Patient Information

Last Name: _____ First Name: _____ DOB: _____
Sex : _____ Home Phone: _____ Mobile Phone: _____
Preferred Phone: Home or Mobile (circle one) Email: _____
Emergency Contact: _____ Relationship: _____
Emergency Contact Phone: _____ Patient Marital Status: _____

Current Address: _____

How did you hear about us: _____

Preferred Pharmacy Address: _____

Reason for visit: _____
_____
_____

Collection of the following information is encouraged by federal health agencies. This information is used to monitor and improve the quality of care provided to all patients.

Ethnicity:
□ Decline Response
□ Hispanic or Latino
□ Not Hispanic or Latino

Race:
□ Decline Response
□ American-Indian or Alaska Native
□ Asian
□ Black or African American
□ Native Hawaiian or Pacific Islander
□ White □ Other

Preferred Language: □ Decline Response

General Medical Questionnaire

Have you EVER had any of the following?

Asthma/Breathing Problems	□ Y	□ N	Heart Disease/Disorder	□ Y	□ N
Arthritis	□ Y	□ N	Lung Disorder	□ Y	□ N
Bleeding/Clotting Disorder	□ Y	□ N	Liver Disease	□ Y	□ N
Blood Pressure Disorder	□ Y	□ N	Neurological Disorder/Chronic Headaches	□ Y	□ N
Blood Transfusion	□ Y	□ N	Psychiatric Disorder/Illness	□ Y	□ N
Bowel/Stomach Problems	□ Y	□ N	Pulmonary Embolism/DVT	□ Y	□ N
Cancer	□ Y	□ N	Stroke	□ Y	□ N
Cholesterol Disorder	□ Y	□ N	Seizure or Epilepsy	□ Y	□ N
Diabetes	□ Y	□ N	Thyroid Disorder	□ Y	□ N
Eye Disorder (i.e. Glaucoma, cataract)	□ Y	□ N	Urinary/Kidney Disorder	□ Y	□ N

If Relevant: Gynecological Issues..... □ Y □ N

Please list any other medical illnesses or problems and provide details for any of the above conditions:

_____
_____
_____
_____

Please list all past surgeries and hospitalizations and the approximate date.

Procedure/ Hospitalization	Date	Complications

Please indicate any major conditions/illnesses that your immediate family members have had:

Relative	Condition and description	Living?	If deceased, at what age?
Mother		□ Y □ N	
Father		□ Y □ N	
Sibling		□ Y □ N	
Other:		□ Y □ N	

Do you currently smoke? □ Y □ N If no, previously? □ Y □ N Years smoked _____ Packs/day _____

Do you use other tobacco products? □ Y □ N Consume alcohol? □ Y □ N If yes, drinks/week: _____

If Relevant: Any past pregnancies? □ Y □ N How many? ___ How many deliveries? ____

Do you have any allergies to medications or other substances (pets, food, etc.)? □Y □N
If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis):

Allergy	Reaction	Allergy	Reaction

Please list ALL of your current medications, including over the counter medications, supplements, and herbs:

Medication Name	Dose	Medication Name	Dose

Please list and give approximate dates of and x-rays and injuries :

PATIENT'S AUTHORIZATION

Thank you for choosing **Exceptional Primary and Preventive Healthcare** for your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Copays are due at the time of service.
- Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:
- Charge for returned checks - $30.00

By my signature below, I hereby authorize assignment of financial benefits directly to **Exceptional Primary and Preventive Healthcare** and any associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Patient Acknowledgement and Authorization

We respect patient confidentiality and only release personal health information about you in accordance with the State and federal law. The attached notice describes our policies related to the use of the records of your care and how you may get access to this information. Please review this policy carefully.

By my signature below, I acknowledge that I have received and read the privacy notice provided by **Exceptional Primary and Preventive Healthcare** I hereby authorize **Exceptional Primary and Preventive Healthcare** and the physicians, staff, and hospitals associated with **Exceptional Primary and Preventive Healthcare** to release medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care.

_____ _____

Patient or Guardian Signature **Todays Date**

INSURANCE INFORMATION

Insurance Carrier:_____ Insurance Plan:_____
Contact Number:_____ Policy Number:_____

Group Number: _____ Social Security: _____

Relationship to Policy Holder: _____ Policy Holder name and DOB: _____

Financial Responsible Person: _____

Financial Responsible Person address and number (if different): _____

HIPPA/NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW CAREFULLY:
Exceptional Primary and Preventive Healthcare is required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA) to provide confidentiality for all medical records and other individually identifiable health information in my possession. This Notice is to inform you of the uses and disclosures of confidential information that may be made by Exceptional Primary and Preventive Healthcare and of your individual rights and Exceptional Primary and Preventive Healthcare 's legal duties with respect to confidential information.

Ways in which Exceptional Primary and Preventive Healthcare may use and disclose your protected Health information: Exceptional Primary and Preventive Healthcare may use and disclose at their discretion your medical records for each of the following purposes only: treatment, payment and health care operations.

- **Treatment** means providing, coordinating or managing health care and related services.
- **Payment** means activities such as obtaining payment for the health care services I provide for you from your insurance or another third party payer.
- **Health care operations** include the business aspects of running a practice.

Exceptional Primary and Preventive Healthcare may contact you to provide **appointment reminders or other services that may be of interest to you**. ☐

Exceptional Primary and Preventive Healthcare will disclose your protected health information to **any person you identify that is involved in payment for your care.**☐

Any other uses and disclosures will be made only with your written authorization. You will be provided with an authorization form upon request. A separate form will be needed for each request for release of information. The authorization for release of records is valid until it expires or is revoked. You may revoke authorization in writing an Exceptional Primary and Preventive Healthcare is required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

X_____

Patient or Guardian Signature and Date

Voice Mail Authorization

Do you authorize **Exceptional Primary and Preventive Healthcare to** convey information about your health care via Voice Mail Message?

Yes|No If so, would you like normal test notification only_____ or a detailed message regarding results_____

Disclosure

____I DO NOT permit Exceptional Primary and Preventive Healthcare to disclose information concerning my care or treatment to any individuals without my express consent or legal authorization.

_____I DO authorize Exceptional Primary and Preventive Healthcare to disclose information related to my care and treatment to the following individuals:

Name: _____Relationship:_____

Name: _____Relationship:_____