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## New Patient Form

Please present valid identification and your insurance card to the receptionist. All questions contained in this questionnaire are strictly confidential and will become part of your medical records.

## Patient Demographics

Today's Date: _____ Patient Name: _____

What you prefer to be called: _____ □Male □Female

DOB: _____ Age: _____ SSN: _____

Home Address: _____

*Street* *City* *State* *Zip Code*

Home Number: _____ Mobile Number: _____ Work Number: _____

Email: _____ Pharmacy Name: _____

Pharmacy Address: _____

*Street* *City* *State* *Zip Code*

Marital Status: □Single □Married □Divorced □Separated □Widowed

Spouse's Name: _____

Race: □American Indian/Alaska Native □Asian □African American □Native Hawaiian □White

□Other Pacific Islander □Other/prefer not to say Ethnicity: □Hispanic or Latino □Not Hispanic or Latino

Previous or Referring Doctor: _____ Date of Last Physical Exam: _____

How did you hear about us: _____

## Insurance Information

Insurance Company: _____

Insurance Phone Number: _____

Insurance Billing Address: _____

*Street* *City* *State* *Zip Code*

□ Check if the patient is a primary subscriber. If not,

Primary subscriber's Full Name: _____

DOB: _____

SSN: _____

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## Patient Health History

Childhood Illness: □Measles □Mumps □Rubella □Chicken Pox □Rheumatic Fever □Polio

Immunizations and Dates:

| | |
|---|---|
| □Tetanus | □Pneumonia |
| □Hepatitis | □Chicken Pox |
| □Influenza | □MMR |

List any medical problems that other doctors have diagnosed:

_____

_____

Past Surgeries and Major Hospitalizations:

| Year | Reason | Hospital |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers:

| Name | Strength | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

List all allergies to medication/substances:

| | |
|---|---|
| | |
| | |
| | |
| | |

Check if you have, or have had any significant symptoms in the following areas:

| | | |
|---|---|---|
| □Skin | □Lungs | Recent Changes in: |
| □Chest/Heart | □Back | □Weight |
| □Head/Neck | □Intestinal | □Energy |
| □Ears | □Bladder | □Sleep |
| □Nose | □Circulation | □Other: |
| □Throat | □Other: | □Other: |

Briefly Explain:

_____
_____
_____

## Family Health History

| Relation: | Age | Gender | Significant Health Problem |
|---|---|---|---|
| Mother | | - | |
| Father | | - | |
| Grandmother (Maternal) | | - | |
| Grandfather (Maternal) | | - | |
| Grandmother (Paternal) | | - | |
| Grandfather (Paternal) | | - | |
| Sibling | | | |
| Sibling | | | |

## Health Habits and Personal Safety

Drugs, Tobacco, Alcohol usage:

| |
|---|
| Do you use tobacco? □Yes □No |
| Do you consume alcohol? □Yes □No |
| Do you use recreational/street drugs? □Yes □No |
| Have you ever given yourself street drugs with a needle? □Yes □No |

| |
|---|
| Please select all that apply: (enter how many times day/week/month you use these substances) |
| Tobacco usage: □Cigarettes __/day □Chew __/day □Pipe __/day □Cigars __/day □Former Smoker |
| Tobacco usage: Number of years: _____ □Approximate date/year quit: _____ |
| Alcohol usage: □ _____drinks/day □ _____drinks/week □ _____drinks/month □rare/n/a |

Sexual History:

| | |
|---|---|
| Are you sexually active? | □Yes □No |
| If yes, are you trying for pregnancy? | □Yes □No |
| If not trying for pregnancy list contraceptive or barrier method used: | |
| Any discomfort with intercourse? | □Yes □No |
| Illness related to the human immunodeficiency virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of illness? | □Yes □No |

Personal Safety:

| | |
|---|---|
| Do you live alone? | □Yes □No |
| Do you have frequent falls? | □Yes □No |
| Do you have hearing or vision loss? | □Yes □No |
| Physical and/or mental abuse have also become a major public health issue in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? | □Yes □No |
| Any urinary tract, kidney, or bladder infections in the last year? | □Yes □No |
| Any blood in your urine? | □Yes □No |
| Any problems with control of urination? | □Yes □No |

## Women Only

| | |
|---|---|
| Age at onset of menstruation: | |
| Date of last menstruation: | |
| How often do you get your menstrual cycle? | Every ___ days |
| Heavy periods, irregularity, spotting, pain or discharge? | □Yes □No |
| Do you have bloating, irritability, pain, menstrual tension, or other symptoms? | □Yes □No |
| Number of pregnancies: | |
| Number of live births: | □Yes □No |
| Are you currently pregnant or breast feeding? | □Yes □No |
| Have you had a D&C, hysterectomy or cesarean? | □Yes □No |
| Any hot flashes or sweating at night? | □Yes □No |
| Experienced any recent breast tenderness, lumps, or nipple discharge? | □Yes □No |
| Date of last pap and rectal exam? | |

## Men Only

| | |
|---|---|
| Do you usually get up to urinate during the night? | □Yes □No |
| If yes, how many times? | |
| Do you feel burning or notice discharge from penis? | □Yes □No |
| Has the force of your urination decreased? | □Yes □No |
| Have you had any prostate infections in the last year? | □Yes □No |
| Any difficulty with ejaculation or erections? | □Yes □No |
| Any testicle pain/swelling? | □Yes □No |
| Date of last prostate and rectal exam: | |

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## Patient Consent Form

I authorize Prime MD to release any medical or other information that may be necessary to process medical claims on my behalf to related physicians, rehabilitation counselors, social workers, insurance carriers, or attorneys.

I authorize Prime MD to initiate a complaint to the insurance commissioner for any reason on my behalf.

I, the undersigned, state that I have read and agree to the terms and conditions set forth.

_____ _____

Patient/ Guardian Signature Date

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## Financial Responsibility/Assignment of Benefits

I understand that I am responsible for paying my co-payments and deductibles at the time of service. I also understand that I am responsible for any balance due after payment by my insurance company.

I, the undersigned, understand that Prime MD will bill my insurance company for services rendered upon verification of coverage by my insurance company. If my insurance company fails to render payment for services rendered, I hereby personally guarantee payment for my medical care and services rendered. If your insurance company does not remit payment within 60 days, the balance will be due in full.

I hereby request that my insurance carrier make payment directly to Prime MD for all services rendered by this facility. If my current policy prohibits direct payment to Prime MD, I hereby instruct and direct my insurance company to make the check out in my name but send the check to the listed address of Prime MD.

If my insurance carrier makes a payment to me, I agree to immediately pay over these funds to Prime MD. I also authorize Prime MD to deposit checks received on my account when made out to me.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all the costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

Charges related to Worker's Compensation injury shall be forwarded to the Worker's Compensation insurance carrier. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you will be held responsible for the total amount of charges for services rendered to you.

I, the undersigned, acknowledge that by signing this form I am authorizing Prime MD to submit charges via mail or internet to my insurance carrier. This is a "signature on file" authorization.

Patient recognizes that policy quotes are not a guarantee of payment by my carrier and the patient is responsible for obtaining actual policy benefits, limits from the carrier and if needed any referrals from primary care physicians or pre-authorization for chiropractic treatment. Patients are responsible for confirming referrals/pre-authorization with insurance. All referrals or recommendations from our office have no confirmation of payment or benefits to referring providers.

I authorize my healthcare provider and/or entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging, or other electronic communication to contact me for any reason by any telephone number, email address and/or mailing address provided. I authorize all my numbers that I have provided to the office in my file to be able to accept phone and/or text messages. I authorize stating a detailed message to all phone numbers I have given to Prime MD.

The patient, a legal guardian or parent (if the patient is under 18 years old) will be responsible for the co-payment and the deductible at the time of service.

**I have read and understand the Financial Responsibilities/Assignment of Benefits and agree to its terms.**

_____ _____

Patient/ Guardian Signature Relationship to Patient

_____ _____

Printed Name Date

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## Medical Appointment Cancellation/No Show Policy

Thank you for trusting your medical care to Prime MD. When you schedule an appointment with Prime MD, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, **no later than 24 hours prior** to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. **Please see our Appointment Cancellation/No Show Policy below:**

- Any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office **at least 24-hour notice** will be considered a No Show.
- On the first occurrence, you will be given a warning
- From the second occurrence you will be charged a **$45.00 fee**.

  **If a fourth No Show or cancellation/reschedule without a 24-hour notice should occur the patient will no longer be able to schedule appointments in advance. <u>You will be seen on a walk-in basis.</u>**
- Any new patient who fails to show up for their initial visit will be given **one** additional appointment. If you are again no show for the second new patient appointment, no further appointments will be scheduled.
- The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit**.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact the Office Manager to discuss your situation. You may contact Prime MD during normal business hours Monday through Friday. Should it be after regular business hours you may leave a message, and we will return your call the next business day.

**I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.**

Patient/ Legal Guardian Signature

Relationship to Patient

Printed Name

Date

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## Patient Authorization of Disclosure

In general, HIPPA Privacy Rules gives individuals the right to request restrictions on uses and disclosures of their protected health information (PHI). The individual is also provided with the right to request confidential communications of PHI made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The patient may revoke or change this authorization at any time with a written request.

I wish to be contacted in the following manner (Mark all that apply):

Home telephone: _____

___OK to leave message with detailed information.

___Leave a message with call-back number only.

___Do not contact me at

Work Telephone: _____

___OK to leave message with detailed information.

___Leave a message with call-back number only.

___Do not contact me at work.

Mobile Telephone: _____

___OK to leave message with detailed information.

___Leave a message with call-back number only.

___Do not contact me on my mobile phone.

Email: _____

___OK to communicate using email.

___Do not contact me using email.

In a further effort to protect your PHI, we ask that you designate below to whom the physicians and staff may discuss your healthcare and scheduling needs as well as billing issues that may arise.

___Only disclose information to me.

_____ _____

Patient/ Legal Guardian Signature Date

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## Acknowledgement of Receipt of Notice of Privacy Rules

I certify that I was offered a copy of Prime MD's Notice of Privacy Practices. The Notice of Privacy Practices describes the types and uses and disclosures of my PHI that might occur in my treatment, payment of my bills or in the performance of Prime MD's health care operations. The notice of Privacy Practices also describes my rights and Prime MD's duties with respect to my PHI. The Notice of Privacy Practices is also posted in the reception area.

Prime MD reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy by sent in the mail or asking for one at the time of my next appointments.

Name Relationship Phone Number(s)

_____

_____

_____

_____

_____ _____

Patient/ Guardian Signature Date