

COLUMBIA INTERNAL MEDICINE, LLP
4 SPRINGHURST DRIVE, SUITE 110
EAST GREENBUSH, NY 12144
TELEPHONE NUMBER 518-391-2889 FAX NUMBER 866-677-1065

PATIENT REGISTRATION FORM

DATE _____

Patient Name _____ Sex: M__ F__ Date of Birth _____
Address _____ Birth Place _____
_____ E-mail Address _____
Phone (Home) _____ (Work) _____ (Cell) _____
Social Security # _____ Occupation _____
Employer Name/Address _____
Pharmacy/Phone _____
Marital Status: Single _____ Married _____ Divorced _____ Widow _____ Significant other _____
Name of Spouse _____ Spouse's Date of Birth _____
Spouse's Employer/Address _____
Number of Children _____ Emergency Contact _____ Phone Number _____
How did you hear about our practice? _____

PRIMARY INSURANCE INFORMATION:

Primary Insurance Company/Address/Phone _____
ID# _____ Group# _____
Name of Policy holder (if other than patient) _____
Birth date of Policy holder _____ SS# of Policy Holder _____

SECONDARY INSURANCE INFORMATION:

Secondary Insurance Company/Address/Phone _____
ID# _____ Group# _____
Name of Policy holder (if other than patient) _____
Birth date of Policy holder _____ SS# of Policy Holder _____

OFFICE POLICIES:

1. All refills will be given at the time off an office visit only. Medications will not be called in and between office visits.
2. Failure to show for an appointment without notice, or cancellation with less than 24-hour notice may be subject to a \$25 surcharge.
3. Copay not paid at the time of service may incur \$5 service charge.
4. Balances on accounts not paid in a timely manner may be turned over to a collection agency. There will be a charge for all costs associated with this action including the collection fees.

PRIVACY:

Do we have permission to:

Leave a message on your answering machine at home? YES _____ NO _____

Leave a message at your place of employment? YES _____ NO _____

Send you your medical information to your personal E-mail YES _____ NO _____

We encourage you to register for secure e-mail through our website: www.doctorpadma.com

Discuss your medical condition with any member of your household? YES _____ NO _____

If yes, whom? _____ Relationship: _____

CONSENT TO TREATMENT/ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE INFORMATION:

I consent to treatment necessary for the care of the patient name on this document. I authorized Columbia Internal Medicine LLC to submit claims to my insurance carrier and release any information needed for the processing of claims related to medical services rendered. I allow for release of my personal health information according to hip law for the treatment, payment and operations. I authorized assignment of benefits for physician and lab services to Columbia Internal Medicine LLC. A copy of the signature is as valid as the original. I understand that I am financially responsible for any services not covered by my insurance carriers.

The information I have provided on this registration form is true to the best of my knowledge.

I acknowledged that I have received, read, and understand the financial and office policies of Columbia Internal Medicine.

Patient (Please print) _____

Signature _____ Date _____

Parent/Guardian (Please print) _____

Signature _____ Date _____

Additions/Changes/Comments _____

MEDICAL INFORMATION:

Chief Complaint _____

Medications/Dosage:

Present _____

Past Year _____

Are you **Allergic** to or intolerant of any drugs? If yes, please list the drugs and your reaction:

Operations/dates _____

Other Major Illnesses and Hospitalizations _____

Do you smoke? _____ Packs/Day _____ Did you smoke? _____ Date stopped? _____

How often do you have a drink (Beer, Wine, Liquor)? _____

Have you ever had any problems related to alcohol? _____

If there is any history in either **yourself** or **immediate family**, please note below:

Alcoholism _____

Arthritis _____

Asthma _____

Cancer _____

Diabetes _____

Heart disease _____

High blood pressure _____

High cholesterol _____

Kidney disease _____

Mental illness _____

Osteoporosis _____

Stroke _____

Tuberculosis _____