

| |
|------------------------|
| Name: _____ |
| DOB: _____ Date: _____ |

Medications: Please list current prescriptions and non-prescription medications including vitamins.

Ex: Levothyroxine 50 MCG Once a day _____

Allergies/Reactions: Please list allergies to medication or food

No Known Allergies to medication or food

Example: Codeine – Rash _____

Past Medical History: **I have been diagnosed by a doctor with:** Please check all that apply.

Heart Disease

- Abnormal EKG
- Angina
- Heart Attack
- Heart Murmur
- High Blood Pressure
- High Cholesterol
- High Triglycerides
- Stroke
- Carotid Stenosis

Endocrine

- Diabetes (Type: 2 / 1) *(Circle One)*
- Thyroid Disease

Lung

- Asthma
- COPD / Emphysema
- Tuberculosis
- Blood Clot (Lungs)

Neurology

- Epilepsy
- Headaches / Migraines *(Circle One)*
- Stroke

Mental Health

- ADD/ADHD *(Circle One)*
- Anxiety
- Bipolar Disorder
- Depression

GI

- Acid Reflux / GERD
- Colitis
- Diverticulitis
- Esophagitis
- Gallstones
- Gastritis / Stomach Ulcers
- Hemorrhoids
- Hepatitis A / B / C *(Circle One)*
- Pancreatitis

Vascular

- Blood Clot (Arm / Leg) *(Circle One)*
- Phlebitis
- Varicose Veins

Musculoskeletal

- Arthritis
- Disk Problems
- Gout
- Osteoporosis / Osteopenia *(Circle One)*

Skin

- Eczema
- Melanoma
- Psoriasis

STD

- Chlamydia
- Genital Herpes
- Genital Warts
- Gonorrhea
- HIV/ AIDS
- Syphilis

Eye

- Cataracts
- Glaucoma

Genitourinary/GYN

- Cystitis
- Endometriosis
- Kidney Stones
- Ovarian Cyst
- Pelvic Problem
- Prostate Problem

Breast

- Fibrocystic Disease
- Mastitis

Cancer

- Breast - Colon - Lung -
- Prostate - Ovarian - Skin

Age at cancer diagnosis:
_____ yrs old

Other Diagnoses: _____

Surgeries/Hospitalizations & Dates:

Example: Left knee surgery 10/2007 _____

Family History: Please check all that apply. **Adopted/Unknown**

L - Living
D - Deceased
U - Unknown

Circle Status for all

| | Circle Status for all | Asthma | Arthritis | Cancer | Dementia | Diabetes | Heart Disease | High Blood Pressure | High Cholesterol | Depression or Anxiety | Stroke | Thyroid Disorder |
|------------------|-----------------------|--------|-----------|---------------|----------|----------|---------------|---------------------|------------------|-----------------------|--------|------------------|
| <i>Example</i> | L D U | | | <i>Breast</i> | | | X | X | | D A | | |
| Father | L D U | | | | | | | | | D A | | |
| Mother | L D U | | | | | | | | | D A | | |
| Dad's Father | L D U | | | | | | | | | D A | | |
| Dad's Mother | L D U | | | | | | | | | D A | | |
| Mom's Father | L D U | | | | | | | | | D A | | |
| Mom's Mother | L D U | | | | | | | | | D A | | |
| # ___ Brother(s) | L D U | | | | | | | | | D A | | |
| # ___ Sister(s) | L D U | | | | | | | | | D A | | |
| # ___ Sons | L D U | | | | | | | | | D A | | |
| # ___ Daughters | L D U | | | | | | | | | D A | | |

→ If you do not have any brothers/sisters or sons/daughters write a zero so we know you did not miss this section.

Please continue the form on the other side

Social History: Must be filled for patients 13 yrs or older

Occupation: _____ Marital Status: _____ Exercise: _____ # times/ week for _____ hrs.
Tobacco Use: Yes No Past Quit Date: _____ # of cigarettes per day: _____ for _____ years.
Drug Use (past 12 months): Yes No Type: _____ last used on: _____
Alcohol Use: No Occasional Daily # of Drinks: _____ per: Day - Wk. - Mo Beer Wine Hard Liquor
Caffeine: No Occasional Daily Drinks per day: _____ Coffee Tea Soda Energy Drinks

Immunizations: Please list the date of the most recent.

Tetanus Shot: _____ Pneumonia Vaccine: _____
Flu Shot: _____ Shingles Vaccine: _____

Screening Test: Please list the date of the most recent tests.

Eye Exam: _____ Bone Density: _____
EKG: _____ Stress Test: _____
Colonoscopy: _____ PSA: _____

Women Only:
(If none please write zero)

1st day of last period: _____
Last Pap Smear: _____
Last Mammogram: _____
of Pregnancies: _____
of Living Children: _____
of Miscarriages: _____
of Abortions: _____
of Still Births: _____

(For Office Use)
Vital Signs

Wt: _____ R: _____
Ht: _____ BP: _____
T: _____ HC: _____
P: _____ O2: _____

Vision: No glasses/contacts
B: _____ L: _____ R: _____

Hearing: L: _____ R: _____

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

Name of Representative/Guardian: _____

Office Use Only

Reviewed By: _____
Date: _____

(PLEASE SIGN SEPARATE CONSENT FORMS TO GET OLD RECORDS FROM OTHER DOCTORS)

Physician Notes: _____

PATIENT INFORMATION

Patient's Last Name: _____ First Name: _____ M.I.: _____ Preferred Name: _____
Street Address: _____ City: _____ Zip Code: _____
Home #: _____ Cell #: _____ Work #: _____ Birth Date: _____ Sex assigned at birth: M / F
Gender you identify with: Male/ Female/ Transgender Male/ Transgender female/ Gender Queer/ Other (please specify):
Pronouns: She/her/hers He/him/his They/them/theirs Other (please specify):
Relationship Status: Single Married Widowed Divorced Legally Separated
Email: _____ Race: _____ Ethnicity: Hispanic/Latino / Not Hispanic/Latino

EMERGENCY CONTACTS

(Must be a person other than a parent/guardian if patient is under 18yrs old)

Name: _____ Relationship: _____ Home #: _____ Cell #: _____
Name: _____ Relationship: _____ Home #: _____ Cell #: _____

PHARMACY INFORMATION

Pharmacy Name: _____ Street Pharmacy is on: _____ City: _____

INSURANCE INFORMATION

(Must be filled in by the patient even if the office scanned your insurance card)

I do not have insurance & will be paying for the visit myself I will pay out of pocket & need an itemized receipt for reimbursement from my insurance

Primary Insurance: _____ ID#: _____ Group #: _____

Policy Holder: _____ Relationship: _____ Policy Holder DOB: _____

Secondary Insurance: _____ ID#: _____ Group #: _____

Policy Holder: _____ Relationship: _____ Policy Holder DOB: _____

Tertiary Insurance: _____ ID#: _____ Group #: _____

Policy Holder: _____ Relationship: _____ Policy Holder DOB: _____

PARENT(S) / LEGAL GUARDIAN INFO
(Please fill if the patient is under 18 years old)

Parent / Legal Guardian: _____ DOB: _____ Relationship to Minor: _____
Home #: _____ Cell #: _____ Work #: _____ Guarantor/Responsible Party
Parent / Legal Guardian: _____ DOB: _____ Relationship to Minor: _____
Home #: _____ Cell #: _____ Work #: _____ Guarantor/Responsible Party

PERSONS AUTHORIZED TO HAVE ACCESS TO MY MEDICAL INFORMATION

(Example: Your spouse calls the office requesting to know the results of you recent labs, are we allowed to give it to them?)

Name: _____ Relationship: _____ Ph #: _____
Name: _____ Relationship: _____ Ph #: _____
Name: _____ Relationship: _____ Ph #: _____

Practice Policies

AGREEMENT OF FINANCIAL RESPONSIBILITY

I understand that it is my responsibility to know my insurance plan and its deductibles, co-insurance and copays. I **also understand that if my deductible has not been met, or a percentage is my responsibility, the office expects payment at the time services are rendered. Payment for charges from earlier visits not covered by your insurance is due at the time you check in.** Filing insurance claims is a courtesy that we extend to our patients, you are responsible for any balance after your insurance processes your claim. If not paid within 120 days, FMSG will begin various collection activities including, but not limited to submitting the past due account to a collection agency.

INSURANCE CARD AND ID POLICY

I understand that I must bring a physical insurance card and a current form of ID to **every appointment**. Without both physically present, I may be asked to reschedule my appointment. Pictures of the insurance card or photo ID on your phone will not be accepted. Nor can we accept for copies to be emailed to the office as that is a violation of HIPAA Regulations.

CONTROLLED MEDICATION POLICY

I understand that this office does **NOT** dispense and refill chronic pain and sleep medications. If needed, the office will give me a referral for pain management.

FEE FOR FORMS

The charge for completion of forms is \$35 or more based on complexity of the form and time needed to complete. Payment of fee is due up front. Please allow for 5 business days, unless the doctor is out of the office. Some forms require a more complex evaluation prior to completion and may require an additional visit to complete the form.

PRESCRIPTION REFILL POLICY

Initials

Contact our office through the '**patient portal**' for all prescription refills. Our office requires 2 business days' notice on ALL refill requests. You may call us at the office number, but the phone lines can get busy and reduces the efficiency.

SELF PAY POLICY

Initials

In order to address the needs of our patients without insurance, we offer a 30% discount off our standard fees. **In order to qualify, payment needs to be made IN FULL prior to or on completion of your visit or procedure.** Any remaining balance is not eligible for a discount. This discount is offered only at time of service. This policy does not apply to any miscellaneous charges.

MEDICAL RECORDS POLICY

Initials

- Processing Fee for both Disk and Paper - \$10 / CD – \$15 + \$2 postage if mailed
 - Paper – 45 cents per page + Postage (based on weight) if mailed
- We require 2 week notice for all medical records request.**

Signature: _____ Date: _____

Name of Representative/Guardian: _____ Relationship: _____

Missed Appointment Policy

Patient's Name

Date of Birth

We want to thank you for choosing us as your healthcare provider. In an effort to give you and all of our patients the best possible care we request that you review our policy regarding missed appointments.

A missed appointment is when you fail to show up for an allotted appointment time, without a phone call or cancellation notice of at least 24 hours. Please remember that we have reserved appointment times especially for you. Therefore, we require at least a 24 hour notice in order to reschedule your appointment. This will enable us to offer your cancelled appointment time to other patients. If you are unable to keep your scheduled appointment time, please call our office at least 24-hours in advance in order to avoid a missed appointment fee. **This fee is not covered by your insurance and would be due upon check-in at your next appointment.** Your phone call is critical in helping us provide continuous care to all of our patients and accommodate those who need to be seen. **Appointments scheduled and cancelled on the same day are subject to this same no-show fees.** If you fail to give us 24-hours' notice, you will be charged the following fees:

\$120.00 (Mon- Saturday)

| |
|-----------------------|
| <hr/> <p>Initials</p> |
|-----------------------|

*I understand that I will no longer be allowed to schedule appointments after my **2nd** Missed Appointment and will only be seen on a walk in basis.*

I have read and understand the policy stated above:

Signature of Patient or Legal Representative

Today's Date

Consent to Obtain External Prescription History



I authorize **Family Medicine Shady Grove** and its affiliated providers to view my external prescription history via the RxHub service.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

Patient Name

DOB

Signature of Patient or Personal Representative

Date

Name of Personal Representative

Relationship



**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
ACUSE DE RECIBO DEL AVISO SOBRE PRÁCTICAS DE PRIVACIDAD**

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

Aviso al Paciente:

Estamos obligados a ofrecerle una copia de nuestro aviso de prácticas de privacidad, que establece la forma en que puede usar y / o divulgar su información de salud. Por favor firme este formulario para acusar recibo de la notificación. Usted puede negarse a firmar este reconocimiento, si así lo desea.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.
Reconozco que he recibido una copia del Aviso Prácticas de Privacidad de esta oficina.

Patient name / *Nobre del Paciente* DOB/FDN Name of Representative / *Nombre del Representante*

Signature / *Firma* Relationship/*Relacion* Date / *Fecha*

FOR OFFICE USE ONLY / PARA USO DE LA OFICINA

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because / *Hemos hecho todos los esfuerzos para obtener el reconocimiento escrito del recibo de nuestro Aviso de Privacidad de este paciente, pero no se pudo obtener porque:*

- The patient refused to sign / *El paciente se negó a firmar.*
- Due to an emergency situation it was not possible to obtain acknowledgement / *Debido a una situación de emergencia no era posible obtener un reconocimiento.*
- Language Barrier / *Barrera de Idioma*
- Other (Please provide specific details) / *Otros (indique los detalles específicos)*

Employee Signature

Date