision Problems</li></ul> <p><b>Ears</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Ear Pain</li><li><input type="checkbox"/> Ringing in Ears</li><li><input type="checkbox"/> Hearing Loss</li></ul> <p><b>Nose</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Sinus Problems</li><li><input type="checkbox"/> Nose Bleeds</li></ul> <p><b>Mouth</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Sore Throat</li><li><input type="checkbox"/> Mouth Sores</li><li><input type="checkbox"/> Dental Problems</li></ul> <p><b>Lungs</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Coughing up Blood</li><li><input type="checkbox"/> Shortness of Breath</li><li><input type="checkbox"/> Chronic Cough</li><li><input type="checkbox"/> Blood Clot in Lungs</li><li><input type="checkbox"/> Painful Breathing</li><li><input type="checkbox"/> Wheezing</li></ul> <p><b>Cardiovascular</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Chest Pain</li><li><input type="checkbox"/> Irregular Heart Beat</li><li><input type="checkbox"/> Ankle or Hand Swelling</li></ul> <p><b>Gastrointestinal</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Frequent Diarrhea</li><li><input type="checkbox"/> Constipation</li><li><input type="checkbox"/> Blood Stools</li><li><input type="checkbox"/> Nausea / Vomiting</li><li><input type="checkbox"/> Hemorrhoids</li></ul>	<p><b>Urinary</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Incomplete Urination</li><li><input type="checkbox"/> Loss of Urine</li><li><input type="checkbox"/> Painful Urination</li><li><input type="checkbox"/> Bloody Urine</li></ul> <p><b>Musculoskeletal</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Muscle Weakness</li><li><input type="checkbox"/> Joint Pains</li><li><input type="checkbox"/> Joint Swelling</li><li><input type="checkbox"/> Clot in Leg Vein</li></ul> <p><b>Neurologic</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Frequent / Severe Headaches</li><li><input type="checkbox"/> Dizziness</li><li><input type="checkbox"/> Seizures</li><li><input type="checkbox"/> Numbness</li><li><input type="checkbox"/> Trouble Walking</li><li><input type="checkbox"/> Fainting Spells</li></ul> <p><b>Skin</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Acne</li><li><input type="checkbox"/> Unwanted Hair Growth</li><li><input type="checkbox"/> Unusual Lump or Growth</li><li><input type="checkbox"/> Dry Skin</li></ul> <p><b>Emotional</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Excessive Worry</li><li><input type="checkbox"/> Depression</li><li><input type="checkbox"/> Frequent Crying</li><li><input type="checkbox"/> Serious Thoughts of harming yourself or others</li></ul> <p><b>Menstrual Problems</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Cramps / Pain</li><li><input type="checkbox"/> Heavy Bleeding</li><li><input type="checkbox"/> Too Frequent Periods</li><li><input type="checkbox"/> Bleeding Between Periods</li><li><input type="checkbox"/> Missed a Period</li><li><input type="checkbox"/> Other Period Issues</li></ul>	<p><b>Pre-Menstrual Problems</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Bloating / Swelling</li><li><input type="checkbox"/> Mood Changes</li><li><input type="checkbox"/> Breast Changes</li><li><input type="checkbox"/> Headaches</li><li><input type="checkbox"/> Acne</li><li><input type="checkbox"/> Other PMS Issues</li></ul> <p><b>Menopause Issues</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Hot Flashes</li><li><input type="checkbox"/> Night Sweats</li></ul> <p><b>Breast Problems</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Breast Pain</li><li><input type="checkbox"/> Breast Lump</li><li><input type="checkbox"/> Nipple Discharge</li><li><input type="checkbox"/> Other Breast Issues</li></ul> <p><b>Other Gynecologic Issues</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Vaginal Discharge</li><li><input type="checkbox"/> Itching / Irritation</li><li><input type="checkbox"/> Vulvar Pain</li><li><input type="checkbox"/> Vulvar Lumps / Growth</li><li><input type="checkbox"/> Vulvar Sores</li></ul> <p><b>Sexual Problems</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Painful Intercourse</li><li><input type="checkbox"/> Bleeding after Intercourse</li><li><input type="checkbox"/> Decreased Desire</li><li><input type="checkbox"/> Orgasm Problems</li><li><input type="checkbox"/> Dryness</li><li><input type="checkbox"/> Possible Exposure to STD</li><li><input type="checkbox"/> Other Sexual Issue</li></ul> <p><b>Would you like to discuss any of the following?</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Contraception</li><li><input type="checkbox"/> Menopause Issues</li><li><input type="checkbox"/> Pregnancy Issues</li><li><input type="checkbox"/> Self Breast Exam</li><li><input type="checkbox"/> Sexuality Issues</li><li><input type="checkbox"/> STD's</li><li><input type="checkbox"/> Other</li></ul>
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**Other (please explain):**

**Doctor's Use Only – Summary:**

# Southwest General Medical Group, Inc.

## General Consent for Treatment and Release of Medical Information

Date of Birth: \_\_\_\_\_ I, \_\_\_\_\_  
First Name M.I. Last Name

Southwest General Medical Group, Inc. (SGMG) is a multi-specialty group practice. I have received care from one or more SGMG physicians and I hereby voluntarily give my consent to SGMG to provide such diagnostic and medical treatment as deemed necessary.

I authorize SGMG to release any information that may be necessary to comply with subpoenas, governmental regulations and laws. I also authorize SGMG to release to the following parties, any information they request from SGMG regarding treatment I received from any SGMG physician:

- Any insurance company that may be obligated to pay my physician bills
- Medicare or Medicaid (if applicable)
- Any other party who may be obligated to pay my physician bill (example: An employer or HMO)
- Any agent, independent contractor, intermediary or other party who is obtaining information at the request of or for the benefit of any of the foregoing parties

For physician services provided to me, I assign to my SGMG physician and SGMG all insurance or other payments made by other for my physician services. This simply means that any insurance company or other party obligated to pay my physician bills may pay the physician or SGMG directly.

I understand that I am responsible for payment of all bills for any service provided by SGMG physicians. If I do not provide the name of an insurance company or other party obligated to pay my bills, I will provide the physician with personal credit information and cooperate with SGMG in establishing a plan for payment of my physician services.

\_\_\_\_\_  
Patient or Responsible Party Signature

\_\_\_\_\_/\_\_\_\_\_  
Date Time

