Print Form

Clear Lake Specialties

Patient Registration Form

PATIENT INFORMATION

Today's Date_____ **DOB**_____

Patient's Name _____ , _____ , _____
(Last) (First) (Middle Initial)

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Social Security _____ - _____ - _____ **Gender:** ☐Female ☐Male ☐Transgender

Race ☐ American Indian/ Alaskan ☐ Asian ☐Native Hawaiian/ Pacific Islander ☐ White

☐ Hispanic ☐Black/African American ☐Other

Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/ Latino ☐ Declined

Language ☐ English ☐ Spanish ☐ Hindu/Urdu ☐ Arabic ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ Other

Email Address _____

Phone Numbers: Home _____ Cell_____ Work_____

Address_____
Street Name City, State Zip Code

PCP_____ **Referring Provider**_____
(Primary Care Physician)

EMERGENCY CONTACT INFORMATION

Emergency Contact: Name_____ Number_____

Relationship to Patient_____

PHARMACY INFORMATION

Pharmacy Name_____ Number_____

AUTHORIZATION TO RELEASE INFORMATION

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

I agree that the information on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature_____ Date _____

Clear Lake Specialties

Patient name: _____ DOB: _____

Please initial and sign the following statements.

ASSIGNMENT OF BENEFITS:

I authorize payment to Clear Lake Specialties, PA for the professional services rendered.

Initial: _____

INSURANCE COVERAGE WAIVER:

I wish to receive medical services for Clear Lake Specialties, PA. If my insurance did not cover all or part of the charges, I will be financially responsible for payment for the services I received.

Initial:_____

RELEASE OF INFORMATION:

I authorize the release of any medical information necessary to process this claim.

Initial:_____

MEDICAL RECORDS RELEASE:

I hereby authorize the release of all hospital records, clinic records, and laboratory and radiology reports to Clear Lake Specialties, PA as necessary for medical care.

Initial:_____

NOTICE OF PRIVACY PRACTICES:

I acknowledge that I have received a copy of Clear Lake Specialties notice of privacy practices.

Initial: _____

Signature:_____ Date:_____

Clear Lake Specialties
Advance Beneficiary Notice (ABN) Form
Commercial/Medicaid

Pt Name: _____ DOB: _____

Insurance: _____

You are receiving this notice because your insurance may not pay for all of the services that you receive during your office visit.

Please read this notice, so you can make an informed decision about your care.

_____ Yes: I want to receive these services. If my insurance carrier denies payment, I am completely responsible for payment in full.

_____ No: I have decided not to receive these services.

_____ OTHER: Should I decide to request these services in the future I understand I will be charged and am responsible for payment in full.

By signing this notice you agree to take financial responsibility for the cost of the supplies and services performed if your insurance company denies coverage for the listed items.

Signature: _____ Date:_____

Clear Lake Specialties
Advance Beneficiary Notice (ABN) Form
Medicare

Pt Name: _____ DOB: _____

You are receiving this notice because Medicare may not pay for all of the services that you received during your office visit.

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN) – Medicare

Note: If Medicare does not pay for the services provided you may be asked to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. If Medicare does not pay for the services you may receive a bill for any unpaid services in which we have provided.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have but Medicare cannot require us to do this.

OPTIONS: Please check only one box. We cannot choose a box for you.

_____ **Option 1**. I understand I may be asked to pay now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay. I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, I may request a refund on payments I made to you, less con-ins or deductibles.

_____ **Option 2**. Do not bill Medicare. I understand I may be asked to pay now as I am responsible for payment I cannot appeal if Medicare is not billed.

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048)

Signing below means that I have received and understand this notice. I understand that I may request a copy.

Signature: _____ Date:_____

Clear Lake Specialties

New Patient Information

Today's Date:_____ Doctor's Name:_____

Patient's Name: _____ Date of Birth: _____

Patient History

Reason for today's visit: _____

_____

Medications

Please list the name, dosage, and how often you take the medication.

Please include IV antibiotics, nebulizer medications, vitamins, over the counter and prescription meds.

1) _____ 11)_____

2) _____ 12)_____

3) _____ 13)_____

4) _____ 14)_____

5) _____ 15)_____

6) _____ 16)_____

7) _____ 17)_____

8) _____ 18)_____

9) _____ 19)_____

10) _____ 20)_____

Allergies

1) Medications:_____

_____

2) Food: _____

_____

3) Other: _____

_____

Clear Lake Specialties

New Patient Information

Please let us know if you have been diagnosed with any of the following:

- ☐ Anemia
- ☐ Angina Aortic Aneurysm
- ☐ Arthritis
- ☐ Asthma
- ☐ Back pain/injury
- ☐ Bleeding Disorders
- ☐ Blood clots in the legs or lungs
- ☐ Bronchitis
- ☐ Cancer; where?

  _____
- ☐ Cirrhosis of the liver
- ☐ Compression fracture
- ☐ Coronary Artery Disease
- ☐ Deep Venous Thrombus
- ☐ Depression/Nervous disorder
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive bleeding
- ☐ Eye Problems
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Goiter/thyroid disorder
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Heart Problems, Other
- ☐ Hepatitis
- ☐ Hernias, Hiatal or Other
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Hypertension
- ☐ Jaundice
- ☐ Kidney stones
- ☐ Kidney/Bladder infection
- ☐ Migraine headaches
- ☐ Osteoporosis (thinning of bones)
- ☐ Pancreatitis
- ☐ Peptic Ulcer Disease
- ☐ Pneumonia
- ☐ Prostate enlargement
- ☐ Prostate infection
- ☐ Psychiatric Illness
- ☐ Pulmonary Embolus
- ☐ Rheumatic Fever
- ☐ Sickle Cell Anemia
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ TB Tuberculosis
- ☐ Lung Problems, Other
- ☐ Ulcers
- ☐ Urinary Problems

Women Only

- ☐ Currently on birth control pills
- ☐ Recurrent Vaginitis
- ☐ Endometriosis
- ☐ Ovarian cysts or tumors
- ☐ Pelvic Infection
- ☐ Menstrual Disorders
- ☐ Recent Miscarriages

OTHER: If there are other illnesses not listed here, please write them in the space below:

_____

_____

_____

_____

_____

Clear Lake Specialties

New Patient Information

Surgeries

Please tell us if you have had any of the following surgeries and list the date of each one.

☐ Lungs/ Chest: What kind? _____ Date: _____

☐ Heart: What kind? _____ Date: _____

☐ Abdominal: What kind? _____ Date: _____

☐ Gallbladder: _____ Date: _____

☐ Appendix: _____ Date: _____

☐ Hernia: _____ Date: _____

☐ Eyes: _____ Date: _____

☐ Prostate: _____ Date: _____

☐ Hysterectomy: _____ Date: _____

☐ Mastectomy: _____ Date: _____

☐ C-Sections: _____ Date: _____

☐ Others: _____ Date: _____

_____

Hospitalizations

Have you ever been hospitalized for any reason? Please explain and list the dates

Date: _____ Reason: _____

Date: _____ Reason:_____

Date: _____ Reason: _____

Date: _____ Reason: _____

Immunizations/ Vaccines

When was the last time you had the following vaccines:

Pneumonia: _____ Flu Shot: _____

Hep A:_____ Tdap: _____

Hep B: _____ Other: _____

Clear Lake Specialties

New Patient Information

Family History

Did any blood relatives (parents, grandparents, children, brothers, or sisters) have any of the following

If yes, please list who had the illness.

☐ Asthma _____

☐ Tuberculosis _____

☐ Heart Disease _____

☐ Diabetes _____

☐ Hypertension _____

☐ Lung Disease _____

☐ Cancer _____

☐ Stroke _____

☐ Excessive Bleeding _____

☐ Thyroid _____

☐ Arthritis _____

☐ Glaucoma _____

☐ Others _____

Social History

Did you ever smoke cigarettes, cigars, or pipes?

How many packs per day _____ How many years?_____ Age quit?_____

Did you ever drink alcohol? If so, what type?

How many drink per week_____ How many years?_____ Age quit?_____

Who do you live with? _____

Do you have any pets? What kind?_____

What jobs/occupations have you had during your lifetime?_____

_____

Were you ever exposed to excessive dust, asbestos, sand etc? _____

_____

Have you travelled outside the US? If so, when? _____

Print Form