Sun City Medical Clinic, P.A.

PATIENT REGISTRATION (PLEASE PRINT)

PATIENT INFORMATION

Patient's Name: _____ (LAST / FIRST / MIDDLE) _____ (SOCIAL SECURITY NUMBER)

Date of Birth: _____ (MO. DAY YR) _____ (AGE) Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Home Address: _____ (STREET / CITY / STATE / ZIP)

Home Phone: _____ Occupation: _____ Referred By: _____

Employer: _____ Work Phone: _____

Cell Phone Number: _____ Email Address: _____

In case of emergency, please notify: _____ Relationship: _____ Phone: _____

SPOUSE/RESPONSIBLE PARTY INFORMATION

Spouse's Name: _____ (SOCIAL SECURITY NUMBER)

Spouse's Employer: _____ Occupation: _____

Work Address: _____ (STREET / CITY / STATE / ZIP) Work Phone: _____

Responsible Party: _____ (LAST / FIRST / MIDDLE) _____ (SOCIAL SECURITY NUMBER)

Address: _____ (STREET / CITY / STATE / ZIP) Home Phone: _____

Employer: _____ Occupation: _____

Work Address: _____ (STREET / CITY / STATE / ZIP)

Work Phone: _____

INSURANCE INFORMATION

Private Insurance

(1) Company: _____ I.D. Number: _____

Address: _____ (STREET) Group Number: _____

_____ (CITY / STATE / ZIP) Insured's Name: _____ D.O.B.

Ins. Phone # _____ Insured's S.S. Number: _____

(2) Company: _____ I.D. Number: _____

Address: _____ (STREET) Group Number: _____

_____ (CITY / STATE / ZIP) Insured's Name: _____ D.O.B.

Ins. Phone # _____ Insured's S.S. Number: _____

AUTHORIZATION:

I hereby consent to any necessary medical treatment/physical examination required by myself or the minor named above for whom I am legally responsible.

ASSIGNMENT:

I permit payment directly to Drs. office any benefits due for their services rendered.
I understand that I am financially responsible for all charges, whether or not covered by my insurance company.

MEDICAL RECORDS:

Authorization is hereby granted for release of any information required to process this claim. A copy of this authorization is as valid as the original. Regardless of any claim pending, you will receive periodic statements if your account has an outstanding balance. We cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim.

Signature: _____ Date: _____

Sun City Medical Clinic, P.A.

1651 JOE BATTLE BLVD.
EL PASO, TEXAS 79936
(915) 849-9010 FAX: (915) 849-9012

PATIENT NAME:	DATE:
HAS INSURANCE INFORMATION CHANGED?	
CHIEF COMPLAINT/REASON FOR VISIT:	
HISTORY OF PRESENT ILLNESS: (WHEN IT STARTED/DURATION/SEVERITY/ASSOCIATED SYMPTOMS)	

PAST MEDICAL HISTORY. CHECK MEDICAL CONDITIONS WHICH HAVE OCCURED:

	Yes	No		Yes	No		Yes	No		Yes	No
Heart attack	☐	☐	Bleeding disorder	☐	☐	High cholesterol	☐	☐	Hepatitis	☐	☐
High blood pressure	☐	☐	Stroke	☐	☐	_____arthritis	☐	☐	Asthma	☐	☐
Other heart disease	☐	☐	Anemia	☐	☐	Blood clots	☐	☐	Pacemaker	☐	☐
Kidney disease	☐	☐	Diabetes	☐	☐	Seizure disorder	☐	☐	Stomach ulcers	☐	☐
Muscle disorder	☐	☐	Breathing difficulty	☐	☐	Heartburn/reflux	☐	☐	Tuberculosis	☐	☐
Serious weight loss	☐	☐	Lung disease	☐	☐	Blood in stool	☐	☐	Thyroid	☐	☐
Anxiety/panic	☐	☐	Depression	☐	☐	Cancer	☐	☐	Type of cancer? _____		
HIV	☐	☐	Colon problems	☐	☐	Other problems _____					

List other past and present medical diseases not listed above:

_____

Past hospitalization and surgeries (please include type of surgery, date, and if any complications:

_____

FAMILY HISTORY: List any major medical problems of immediate family.

	FATHER ☐ Alive ☐ Deceased	PRESENT ILLNESS/CAUSE OF DEATH:	**MOTHER** ☐ Alive ☐ Deceased	PRESENT ILLNESS/CAUSE OF DEATH:
MATERNAL	**GRAND-MOTHER** ☐ Alive ☐ Deceased	PRESENT ILLNESS/CAUSE OF DEATH:	**GRAND-FATHER** ☐ Alive ☐ Deceased	PRESENT ILLNESS/CAUSE OF DEATH:
PATERNAL	**GRAND-MOTHER** ☐ Alive ☐ Deceased	PRESENT ILLNESS/CAUSE OF DEATH:	**GRAND-FATHER** ☐ Alive ☐ Deceased	PRESENT ILLNESS/CAUSE OF DEATH:
BROTHERS	NUMBER ALIVE	HEALTH STATUS:	NUMBER DECEASED:	CAUSE OF DEATH:
SISTERS	NUMBER ALIVE	HEALTH STATUS:	NUMBER DECEASED	CAUSE OF DEATH:

SOCIAL HISTORY:

Smoke currently: Y or N Number of years?_____ Average packs/cigarettes per day (circle one) _____
Smoked in the past: _____ Year you quit?_____ Never smoked:_____
Do you drink alcohol? Y_or_N_____ Quantity?_____ Number of years?_____
Do you use/have ever used recreational drugs (including I.V. drugs)? Y or N Which ones?:_____
Coffee: Y or N -how many cups?_____ Soda: Y or N -how much?_____ How often do you exercise?_____
Marital status: ☐ married ☐ single ☐ divorced ☐ widowed ☐ long term partner

PATIENT NAME: _____

LIST ALL CURRENT **MEDICATIONS**, DOSAGE, AND FREQUENCY. INCLUDE HERBAL & OVER THE COUNTER:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

PLEASE LIST ANY MEDICATION **ALLERGIES:** _____

PREVENTATIVE HEALTH:
Date of last routine health exam: _____
Date of last colonoscopy: _____ Result: _____

WOMEN ONLY:
Are currently pregnant? _____ Date of last pap smear: _____ Result: _____
Date of most recent mammogram: Result:
Number of pregnancies? _____ Number of children: _____ Number of miscarriages: _____
Still menstruating: Age periods started: Age periods stopped: _____
Are you sexually active?: _____ If so, type of birth control method: _____

MEN ONLY:
Date of last prostate exam: _____
Date of last blood test for early detection of prostate disease? _____

********** **FOR OFFICE USE ONLY** **********

Vitals:
Height: Weight: Temp: Pulse: BP:
Respirations: O2 sat%: Vision: **LMP:** Head Circ:

A/P:

RTC ____PRN/DAYS/WEEKS/
MONTHS/YEARS

Treatment or diagnostic plan:

LABS: ☐ CBC ☐ CMP ☐ LIPIDS ☐ TSH
☐ AFFIRM ☐ ANA ☐ FERRETIN ☐ FOLIC ACID ☐ FSH ☐ GC/CT
☐ HCG SERUM QUAL ☐ HCG SERUM QUANT ☐ HGA1C ☐ HEPATITIS PANEL
☐ HIV ☐ IRON TOTAL ☐ LH ☐ MICROALBUMIN ☐ PROACTIN ☐ PSA
☐ PT W/INR ☐ PTT ☐ RF ☐ RPR ☐ SED RATE ☐ TESTOSTERONE ☐ URIC ACID
☐ UA CULTURE ☐ VIRAL CULTURE ☐ OTHER: _____

IN HOUSE: ☐ FOB ☐ GLUCOSE FINGER STICK ☐ H. PYLORI ☐ HGAIC
☐ URINE HCG ☐ RAPID STREP ☐ MICROALBUMIN ☐ URINE DIP
☐ VENIPUCTURE

IMAGING OR OTHER TESTING:

IMMUNIZATIONS:

REFERRALS:

Sun City Medical Clinic, P.A.

PAYMENT POLICIES

Payment Options
Sun City Medical Clinic accepts cash, Visa, MasterCard and Discover.

Insurance Billing Process
It is the patient's responsibility to bring a current insurance card to every appointment. As a courtesy to our patients, Sun City Medical Clinic submits claims to primary and secondary insurance carriers. Any balance not payable by insurance is considered the patient's responsibility. Not all services are a "covered" benefit in all insurance policies. Although we will call and attempt to verify benefits and coverage, we cannot determine the benefits of your insurance policy. Verification of benefits is not a guarantee of payment.

All co-payment, co-insurance, deductible, and non-covered amounts are due and payable at the time of service. Please be prepared to pay any outstanding balances at your visit or when you receive your statement.

Patients may also be charged a "no show" fee of $50 if they fail to cancel at least one week prior to their scheduled appointment time. *This charge may be waived if I reschedule and keep the new appointment.* **We are not responsible for lost/items left behind after a visit.**

Medicare Guidelines
For patients eligible for Medicare, Sun City Medical Clinic is considered "participating physician." That means we will submit claims to Medicare on your behalf. Medicare will send a check to Sun City Medical Clinic for 80% of the approved amount, minus the patient's Part B deductible.

Therefore, patients are responsible for the remaining 20% of the approved amount, plus the annual Part B deductible. Additionally, patients are responsible for any portion of the bill not covered by Medicare or a secondary insurance carrier. If you have supplemental insurance coverage, please make certain we have a copy of your insurance card. We don't accept Medicaid.

Forms
I agree to be billed and pay $20 to have the staff at Sun City Medical Clinic, P.A. fill out any forms for either my spouse or myself. This includes Family Medical Leave Act Forms, Insurance Forms, Disability Forms and any other forms required by my Employer, School, or Government Agency.

For More Information
If you have questions regarding your bill or claim, please call 1(877)822-7737 or (915) 849-9010.

I fully understand and agree that as a condition of being accepted as a patient of Sun City Medical Clinic, I accept all responsibility in paying all charges, in full and in a timely manner, that are not covered by my insurance.

Signature	Date	Date of Birth
Print Name	Witness	Date

Sun City Medical Clinic, P.A.
1651 JOE BATTLE BLVD.
EL PASO, TEXAS 79936
(915) 849-9010 FAX (915) 849-9012

Acknowledgement of Notice of Privacy Practices

I have been presented and reviewed a copy of the *Notice of Privacy Practices* for Sun City Medical Clinic, P.A., detailing how my information may be used and disclosed as permitted under federal and state law. I understand I may request and receive a copy of our *privacy practices.*

Signed: _____ **Date:** _____

If not signed by patient, please indicate relationship to patient (e.g., mother) and patient's name.

Patient: _____

Relationship: _____

Reconocimiento Notificasion De Practicas De Privacidad

He recibido una copia de *Practicas de Privacidad* de Sun City Medical Clinic, P.A. que detalla como mi informacion puede ser utilizada y revelada.Entiendo que yo puedo pedir una copia de nuestra *Practicas de Privacidad.*

Firma de paciente: _____ **Fecha:** _____

Si no fue firmado por el paciente, porfavor indique la relacion al paciente (ejemplo, madre) y el nombre de el paciente.

Nombre de el Paciente: _____

Relacion a el paciente: _____

Sun City Medical Clinic, P.A.

Manuel A. Padilla, D.O / Maria Isabel Padilla, DNP,APRN, FNP-C
Eduardo Gonzalez, FNP-C / Veronica Padilla, FNP-C
Board Certified Family Medicine
1651 Battle Blvd · El Paso, TX 79936
Ph. (915) 849-9010 · Fax (915) 849-9012

General Consent to Treat

I have the legal right to consent to medical and surgical treatment because (a) I am the patient or (b) I am the parent/guardian of the patient. All references to "patient", "me" and "my" in this document means: _____ (name of Pt).

I voluntarily authorize and consent to the medical care, treatment, and diagnostic tests that the providers at Sun City Medical Clinic P.A and their designated associates or assistants believe are necessary. I also consent to the taking of photographs related to the care and treatment of the patient and understand that such photographs may be made part of the medical record. I understand that by signing this form, I am giving permission to the doctor, nurses, physician assistants, and other health care providers in this medical office to provide treatment as long as a physician/paitnet relationship exists, or until I withdraw my consent by written notice.
_____ (Please Initial)

Sharing Records for Treatment

We share medical records electronically with other health care providers to allow and promote continuity of care among providers. If you visit another provider who also participates in an electronic medical system, they may have access to your medical record.
_____(Please Initial)

Voicemail and Text Notication

As a service to our patients, Sun City Medical Clinic P.A provides courtesy appointment reminder calls/texts/ emails and possibly other important calls that may be placed using a prerecorded auto messaging system. The information may include protected health information. By initialing below you consent to receiving such calls/texts at the cell phone number you have provided to us.
_____(Please Initial)

Electronic Prescriptions (e-Prescribing)

I voluntarily authorize Sun City Medical Clinic P.A to allow e-Prescribing for prescriptions, with allows health care providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medication dispense history as long as a physician/patient relationship exists or until I withdraw my consent.
_____(Please Initial)

I have read this form or this form has been read to me in a language that I understand and I have had an opportunity to ask questions about it.
_____(Please Initial)

Patient's Name _____ Date of Birth _____

Name of Patients's Representative, if patient under 18 (Print) _____
Relationship to patient _____

Signature of Patient or Patient's Representative _____ Date _____