New Patient Forms

Please print an answer for all questions, if you have no answer then mark N/A.

Today's Date _____/_____/_____

Name (First & Last)_______________________________________ **Sex** F / M **Date of birth** _____/_____/_____

Address ____ **City** ____________ **State** ___________ **Zip**________

Home Telephone: ________-________-_______ **Cell phone**: ________-________-_______ **Social Security No**._______/_______/_______

Marital status: S D M W E-mail address: ____ If none check here ( )

Who referred you to our office? ____

Type of Occupation _______________________________________ (or please circle one: child, student, housewife, retired)

Employer's Name__________________________________ **Employer's Phone Number** ___________________________________

Spouse Name ____ **Date of birth** _______/_______/_______

Emergency contact ____ **Telephone No**______-______-__________

Race (circle one) American Indian or Alaska Native / Asian / Black or African American / White / Native Hawaiian or Pacific Islander /

Decline to answer

Ethnicity (circle one) Hispanic or Latino / Non-Hispanic or Latino / Decline to answer

Preferred Language _________________________**Religious Preference (optional)** _______________________________________

Health Insurance

Company ______________________________ **Policy Number** ____________________________________

Our office is fully compliant with HIPPA (Health Insurance Portability and Accountability Act of 1996) and as such we will do our best to protect the privacy of your medical records and information, in both paper and electronic, and will in most circumstances only release what is needed for medical treatment and insurance payments. Our privacy policy is posted in the waiting room and a copy is available upon request at our receptionist's desk. I understand this will be in my chart and maintained for 6 years.

Patient Name ____ **Date** _________________

Signature of Patient, Parent or Guardian, or Legal Representative ____

Please List ALL other providers. If none, check here ( )

Name	Specialty	Reason	Approximate start date

Please fill out a records release for ALL other providers so we can obtain the records.

Please List ALL medications, Prescription and Over the Counter, you are taking. Or give a current List to the receptionist to Copy.

Medication Name	Dosage	Reason for Use	Approximate start date

Please List ALL allergies to Medications. Or if: No Known Drug Allergies check here ( )

Name of Drug/Medication	Type of Reaction to drug/medication

List ALL previous surgeries. If none check here ( )

Name / Type	Approximate date of surgery

Please list Family History for the following: If unknown check here ( )

Mother	
Father	
Siblings	
Children	
Other:	

Social History

Do you smoke or use tobacco products?	**Yes / No**	**If so, what? For how long? How much/often?**
Any recreational drug use?	**Yes / No**	**If so, what? For how long? How much/often?**
Alcohol use?	**Yes / No**	**If so, what? For how long? How much/often?**

Have you completed any recent diagnostic testing? Y / N If yes, please explain:

Please mark an X on any that apply and year completed:					
Immunizations		**Labs**		**Other**	
	Td Year:		CBC Year:		Pap Year:
	Flu Year:		Chem Year:		Dental Exam Year:
	Pneumovax Year:		TSH Year:		Mammo Year:
	Hep. B Year:		PSA Year:		DEXA Year:
	Hep. C Year:		Lipid Profile Year:		Colonoscopy Year:
	Varicella Year:		U/A Year:		Stress Test Year:
	Shingles Year:		Hemoccults Year:		Eye Exam Year:
	MMR Year:		A1c Year:		CXR Year:
	Other Year:		PPD Year:		EKG Year:

Medical History (Check all those that apply and whether they are current or prior and when)

Sign/Symptom	***N/A***	***Current***	***Past***	***Year***	***S/S***	***N/A***	***Current***	***Past***	***Year***
Fatigue					Muscle Strength / Loss				
Weakness					Back or Neck Pain				
Weight Loss/Gain					Decreased Appetite				
Rash or skin lesion					Stomach Ulcers				
Headaches					Abdominal Pain				
Vision changes					Diarrhea				
Hearing changes					Hemorrhoids				
Tinnitus					Constipation				
Reading Glasses					Blackouts				
Congestion					Frequent Urination				
Sore throat					Heartburn				
Trouble swallowing					Nausea / Vomiting				
Vertigo / Dizzy					Kidney Stones				
Toothache					Burning with urination				
Chill / Fever					Diabetes				
Wheeze					Lupus				
Hoarseness					Gout				
Asthma					Arthritis				
Shortness of breath					Joint Pain				
Cough					Joint Swelling				
COPD					Numbness/Tingling				
Snoring					Poor wound healing				
Tuberculosis					Seizures				
Lung Disease					Alcoholism				
Abnormal Heartbeat					Depression				
High Blood Pressure					Anxiety				
Elevated Cholesterol					Panic Attacks				
Ankle/Leg Swelling					ADHD / ADD				
Known heart murmur					Cancer				
Breast lumps					Hot/Cold Spells				
Polio					Anemia				
Stroke					Elevated liver enzymes				
Thyroid Issues					Bleeding Disorders				
AIDS/HIV					Easy bruising				

Medication Agreement

The purpose of this agreement is to protect your ability to get prescriptions for medications and to protect our ability to prescribe them for you. The long-term use of prescriptions such as pain medications, tranquilizers, and sedatives may carry a risk of becoming addicted or a relapse occurring in a person with prior addiction. The level of risk is unknown and different for each person. Because medication can be abused or diverted, strict terms must be followed with long term use. For this reason the following terms are agreed to by you in order for your physician to continue to prescribe any medication. While you receive prescription medications from a provider at Access Injury and Primary Care, you understand and agree to the following terms

Initials **Agreement**

_____ 1. I will only use 1 pharmacy for all medication and refills. If I change pharmacies, I will notify your office in writing. My Select Pharmacy is: _______________________________ Phone #:______________________

_____ 2. I understand I am required to come in for a follow up at least every 6 months for non controlled prescriptions, and every month for controlled prescriptions.

_____ 3. I will call the doctor's office at least 1 week before my medication(s) run out. During office hours, a request for a refill will be taken care of as soon as possible; however it may take up to 5 business days. If the doctor is going to be out of the office, a prescription may be issued early if that refill is due. These prescriptions will contain instructions to the pharmacist that they are only to be filled on the appropriate date.

_____ 4. I will not wait until I'm completely out of medication(s) before I call.

_____ 5. I will NOT phone in for prescriptions after hours or on weekends.

_____ 6. I will NOT get a prescription renewal if I do not keep my scheduled appointments.

_____ 7. I will let my doctor know if I have any concerns about getting or taking my medication(s).

_____ 8. I will complete any and all tests or blood work order by my doctor, in order to continue my medication(s).

_____ 9. I will not share, sell, or place my medication(s) where other people can reach them. I will be responsible and protect any medication(s) or prescription(s).

_____ 10. I will follow the directions on how to take my medication(s), I will not stop taking medication(s) without consulting my doctor 1st.

_____ 11. I will tell this office and my doctor about any changes in medication, new medication(s), changes or new medical conditions, and/or any side effects.

_____ 12. I will ask my doctor if my other medication(s) are safe to take with my prescriptions.

_____ 13. I know my doctor has permission to discuss my medical information with my pharmacist or other medical professionals who provide my health care to make sure prescriptions are not being duplicated by other doctors.

_____ 14. I know that my medication(s) may not be replaced if they are lost, stolen, get wet, are destroyed, forgotten somewhere, etc. If my medication is stolen, then I will complete a police report regarding the theft and provide a copy to this office for an exception to be made.

I have read and understood this agreement. I have had my questions answered to my satisfaction. I understand failure to follow the listed terms may result in discontinuation of my medications, and could mean I would be discharged from this doctors care.

Patient Full Name:_________________________________ Date: ______________

Patient Signature:_________________________________ Date: ______________

Assignment of Benefits

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government benefits to ACCESS INJURY CARE, LLC. I authorize payment of medical benefits to Access Injury Care, LLC or supplier for the appropriate medical services.

PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance company. I understand any unpaid balance within 30 days will result in an additional 1%interest charge. If this account is assigned to a collection agency, an additional fee of 40% of amount owed will be added.

This assignment is meant to assign any and all rights and benefits of any and all of the undersigned patients' (assignors) insurance policies and any other benefits that cover services by Access Injury Care, LLC (assignee) its' employees, independent contractors, etc. This assignment includes, but is not limited to any and all health insurance, personal injury protection,

Medicare, Medicaid, Worker's Compensation or any other health care benefit. This included the right of Access Injury Care, LLC, to file suit for any and all such benefits.
I, the patient/assignor, acknowledge that I have received, and will receive, good and sufficient consideration from assignee, Access Injury Care, LLC, to include, but not be limited to, documentation of billing relevant insurance companies, legal claim for said benefits, and if necessary, file suit for such benefits instead of assignor having to do so. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

____ ________________

Patient/Guardian's Signature Date

Consent to Treat

The patient and / or authorized representative of the patient, whose signature is affixed below, does hereby consent to any and all medical treatments and diagnostic examinations administered at or in offered in association with the operations of Access Injury Care, LLC which treatments / examinations may be deemed advisable by my / the patient's physician to diagnose and / or treat me / the patient during the period I/ the patient am accepted as a patient of Access Injure Care Center, LLC.

____ ________________

Patient/Guardian's Signature Date