Health First
FAMILY MEDICINE

PATIENT INFORMATION

Name _____ **Date** _____/_____/_____
Last First MI

DOB _____/_____/_____ **SSN** _____-_____-_____ **Age** _____ **Sex** ☐ **M** ☐ **F**

Address _____
Street Apt # City State Zip

Home Phone (_____)_____ **Cell Phone** (_____)_____ **Work Phone** (_____)_____

☐ Yes, messages can be left at this number. ☐ Yes, messages can be left at this number. ☐ Yes, messages can be left at this number.

Which would you prefer we call? ☐ Home ☐ Cell ☐ Work

Email Address _____

Preferred Language ☐ **English** ☐ **Other** _____ **Race** _____

Marital Status _____ **Do you have an advance directive or living will?** ☐ **Yes** ☐ **No**

Emergency Contact _____
Name Phone Relationship

If you would like to authorize Health First Family Medicine to release information regarding your medical care to someone in addition to yourself (spouse, parent, etc.) please list name below. If not, please check the box below:

☐ **Please do not disclose information to anyone but myself**

_____ _____
Name **Relationship**

INSURANCE POLICY HOLDER (IF DIFFERENT FROM PATIENT)

Print Name as it appears on your insurance card:

Name _____ **DOB** _____/_____/_____
Last First MI

Address _____
Street Apt # City State Zip

Contact Number (_____)_____ **Relationship to Patient** _____

PRIMARY INSURANCE INFORMATION

Insurance Company _____ Benefit Phone _____

Subsciber ID # _____ Group # _____

SECONDARY INSURANCE INFORMATION

Insurance Company _____ Benefit Phone _____

Subsciber ID # _____ Group # _____

I have read all of the above information and have completed it to the best of my knowledge. I will notify you of any changes in my health status or demographic information. I hereby authorize Health First Family Medicine to furnish information to insurance carriers concerning my medical status. I understand that I am responsible for any amount not covered by my insurance.

_____ _____
Signature of Patient/Guardian **Date**

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MEDICAL HEALTH QUESTIONNAIRE

Name: _____ ____/____/_____ _____ **Sex:** ☐ **M** ☐ **F**
Last **First** **MI** **DOB** **AGE**

REASON FOR VISIT: _____

CURRENT MEDICATIONS (Prescription, Over-the-counter, Herbs, Vitamins)

Name of Medication	Dose	Dosing Instructions	Name of Medication	Dose	Dosing Instructions
1			5		
2			6		
3			7		
4			8		

ALLERGIES **(Please specify Allergen and Reaction below)**

☐ No Known Allergies ☐ Medication Allergies ☐ Environmental/Seasonal Allergies ☐ Latex Allergy

PERSONAL MEDICAL HISTORY (Check all that apply & Specify Type and Date)

☐ Alcoholism_____ ☐ Bleeding Disorders_____ ☐ Headaches_____ ☐ Liver Disease_____
☐ Allergies_____ ☐ Cancer_____ ☐ Hearing Loss_____ ☐ Osteoporosis_____
☐ Anemia_____ ☐ Depression_____ ☐ Heart Disease_____ ☐ Stroke_____
☐ Anxiety_____ ☐ Diabetes (type)_____ ☐ Hepatitis_____ ☐ Hyperthyroid Disease_____
☐ Asthma_____ ☐ Emphysema/COPD _____ ☐ High Blood Pressure_____ ☐ Hypothyroid Disease_____
☐ Arthritis_____ ☐ Epilepsy/Seizure Disorder_____ ☐ High Cholesterol _____ ☐ Other (specify)_____
☐ Blood Transfusion____ ☐ Glaucoma/Cataracts_____ ☐ Kidney Disease_____ ☐ NONE APPLY

HOSPITALIZATION & SURGERIES (Check all that apply. Specify and write in date)

☐ Appendix_____ ☐ Gallbladder _____ ☐ Tonsillectomy _____ ☐ NONE APPLY
☐ Adenoids _____ ☐ Heart _____ ☐ Tubal Ligation _____ ☐ Other _____
☐ Back _____ ☐ Hernia _____ ☐ Vasectomy _____
☐ Breast _____ ☐ Hysterectomy _____ ☐ C-Section _____

FAMILY HISTORY (Check all that apply. Specify type and list who had it)

☐ Asthma _____ ☐ Diabetes (specify) _____ ☐ Thyroid Disease (specify)_____
☐ Cancer (specify) _____ ☐ Heart Disease (specify) _____ ☐ High Blood Pressure _____
☐ Dementia/Alzheimer's _____ ☐ High Cholesterol _____ ☐ Other (specify)_____
☐ Depression _____ ☐ Stroke (specify)_____ ☐ NONE APPLY

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Name of Spouse, if applicable:** _____

Children (List names and Ages): _____

If applicable: ☐ Pregnant ☐ Breastfeeding

Living Situation: ☐ Live Alone ☐ With Spouse ☐ With Children/Family Members ☐ Other _____

Occupation: _____

Tobacco

Have you ever smoked? ☐ No ☐ Yes If YES, how many packs daily? _____ For how many years?_____
Do you still smoke? ☐ No ☐ Yes If NO, how many years quit? _____

Alcohol

Do you drink alcohol including beer, wine or other alcohol? ☐ No ☐ Yes ***If yes, please specify frequency:***
☐ Daily ☐ Almost Daily (4-6 times/week) ☐ 1-3 times per/week ☐ Less than one time/week

Illicit Drugs

Do you use any drugs or prescription medications not prescribed to you? (including marijuana, cocaine, amphetamines, pain or anxiety medications, etc)
☐ No ☐ Yes

If yes please specify type of drug and frequency of use: _____

HEALTH MAINTENANCE

Please provide the dates and results of the following immunizations, examinations, and tests to the best of your ability. If you have not had one of these services please indicate N/A (not applicable).

All Patients:

Last Tetanus Booster	☐ Within past 5 years	☐ Within past 10 years		☐ Unknown
Last Eye Examination	Date: _____	☐ Normal	☐ Abnormal	☐ Unknown
Last Colonoscopy	Date: _____	☐ Normal	☐ Abnormal	☐ Unknown
Last DEXA Bone Scan	Date: _____	☐ Normal	☐ Abnormal	☐ Unknown

Women:

Last Pap Smear	Date: _____	☐ Normal	☐ Abnormal	☐ Unknown
Last Mammogram	Date: _____	☐ Normal	☐ Abnormal	☐ Unknown

Men:

Last Prostate Specific Antigen (PSA)	Date: _____	☐ Normal	☐ Abnormal	☐ Unknown

Patient/Guardian Signature:_____ **Date:**_____

The information provided on this form has been reviewed by the physician.

Physician Signature:_____ **Date:**_____

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Name (Please Print):_____ **DOB**: _____/_____/_____

NOTICE OF PRIVACY POLICIES

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. There are certain circumstances that require us to use or disclose your health information. Some of these circumstances are: **to public health authorities, lawsuits, law enforcement officials, federal officials, correctional institutions, military officials (for members of the military only), Workers Compensation and Health Insurance programs**.

You have rights regarding your health care and information. These rights include but are not limited to: communication regarding your healthcare, inspection of any health information or medical records (including billing records but not including psychotherapy notes), requesting amendments to health information, filing complaints against privacy, written consent and authorization to disclose any health or personal information to certain individuals. If you have any questions regarding this notice or our health information privacy policies please contact a member of our staff.

***A full copy of our privacy policy is provided upon request.**

I have read and understand the copy of Privacy Policies provided on this clipboard. Initials: _____

HIPAA

Health First Family Medicine upholds the standards of the HIPAA laws. As a patient, we want you to know:

- We respect the privacy of your personal medical records and will do all we can to secure and protect that privacy.
- When it is appropriate and necessary, we provide the minimum necessary information to only those individuals required by law or who we feel are in need of your health care information and information about treatment, payment or health care operations in order to provide health care that is in your best interest.
- You may refuse consent to use or disclosure your personal health information, but this must be in *writing*.
- You have the right and we agree to provide you with access to your medical records in accordance with state and federal laws.

***A full copy of our HIPAA policy is provided upon request.**

I have read and understand the copy of HIPAA Policies provided on this clipboard. Initials: _____

***If you have any questions regarding this content, please speak with a member of the staff of Health First Family Medicine.**

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PAYMENT POLICY

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate in, payment in full is expected at each visit. If you are insured by a plan we participate in but do not have a current insurance card, payment in full for each visit is required until we can verify your coverage. When insurance is involved, we can file claims on your behalf in most cases. At times however, a portion of care is paid by the patient based on your specific plan. We will bill the responsible party for those services clearly outlined by the insurance plan that are the patients responsibility. Knowing your insurance benefits is your right and responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-Payments.** All co-payments must be paid at the time of service. This arrangement is part of our contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Non-Covered Services.** Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of your visit.

4. **Proof of Insurance.** All patients must complete our patient information forms before seeing the doctor. We must obtain a copy of your photo ID and a valid current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of your claim.

5. **Claims Submission.** We will submit your claims and assist you in any reasonable way to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their requests. The amount owed to the office as outlined in your insurance contract is your responsibility.

6. **Coverage Changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

7. **Missed Appointments**. Our policy charge is $25.00 for missed appointments not canceled 24 hours prior to your scheduled appointment time. These charges will be your responsibility and billed directly to you. Missing two or more scheduled appointments may result in being discharged from our office. Please help us to serve you better by keeping your regularly scheduled appointments.

8. **Financial Policy.** We are committed to providing you with the best possible care. In order to achieve this goal, we need your assistance and understanding of our payment policy. Co-payments and fees that you are responsible for are due in full at the time of service. Should the account become delinquent, your account will be referred to a collections agency and you will be responsible for those fees. In this case, you may be asked to seek treatment elsewhere until your account is reconciled. Acceptable forms of payment are cash, Visa, MasterCard, Discover or American Express.

Please leave a credit card to be on file for any balance due. We will NOT bill your credit card for any amount that is not your responsibility. This credit card will be used for any outstanding payment that is not settled after three attempts to contact the patient or representative.

PLEASE SELECT CREDIT CARD TYPE: ☐ **VISA** ☐ **MASTER CARD** ☐ **DISCOVER** ☐ **AMERICAN EXPRESS**

CARD #: _____ **EXP DATE:** _____ **SECURITY CODE:** _____

NAME AS IT APPEARS ON CARD: _____

By signing below you agree that you have read and understand the above information and comply with these policies.

_____ _____

Signature of Patient or Representative **Date**