Eternity Med Spa Medical Group
Adult Patient Registration

Please Print Clearly

Date_____

Patient Information

Name _____

Address _____

City _____

State _____ Zip Code_____

Home Phone_____

Cell Phone Number _____

Work Phone Number _____

Primary Care Physician_____

Referred By_____
(If different from Primary Care Physician)

Date of Birth _____ Male □ Female □

Single □ Married □ SSN_____

Name of Employer_____

Emergency Contact _____
(not living with you)
Emergency Contact phone _____

Relationship to Emergency Contact _____

Primary Insurance _____

Secondary Insurance_____

Local Pharmacy _____
(Please list name and location)

Mail In Pharmacy_____

Email address _____

Physician _____

Responsible Party (person who will receive statements)

Name_____

Address _____

City _____

State _____ Zip Code _____

Spouse Information

Name_____

Cell Phone Number _____

Work Phone Number _____

Insured Information (only complete if other than patient)

Primary Ins: Insured Name _____
Date of Birth _____ SSN_____
Relationship to Patient _____

Secondary Ins: Insured Name _____
Date of Birth _____ SSN_____
Relationship to Patient _____

Accident Information (if applicable)
Workmen's Comp □ Auto Accident □

Workmen's Comp Contact _____

Workmen's Comp Phone _____

Workmen's Comp Claim # _____

Name of Attorney_____

Phone Number_____

Additional Information
Race _____

Ethnicity _____

Language _____

I authorize the physicians and staff of Eternity Med Spa to leave detailed information regarding follow up appointments, test results or other routine medical care on voicemail at the following phone number (____)_____

_____
Patient/Guardian Signature

Patient Name _____

Authorization to Release Information and Pay Benefits

I hereby authorize Eternity Med Spa to furnish information to my insurance carrier(s) concerning my illness, treatments and diagnosis, upon written request.

I further authorize my insurance company to pay directly to the doctor all payments for medical services rendered to my dependents or myself. I understand that I am financially responsible for any charges not paid by my insurance carrier and that this authorization will remain in effect until all charges are paid in full.

Consent to Treat

I, the undersigned, as the patient or his/her authorized representative, hereby consent to treatment by the physicians and staff of the Eternity Med Spa. I further authorize such medical services on any subsequent visits. I have the right to revoke this consent at any time by communicating such decision in writing.

Office Policies Received (Please Initial) _____

I have been offered the Notice of Privacy Practices (Please Initial) _____

_____ _____

Signature Date

Medicare Patients: Please sign additional consent

Medicare Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to Eternity Med Spa providers for any services furnished me by the listed provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If “other health insurance” is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown.

Patient Signature _____ Date _____

At Eternity Med Spa we take the privacy of your health information seriously. We will not release a patient's health information outside of the allowed exceptions spelled out in our Notice of Privacy Practices without your verbal or written permission.

This form gives you the opportunity to tell us who we can speak to regarding your health information. You are not required to list anyone and you can change who we are permitted speak to at any time by completing a new form.

I authorize Eternity Med Spa physicians and/or staff to speak to the individuals listed below regarding my health and billing information. I understand that I can revoke this authorization at any time by completing a new form.

	Name	Relationship
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

_____ _____

Signature **Date**

_____

Witness

Patient Printed Name _____ Date of Birth _____

Early TB Prescreen Checklist

Patient Name _____ Date of Birth _____

This is a required screening checklist. Please circle yes to any of the questions that apply. Answering yes does not necessarily indicate that you have TB.

Persistent cough greater than 3 weeks	yes	no
Coughing up blood	yes	no
Frequent night sweats	yes	no
Low-grade fever (100°-101°F) greater than 3 days	yes	no
Recent unexplained weight loss with loss of appetite	yes	no
Previous Active TB disease	yes	no
Chest x-ray suggest rule out TB	yes	no

In Office Use Only:

Comments for yes responses _____

_____

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