PINNACLE HEALTH CARE
Taking Health Care to a Higher Level

PATIENT REGISTRATION

Welcome to Pinnacle HealthCare,

Thank you for choosing us as your primary source of medical services. Please provide us some basic information to get started. We will get back to you as soon as we receive this form.

Full Name_____DOB_____
Full address_____
City/State/Zip_____SSN_____
Phone _____ Fax _____

Responsible party name (if any) _____
Responsible party address with phone number _____
_____

INSURANCE INFORMATION:
Primary_____ ID#_____ Group #_____
Secondary_____ ID#_____ Group#_____
Self Pay _____

CONSENT FOR TREATMENT:
I hereby authorize the physicians and mid-level providers of Pinnacle HealthCare to administer medications and perform examinations and diagnostic procedures. This consent will remain in effect until such time I notified Pinnacle HealthCare in writing of termination of said consent.

FINANCIAL AGREEMENT:
I hereby authorize Pinnacle HealthCare to furnish information necessary to the payer(s) concerning each illness/accident for which I seek treatment and hereby irrevocably assign Pinnacle HealthCare all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by my third-party payer(s).

Patient (or Legal Guardian) Name: _____

Patient (or Legal guardian) Signature and Date: _____

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MEDICAL INFORMATION

Current PCP: _____ Phone No. _____

Medical History: **Allergies**_____

List ALL medical conditions and any surgeries you have had.

_____
_____
_____
_____

Have you ever had the following and when?

Colonoscopy	YES/No	Date_____
Mammogram	YES/No	Date_____
DEXA Scan	YES/No	Date_____
Cardiac Stress test	YES/No	Date_____

Social History:

Live alone? Yes/No If No, Who lives with you? _____
Use an assist device as cane, wheel chair walker to ambulate? Yes/No
Smoke? Yes/No Drink? Yes/No Recreational drug use? Yes/No

Medications: (You can also attach a list)
List ALL medicines you are currently taking with correct dosage and frequency.

_____
_____
_____
_____
_____

Advance Directive: DO NOT RESCUCITATE/DO NOT INTUBATE/DO EVERYTHING

Authorization for release of information:
I authorize the release of my medical information to Pinnacle HealthCare, LLC.

Patient or Legal guardian Name: _____ Signature_____
Dated: _____