PATIENT INFORMATION

Name _____
First Middle Last

Date of Birth: _____ Social Security _____/_____/_____ Male ____ Female____

Mailing Address _____
City State Zip

Home Telephone _____ Alternate/Cellular Phone _____

Marital Status: Single Married Separated Divorced Widow/Widower
(please circle one)

Employer: _____ Occupation _____

BILLING INFORMATION

Person responsible for paying bill (please circle one):
Patient Parent Spouse Other _____

Name (if different from above) _____
Address (if different from above) _____
Home telephone _____

INSURANCE INFORMATION

PRIMARY INSURANCE

_____
Insurance Co. Name Address Telephone

Subscriber's ID Number Group Number Policy Holder's Name

_____

Patient's relationship to policy holder _____ Subscriber's date of birth _____

SECONDARY INSURANCE

_____
Insurance Co. Name Address Telephone

Subscriber's ID Number Group Number Policy Holder's Name

_____

PERSON TO CONTACT IN CASE OF EMERGENCY
Name_____ **Telephone** _____
Relationship:

*****PLEASE COMPLETE ALL INFORMATION SECOND PAGE****

FINANCIAL POLICY

We strongly feel all patients deserve the very best care that we can provide. Everyone benefits when financial arrangements are agreed upon. We have prepared this material to acquaint you with our policy.

Our professional services are rendered to you, not the insurance company. Payment for treatment is your responsibility, not the insurance company.

FINANCIAL AGREEMENTS

Initial

_____ I have no insurance coverage. I understand that I am responsible for payment of services rendered to myself or dependents ***at the time of service***.

_____ I understand that if I fail to pay amounts owed, the clinic has the right to secure an outside collection agency and/or attorney to collect the unpaid debt and to report the unpaid debt to a credit-reporting agency. I further understand that I will be responsible for any additional charges or fees necessitated by securing the collection agency, including reasonable attorney's fees.

INSURANCE AUTHORIZATION AND ASSIGNMENT

Initial

_____ I hereby authorize the release of any information necessary to process insurance claims and request payment of benefits to be made for services rendered.

_____ I understand I am responsible ***at the time of service*** for paying any required co-payment and deductible.

MEDICARE/MEDIGAP

For Medicare Patients Only

_____
Medicare Number

_____ I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Finance Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information). Regulations pertaining to Medicare assignment of benefits also apply.

Medigap authorization statement

_____
Policy Number

THERE WILL BE A $25.00 CHARGE ON ALL RETURNED CHECKS

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY OF THIS OFFICE AND AGREE TO ABIDE BY THE SAID POLICY.

_____ Date: _____
Patient/ Parent/ Guardian

I will be paying by (please circle) Check Cash Credit/Debit

Patient History

Date:_____

Name:_____

Date of Birth:_____ Age:_____ SSN:_____

Past Medical and Surgical History/Family Medical History

	Self	Family (Relationship)		Self	Family (Relationship)
Diabetes			ADD/ADHD		
High Blood Pressure			Learning Difficulties		
Heart Disease			Eye Problems		
High Cholesterol			Congenital Problems		
Heart Failure			Failure to Thrive		
Thyroid Problems			Heart Murmur		
Cancer			Asthma		
Anemia			Menstrual Problems (LMP)		
Bowel Disorders			Pregnancies (number)		
Migraines/Headaches			Gall Bladder Surgery		
Kidney Disease			Appendectomy		
Hepatitis (type)			Hernia Repair		
Liver Disease			Tonsillectomy		
Arthritis			Joint Surgery (type)		
Anxiety/Depression			Thyroid Surgery		
Blood Transfusion			C Sections (number)		
Epilepsy			Tubal Ligation		
Menopause (LMP)			Hysterectomy		
STDs			Cervical Procedures (Type)		
Other:			Other:		
Other:			Other:		

Allergies:_____

Immunizations: (circle and indicate year, children include shot record)
Tetanus Flu Hep B Hep A HPV Pneumonia
Meningitis Pertussis

Habits: Tobacco (Amt and Years of Use):_____
Alcohol (Amt and Years of Use): _____
Have you ever had shakes or seizures when off of alcohol? _____
Drugs (Type and route)_____
Exercise:_____

Living Situation: _____

Patient Consent for E-Prescribing (Electronic Prescribing)

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

I have been provided the Electronic Prescribing Notice.

Parent, Patient's Signature or Legal Representative				Date	Time
Relationship to Patient			Interpreter, if Utilized	Date	Time
Witness Signature	Date	Time	If Telephone Consent, Second Witness Signature	Date	Time

Patient Label

NOTICE OF PRIVACY PRACTICES:

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I was provided a copy of the Facility's Notice of Privacy Practices.

Patient's Signature or Legal Representative			Date	Time
Relationship to Patient	Interpreter, if Utilized		Date	Time
Witness Signature	Date	Time		

Physician Practice

Notices of Privacy Practices Acknowledgement Form

Patient Label