DEMOGRAPHIC INFORMATION, New Patient

Patient Information

Patient Name: _____
Mailing Address:_____
Primary Phone: _____ ☐ ok to leave brief msg? ☐ ok to leave detailed msg?
Second Phone: _____ ☐ ok to leave brief msg? ☐ ok to leave detailed msg?
Work Phone: _____ ☐ ok to leave brief msg? ☐ ok to leave detailed msg?
Employed? ___yes, full time ____yes, part time ____no ____retired ___other
Employer Name: _____
Address**:** _____
Date of Birth: _____ Social Security Number: _____
Marital Status: _____ Email Address *(only if wants web-enabled)*: _____

Insurance Information

Primary Insurance: _____
Primary Insurance Phone Number: _____
Primary Insurance Address**:** _____
Policy Holder Name: _____ Date of Birth : _____
Subscriber ID_____ Group Number: _____ SSN:_____
Relation to Patient _____

Secondary Insurance: _____
Secondary Insurance Phone Number: _____
Secondary Insurance Address: _____
Policy Holder Name: _____ Date of Birth: _____
Subscriber ID: _____ Group Number: _____ SSN:_____
Relationship to Patient: _____
Guarantor Name: _____
Guarantor Address: _____

Other Information

Please list an emergency contact number other than home number

Emergency Contact Name:_____Phone Number:_____ Relationship: _____
Local Pharmacy Name: _____ Pharmacy Phone: _____
If you have a mail away pharmacy, list here: _____
Race_____ Ethnicity_____Primary Language_____

Do you have Advanced Directives? ("Living Will", etc,)? __yes __no If yes please specify: _____

I hereby assign all medical and or surgical benefits to which I am entitled including all major medical, Medicare, Medicaid, private insurance, and any other health plans to Community Health Care Inc. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize Community Health Care to release all information necessary to secure payment.

****NEW PATIENTS ONLY: How did you hear about our office?** _____

Signature: _____ Date: _____

Please review this information, make any corrections necessary, and return form to the front desk when complete

MEDICAL RECORDS RELEASE TO OUR OFFICE

COMMUNITY HEALTH CARE (Community Health Care, Inc.)

Patient's Name: _____ **Patient's birthdate:** _____
Patient's Address: _____

FROM: Physician/person/facility to receive records:	TO: COMMUNITY HEALTH CARE OFFICES
Name_____	Name:_____
Address_____	Address:_____
City/State/Zip_____	City/State/Zip:_____
Phone_____ Fax_____	Phone:_____ Fax:_____

Purpose for release: _____

Documents to be released digitally or in print (check yes or no for EACH of the following items):

Yes	No	
☐	☐	**Standard Medical record: Office visit notes, labs, diagnostic imaging (non-privileged information) From _____/_____/_____ to _____/_____/_____**
☐	☐	Office visit notes only from ____/____/____ to ____/____/_____
☐	☐	Specific reports, photographs, results, or other medical information (Specify) : _____ from date _____/____/____ to ____/____/____

Privileged or specifically protected information:

YES	NO		
☐	☐	☐	Alcohol or drug abuse treatment
☐	☐	☐	Sexually transmitted diseases
☐	☐	☐	Domestic violence Victim's counseling
☐	☐	☐	Sexual assault Victim's counseling
☐	☐	☐	Psychiatric health---mental health information including communication between patient and a psychiatrist, psychologist, or other mental health care specialist
☐	☐	☐	Communication between patient and a Social Worker

YES	NO	
☐	☐	HIV/AIDS diagnosis and treatment: I specifically give permission to share information in my record about my HIV/AIDS diagnosis and/or treatment information. Initial here _____to specifically authorize its release as required.
☐	☐	Genetics testing: I specifically give permission to share information in my record about my genetics testing (excludes therapeutic generic tests). Initial here_____ to authorize its release.

I understand and agree that:

- The information which I authorize for release may be re-disclosed by the recipient and no longer protected by federal privacy regulations
- I may be charged a fee for information that is sent directly to me
- I decline the opportunity to inspect or copy the information released
- I have received a copy of this authorization.
- I may take back this authorization at any time by notifying the office from whom I am requesting this information, provided that the information has not already been released
- This authorization is voluntary
- My treatment will not be conditioned on the completion of this authorization
- My questions about this authorization form have been answered

This authorization expires 12 months from the date it was signed OR as specified: ____/____/____ .
If not specified, this authorization will expire 12 months from the date it was received.

_____ _____
Patient or Patient's Legal Guardian Date

FINANCIAL POLICY

Name: _____ DOB: _____

We are committed to providing you with the best possible care. We are anxious to help you receive your maximum allowable benefits if you have medical insurance. In order to do this, we need your assistance and your understanding of our **FINANCIAL POLICY**. We will also be asking you to periodically update your information.

We provide equal access to medical care regardless of source of payment.

Payment for services is **DUE AT THE TIME SERVICES ARE RENDERED**, unless payment arrangements have been approved in advance by our office manager. **We accept CASH, CHECKS, MASTERCARD, VISA, and DISCOVER**. Returned checks are subject to a $30.00 NSF FEE. Non-payment of returned checks may result in your termination as a patient of Community Health Care, Inc.

If there is a divorce involved, please remember that our policy requires that regardless of which parent is responsible for the bills, **PAYMENT IS DUE AT THE TIME OF SERVICE**. The person that brings the child to the office for the appointment is expected to make payment. As you should be able to understand, we will not get involved with divorce disputes. Please feel free to discuss this with our office manager if you have any questions.

Auto accident claims will either be paid at the time of service or be billed through your medical insurance coverage.

We will submit your insurance forms for you with a current signature on file permitting us to do so. Please remember that:

1. Your insurance is a contract between YOU, YOUR EMPLOYER, and the insurance company. We are not a party to that contract.
2. Not ALL services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services that they will NOT cover.

We must emphasize that as a provider of medical services, our relationship is to YOU, not your insurance company. While the filing of patient insurance forms is a courtesy we extend to our patients, all charges are YOUR responsibility from the date the service is rendered.

We are not providers for Workers' Comp care, and do not do any type of Workers' Comp paperwork or billing.

We realize that temporary financial problems may affect your timely payment of your account. If such problems DO arise, we encourage you to contact us promptly for assistance in the management of your account.

_____ _____

Signature Date

Yearly Consent Forms

✓ Consent to bill insurance

I hereby assign all medical and or surgical benefits to which I am entitled including all major medical, Medicare, Medicaid, private insurance, and any other health plans to Community Health Care Inc. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize Community Health Care to release all information necessary to secure payment.

✓ Consent to verify prescription records

I also consent to my physician to retrieve prescription records from external sources.

✓ Consent to verbally release records (HIPAA)

This is my authorization to allow VERBAL discussion of my condition, care, reminders of appointment times, or other medical information regarding the following patient:

- ☐ Me
- ☐ My child or ward, name: _____
- ☐ Other: _____

The following are AUTHORIZED to receive the patient's protected health information:

1. _____ Relationship:_____
2. _____ Relationship:_____
3. _____ Relationship:_____
4. _____ Relationship:_____

I have received today or at a previous visit a copy of Community Health Care's HIPAA "Notice of Privacy Practices".

Signed: _____ Signing Date: _____

Print Name: _____

Date of Birth: _____

Community HEALTH CARE

MEDICATION REFILL POLICY
(Effective September 1, 2016)

Currently our office receives a large volume of calls daily for medication refill requests. Our office staff can no longer safely manage this volume of phone requests. As of September 1, 2016 we have a new Prescription Refill Policy. We understand that this is a change for both you and Community Health Care.

- Please look over your medications and bring any refill requests to your upcoming scheduled appointment.

- We do require office visits on a regular basis for all of our patients taking prescription medication. The interval will vary depending on the type of medication prescribed. Please be sure you have enough medication to last until your **NEXT** scheduled visit**.**

- It is very important to request your prescriptions during your office visit. We will charge a fee of $15.00 for any refill requests outside of your regularly scheduled visit.

- Please bring all your prescription bottles with you to your appointment. This is important to make sure that you are taking the correct medications and the correct doses. We will continue to take the time to carefully review your medications and provide refills at your office visit.

Thank you for choosing Community Health Care for your health care needs.

We look forward to working with you to meet your health care needs.

_____ _____

Patient Name Date of Birth

_____ _____

Patient/Guardian Signature

MEDICAL HISTORY QUESTIONNAIRE—New Patient

Name: _____ **DOB:**_____ **Today's Date:** _____

Medical History: (if yes, please circle and indicate approximate date):

Abnormal chest Xray	Diverticulosis/itis	Irritable bowel
Abnormal EKG	Duodenal ulcer	Kidney disease
Abnormal labwork	Dysentery	Melanoma
Allergies	Ear infections	Menopause (female)
Alzheimers	Emotional problems	Migraines
Anemia	Emphysema	Multiple sclerosis
Angina	Endometriosis (female)	Osteoporosis
Anxiety disorder	Epilepsy	Overactive thyroid
Arthritis	Fibroids	Panic attacks
Asthma	Gall bladder disease	Phlebitis
Bleeding disorder	Glaucoma	PMS
Blindness	Goiter	Prostate enlargement (male)
Blood clot	Gonorrhea	Polio
Breast disease	Gout	Raynaud's
Broken bone(s)	Hay fever	Skin cancer
Cancer: Type_____	Heart disease	Syphillis
Carpal tunnel	Heart murmur	Tuberculosis (TB)
Cataracts	Hemorrhoids	Underactive thyroid
COPD	High blood pressure	Other: _____
Depression	Herpes: type_____	Other: _____
Diabetes Type I	High cholesterol	Other:_____
Diabetes Type II	Hypoglycemia	Other:_____
Diarrhea (chronic	Impotence	Other:_____

Allergies:

✓ **DRUG allergies:** Are you aware of any medication allergies? **Yes** **No** If yes, list the medicines below.

✓ **ENVIRONMENTAL allergies:** Please circle all below that apply to you.

Flowers	Grass	Tree pollen	Mold	Chemicals	Perfumes	Dyes	Animals
Soaps	Insect bites	Dust	Cosmetics	Fumes	Latex	Adhesives	

Other Environmental Allergies:_____

✓ **FOOD allergies:** please circle all that apply.

Eggs	Dairy	Wheat	Soy	Shellfish	Fruit	Vegetables	Peanuts

Other:
_____

Gyn and OB History (Females only!)

Issue	Comments
Periods	How often?
Sexual activity	Are you sexually active?
Pap	Date of last pap smear-
Mammogram	Date of last mammogram-
Bone density	Date of last bone density test-
Abnormal paps	Ever had an abnormal pap? _____ If yes, do you know the issue? _____
STD	Have you ever had a sexually transmitted disease? _____ If yes, what?
Birth control	What kind of birth control do you use?
Total Pregnancies	# of pregnancies
Total Living children	# of children born alive
Stillbirths	# of stillbirths
Miscarriages	# of miscarriages
Abortions	# of abortions
C-sections	# of C-Sections

Past Surgical History: (list all surgeries you have had, plus dates):

DATE	SURGERY
	Have you had a colonoscopy? _____no _____yes If yes, indicate date

Hospitalizations:

When	Why?

Family History:

Family Member	Now alive or deceased	Age	Health issues or cause of death
Father			
Mother			
Paternal GMA			
Paternal GPA			
Maternal GMA			
Maternal GPA			
Uncles			
Aunts			
Siblings			
Children			
Other			

Social History:

Issue	Details
Tobacco	Have you ever used tobacco? Never Former Currently
Alcohol	Do you use alcohol?
Narcotics	Using prescription narcotics?
Street Drugs	Using illegal drugs?
Herbal/Supp	Are you using herbal drugs or nutritional supplements?
Dietary	What is your usual diet?
Caffeine	How many cups of coffee/cola/caffeinated drinks per day?
Adv Directives	Do you have a Durable Power or Atty for Health and/or a Living Will?
Marital status	Status:
Children	
Occupation	What is your occupation?
Occupation Exp	Do you have exposure to dangerous substances at work? If yes, what?
Religion	(Optional answer)
Exercise	What kind of exercise do you do?
Travel	Do you travel outside the US?
Pets	Do you have pets? What kind?
Smoke detectors	Do you have smoke detectors at home?

Assistive devices (please circle all that apply):

Hearing Aid	Contacts	Glasses	Cane	Pacemaker	ICD (internal defibrillator)
Wheelchair	Neck brace	Back brace	Dentures	Walker	Other:_____

Patient Name: _____ DOB: _____

CIRCLE OF CARE

What specialists do you see?

☐ **None**

Specialist Name	Kind of specialty

☐ **Do you have a caregiver? ___no ___yes**

If yes, list who takes care of you:_____

☐ **Do you have a Legal Guardian?** __no _yes

If yes, list who is your guardian:_____