Welcome

Thank you for selecting us.

To help us meet all your healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Patient Number ____________

Name ____________ Date ____________

Soc. Sec. # ____________ Birthdate ____________ Home Phone ____________

Address ____________ City ____________ State ______ Zip ______

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College ____________ City ____________ State ______ ☐ Full Time ☐ Part Time

Patient's or Parent's Employer ____________ Work Phone ____________

Business Address ____________ City ____________ State ______ Zip ______

Spouse or Parent's Name ____________ Employer ____________ Work Phone ____________

Whom May We Thank for Referring You? ____________

Person to Contact in Case of Emergency ____________ Phone ____________

Responsible Party

Name of Person Responsible for this Account ____________ Relationship to Patient ____________

Address ____________ Home Phone ____________

Drivers License # ____________ Birthdate ____________ Financial Institution ____________

Employer ____________ Work Phone ____________ SSN# ____________

Is This Person Currently a Patient in our Office? ☐ Yes ☐ No

Insurance Information

Name of Insured ____________ Relationship to Patient ____________

Birthdate ____________ Social Security # ____________ Date Employed ____________

Name of Employer ____________ Union or Local # ____________ Work Phone ____________

Employer Address ____________ City ____________ State ______ Zip ______

Insurance Company ____________ Group # ____________ Policy/ID# ____________

Ins. Co. Address ____________ City ____________ State ______ Zip ______

How Much is Your Deductible? ____________ How Much Have You Used? ____________ Max. Annual Benefit ____________

Do You Have Any Additional Insurance? ☐ Yes ☐ No If Yes, Complete the Following

Name of Insured ____________ Relationship to Patient ____________

Birthdate ____________ Social Security # ____________ Date Employed ____________

Name of Employer ____________ Union or Local # ____________ Work Phone ____________

Employer Address ____________ City ____________ State ______ Zip ______

Insurance Company ____________ Group # ____________ Policy/ID# ____________

Ins. Co. Address ____________ City ____________ State ______ Zip ______

How Much is Your Deductible? ____________ How Much Have You Used? ____________ Max. Annual Benefit ____________

Over Please

Patient Medical History

Physician ______________________ Office Phone ______________________ Date of Last Exam ______________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain ______________________		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? ______________________		
4. Do you use tobacco?	☐	☐
5. Do you use controlled substances?	☐	☐
6. Are you wearing contact lenses?	☐	☐

	Yes	No
8. Are you allergic to or have you had any reactions to the following:		
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (eg. nickel, mercury etc.)	☐	☐
Latex Rubber	☐	☐
Other ______________________	☐	☐
9. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

7. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles/Ulcers	☐	☐	Other ______________	☐	☐

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash
☐ Personal Check
☐ Credit Card ☐ Visa ☐ Mastercard
☐ I wish to discuss the office's payment policy.

LATE CHARGES

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional services except for emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such health care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor or medical group insurance benefits otherwise payable to me. I understand that my health insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X

Signature of patient (or parent if minor)

Doctor's Comments ______________________________________

____

Signature ______________________ Date ______________

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Our Legal Duty

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

Use and Disclosure of Your Medical Information

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

For Treatment:

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

For Payment:

We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

For Health Care Operations:

We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

Additional Uses and Disclosures:

In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory:

Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification:

We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief:

We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising:

We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances:

We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.