



# Welcome To Our Clinic!

We look forward to helping you with your health in any way we can. Please help us to do so by filling out the following form as completely as possible. If you have any questions fill in your best guess or ask one of the staff members for help. Thank you!

## PATIENT INFORMATION:

Name: \_\_\_\_\_  
Gender:  Male  Female  
Marital Status:  Single  Married  Divorced  Widow  
Address: \_\_\_\_\_  
City/State/ZIP: \_\_\_\_\_  
Phone: \_\_\_\_\_  Home  Work  Other  
Phone: \_\_\_\_\_  Home  Work  Other  
Social Security Number: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

## Patient Email:

Email Address: \_\_\_\_\_

May we contact you by email?  Yes  No (This would only be directly on behalf of the practice – we will never give out your email address to any third party).

## Patient Employment:

Employment Status:

- Employed  Retired  Student  Unemployed  
 Self-Employed  Stay-at-Home  Other

Employer: \_\_\_\_\_

Employer phone: \_\_\_\_\_

Same as Patient

## RESPONSIBLE PARTY (GUARANTOR) INFORMATION:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/ZIP: \_\_\_\_\_  
Phone: \_\_\_\_\_  Home  Work  Other  
Social Security Number: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

## Responsible Party Employment:

Employer: \_\_\_\_\_

Employer phone: \_\_\_\_\_

## PRIMARY INSURANCE:

Insurance Company: \_\_\_\_\_  
Insured Party: \_\_\_\_\_  
Insured ID: \_\_\_\_\_  
Policy Group: \_\_\_\_\_  
Group Name: \_\_\_\_\_  
Relationship to Insured: \_\_\_\_\_

## SECONDARY INSURANCE:

Insurance Company: \_\_\_\_\_  
Insured Party: \_\_\_\_\_  
Insured ID: \_\_\_\_\_  
Policy Group: \_\_\_\_\_  
Group Name: \_\_\_\_\_  
Relationship to Insured: \_\_\_\_\_

**EMERGENCY CONTACT:** Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**CONTACT PREFERENCES:** When we call and you are not available, should we:

- Leave lab results and other detailed messages on your answering machine, or  
 Indicate only that a return call is required?

**HOW DID YOU HEAR ABOUT US?**  Ad or Mailer  ER or hospital  Insurance Company  Phone Book  
 Friend: \_\_\_\_\_  Physician: \_\_\_\_\_  Other: \_\_\_\_\_

*"We welcome any family member or friend you may recommend and will provide them the same high level of care we provide you."*

**CONSENT TO TREAT:** I authorize the provider responsible for care of the above named patient to provide diagnosis and treatment services.

**FINANCIAL RESPONSIBILITY:** I agree to be personally responsible and fully responsible for payment for services rendered in accordance with any insurance benefits where applicable. I understand that I am financially responsible for charges not covered by my plan or for claims denied because of my failure to comply with conditions set by my insurance carrier. These conditions may include but are not limited to: failure to make co-payment or obtain a written referral for services provided by someone other than my primary care physician. A finance charge of 1 ¼ % per month (21% annual rate) will be added to the amount not paid after 60 days. Should collection become necessary, the responsible party agrees to pay an additional 40% collection fee, and all legal fees of collection, with or without suit, including attorney fees and court costs.

**ASSIGNMENT OF BENEFITS:** I request insurance benefits for services provided be paid directly to the medical clinic. I verify the accuracy of the above listed demographic and insurance information, and I authorize the release of any medical information necessary to process payment for services provided.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## FINANCIAL POLICY AND AGREEMENT

Thank you for choosing us as your health care provider. We are committed to excellent patient care. The following is an explanation of our Financial Policy and Agreement, which you must read and sign prior to any current and future medical evaluation or treatment in this office. All patients must also complete the information and insurance form before seeing a provider.

1. Each patient is responsible for his or her own bill.
2. Payment of all insurance co-payments and deductibles is required at the time medical services are rendered. A billing fee of \$10 will be charged if you are unable to pay required co-payments on the day of service.
3. Patients who have no insurance are required to pay 100% of services rendered at each visit. If this is impossible you will need to make payment arrangements with our billing office prior to any medical evaluation or treatment. We accept cash, checks and major credit cards.
4. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, this office will submit bills to your insurance carrier. In order to facilitate claims processing, you must provide all insurance policy information and changes to our office. Your bill is your responsibility whether your insurance company pays or not. At times, you may need to contact your insurance carrier regarding slow or non-payment of your insurance claim.
5. You are responsible for knowing what your insurance covers and the providers and network(s) covered under your health insurance plan. Any service provided, but not covered by your insurance company, will be your responsibility to pay.
6. If your insurance company has not paid your full account within 60 days, you must pay the outstanding balance without further delay.
7. Monthly payments are required on all accounts with outstanding balances. A monthly finance charge of 1  $\frac{3}{4}$  % per month (21% annual rate) will be added to the amount not paid after 60 days, with a minimum charge of \$.50 per month. By signing below, you agree to pay collection costs up to 40% with or without suit and/or reasonable attorney's fees on any delinquent balance, if referred to any agency or attorney for collection or suit.
8. A \$25.00 fee will be charged on all returned checks.
9. Patients who fail to appear for their scheduled appointments may be charged a fee of \$50.00, unless the patient cancels the appointment at least 24 hours before the scheduled appointment time.

### USUAL AND CUSTOMARY RATES

Our rates for medical services reflect the usual and customary rates in the community. Unless we have accepted an alternate fee schedule from your insurance, you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates for medical services.

### AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize this office to release all information concerning my medical treatment to my insurance carriers and to requesting referring providers (if any).

### AUTHORIZATION TO PAY BENEFITS

I further authorize and direct said agency, attorney of Insurance Company, to pay from the proceeds of benefits of any recovery of insurance payments in my case, directly to the providers of this office, for their professional services rendered. I understand this in no way relieves me from my personal responsibility for paying my provider when a statement is rendered. It is understood that the signing of this form does not prohibit customary monthly billings.

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*Signature of Patient or Responsible Party*

*Date*

Name

Date

### Health History Form

Your answers on this form will help your physician better understand your medical concerns and conditions. If you cannot remember specific details, please provide your best guess.

**MEDICATIONS:** Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.  
Medication (ex: Ambien, Zoloft...)    Dose (10 mg, 5mg)    How often (daily, twice a day, weekly...)    Reason (insomnia, depression...)

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If additional space is needed, please check this box and continue your medication list on the back of this page.

**Do you have any allergies (including medications, hay fever, food allergies...)?** If so, what are you allergic to and how do you react?

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**PERSONAL MEDICAL HISTORY:** Please indicate whether you have or have had any of the following medical problems.

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Depression          | <input type="checkbox"/> Kidney Stone                 |
| <input type="checkbox"/> Atrial Fibrillation           | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Heart Attack                 |
| <input type="checkbox"/> Anemia                        | <input type="checkbox"/> Blood clots in legs | <input type="checkbox"/> Neurologic Disorder          |
| <input type="checkbox"/> Anxiety Disorder              | <input type="checkbox"/> GI Bleed            | <input type="checkbox"/> Osteoarthritis               |
| <input type="checkbox"/> Blood Transfusions            | <input type="checkbox"/> GERD                | <input type="checkbox"/> Osteoporosis                 |
| <input type="checkbox"/> Stroke or mini-strokes (TIAs) | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Seizure Disorder             |
| <input type="checkbox"/> COPD                          | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disorder             |
| <input type="checkbox"/> Heart Disease                 | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Recurrent Bladder Infections |
| <input type="checkbox"/> Crohn's Disease               | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Other _____                  |

**Have you currently or in the past been diagnosed with any condition not listed above? If yes, please explain:**

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**SURGICAL HISTORY:** Please indicate any prior surgeries (with dates).

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Amputation             | <input type="checkbox"/> Gall Bladder Removal   | <input type="checkbox"/> Tonsillectomy                |
| <input type="checkbox"/> Appendectomy           | <input type="checkbox"/> Gastric Bypass         | <input type="checkbox"/> Urinary incontinence surgery |
| <input type="checkbox"/> Back surgery           | <input type="checkbox"/> Total Hip Replacement  | <input type="checkbox"/> Other _____                  |
| <input type="checkbox"/> Bypass Surgery (Heart) | <input type="checkbox"/> Total Knee Replacement | <input type="checkbox"/> Other _____                  |
| <input type="checkbox"/> Carpal Tunnel Release  | <input type="checkbox"/> Pacemaker              |   |

**FAMILY HISTORY:** Please indicate if any immediate family members (parent, sibling, grandparent, aunt, or uncle) have been treated for any of the following conditions.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Alcoholism    | <input type="checkbox"/> Cervical cancer     | <input type="checkbox"/> Osteoporosis        |
| <input type="checkbox"/> Anemia        | <input type="checkbox"/> Colon cancer        | <input type="checkbox"/> Bowel Disease       |
| <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Depression          | <input type="checkbox"/> Kidney Disease      |
| <input type="checkbox"/> Anxiety       | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Asthma/COPD   | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Liver Disease       |
| <input type="checkbox"/> Birth defects | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ulcers              |
| <input type="checkbox"/> Blood clots   | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Lung Cancer         |
| <input type="checkbox"/> Breast cancer | <input type="checkbox"/> Psychiatric Care    | <input type="checkbox"/> Other _____         |

**SOCIAL HISTORY:**

**Tobacco Use**

Cigarettes:  Never  
 Previous smoker: packs/day \_\_\_\_\_ # of years \_\_\_\_\_  
Quit Date \_\_\_\_\_  
 Current smoker: packs/day \_\_\_\_\_ # of years \_\_\_\_\_  
Other Tobacco:  Pipe  Cigar  Snuff  Chew  
Are you interested in quitting?  Yes  No

**Alcohol Use**

Do you drink alcohol?  Yes  No, # of drinks/week \_\_\_\_\_  
Is your alcohol use a concern for you or others? \_\_\_\_\_

**Drug Use**

Do you use any recreational drugs?  Yes  No  
Have you ever used needles to inject drugs?  Yes  No

**Sexual Activity**

Are you sexually active:  Yes  No  Not currently  
Do you have any concerns about sexual activity?  
 Yes  No

**OTHER CONCERNS:**

**Weight:** Are you satisfied with your weight?  Yes  No

**Diet:** How do you rate your diet?  Good  Fair  Poor

**Exercise:** Do you exercise regularly?  Yes  No  
What kind of exercise? \_\_\_\_\_  
How long on average (minutes) \_\_\_\_\_  
How often? \_\_\_\_\_  
If you do not exercise, why? \_\_\_\_\_

**Caffeine Intake:**  None  Coffee/tea/soda \_\_\_ cups/day

**Safety:** Do you use a bike helmet?  Yes  No  
Do you use seatbelts consistently?  Yes  No  
Is violence at home a concern for you?  Yes  No  
Have you ever been abused?  Yes  No

**Advanced Medical Directive:**

Have you completed a living will?  Yes  No  
Do you have an advanced directive?  Yes  No

**IMMUNIZATIONS:** Please list the approximate date (month/year) of your most recent immunizations.

Hepatitis A \_\_\_\_\_ Hepatitis B \_\_\_\_\_ Influenza (flu shot) \_\_\_\_\_ MMR \_\_\_\_\_ Pneumovax (pneumonia) \_\_\_\_\_  
Meningitis \_\_\_\_\_ Tetanus (Td) \_\_\_\_\_ Varicella (chicken pox) shot or illness \_\_\_\_\_ Tdap (tetanus & pertussis) \_\_\_\_\_

**HEALTHY LIVING GUIDELINES:**

Do you take a multivitamin daily?  Yes  No  
If you are over the age of 40, do you take an aspirin daily?  Yes  No

**REGULAR SCREENING TESTS (for the date please put the approximate date this was last performed. If results were normal please mark "yes" if abnormal please mark "no").**

*Cholesterol* (once before age of 40, annually after that) Date \_\_\_\_\_ Normal?  Yes  No  
*Colonoscopy* (every 10 years starting at age 50) Date \_\_\_\_\_ Normal?  Yes  No  
*Thyroid* (every year after age 40) Date \_\_\_\_\_ Normal?  Yes  No  
**Women:**  
*Mammogram* (annually after age 40) Date \_\_\_\_\_ Normal?  Yes  No  
*Pap Smear* Date \_\_\_\_\_ Normal?  Yes  No  
*Dexascan* (osteoporosis) Date \_\_\_\_\_ Normal?  Yes  No  
**Men**  
*Prostate* (PSA or physical exam – annually after age 40) Date \_\_\_\_\_ Normal?  Yes  No

**Who were your previous doctors? Please fill out as completely as you remember:**

Name: \_\_\_\_\_ Name: \_\_\_\_\_  
Clinic Name: \_\_\_\_\_ Clinic Name: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Fax Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
Address: \_\_\_\_\_ Address: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

*Many of our best new patients are referred by our current patients – it would be an honor for us to care for your family and friends.*

**Thank you for visiting us!**