## PATIENT INFORMATION

| Date | | Last Name | | First Name | | Initial | |
|---|---|---|---|---|---|---|---|

| SS # | | Home Phone | | Cell Phone | |
|---|---|---|---|---|---|

| Address | | City | | State | | Zip | |
|---|---|---|---|---|---|---|---|

| Sex | ☐ M ☐F ☐Unspecified | DOB | | ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other |
|---|---|---|---|---|

| Race | | Ethnicity | | Language | |
|---|---|---|---|---|---|
| Your Pharmacy | | Town | | Phone | |
| How did you find us? | | Date of last physical | | By whom | |

| Family MD | | Address | |
|---|---|---|---|

| Driver's license Number | | State | | Email | |
|---|---|---|---|---|---|

| Patients Employer | | Occupation | |
|---|---|---|---|
| Business Address | | Business Phone | |

| Emergency Contact | | Emergency Phone | | | |
|---|---|---|---|---|---|

## PRIMARY INSURANCE

| *Person Responsible for Insurance Account* | *If information same as above (skip to section 2)* |
|---|---|

***Section 1***

| Relation to Patient | | Last Name | | First Name | |
|---|---|---|---|---|---|
| DOB | | SS # | | Phone | |

| Address if Different | | City | | State | | Zip | |
|---|---|---|---|---|---|---|---|

***Section 2***

| Insurance Company | | ID# | | Group# | |
|---|---|---|---|---|---|

## ADDITIONAL INSURANCE

| Is the Patient covered by additional insurance | ☐Yes ☐ No |
|---|---|

| Subscribers Name | | Relationship to Patient | | DOB | |
|---|---|---|---|---|---|

| Address if Different | | City | | State | | Zip | |
|---|---|---|---|---|---|---|---|

| Insurance Company | | ID# | | Group# | |
|---|---|---|---|---|---|

## MEDICATION LIST

| Name | | Date | |
|---|---|---|---|

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING,
BOTH PRESCRIBED BY YOUR DOCTOR AND OVER-THE-COUNTER.

| | Medication Name | Why are you taking this medication? | Dosage | Medication taken today | When did you begin taking this medication? |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |
| 6 | | | | | |
| 7 | | | | | |
| 8 | | | | | |
| 9 | | | | | |
| 10 | | | | | |
| 11 | | | | | |
| 12 | | | | | |
| 13 | | | | | |
| 14 | | | | | |
| 15 | | | | | |
| 16 | | | | | |

| Name | | Date | |
|---|---|---|---|

Please check all symptoms which apply ☒

## CONSTITUTIONAL SYMPTOMS

- ☐ Good general health lately
- ☐ Recent weight change
- ☐ Fever
- ☐ Fatigue
- ☐ Headaches

## EYES

- ☐ Eye Pain
- ☐ Wear glasses/contact lens
- ☐ Blurred vision
- ☐ Double vision

## EARS-NOSE-MOUTH-THROAT

- ☐ Hearing loss or ringing
- ☐ Earaches or drainage
- ☐ Nose bleeds
- ☐ Mouth sores
- ☐ Bleeding gums
- ☐ Bad breath or bad taste
- ☐ Sore throat or voice changes
- ☐ Swollen glands in neck

## CARDIOVASCULAR

- ☐ Chest pain or angina pectoris
- ☐ Palpitation
- ☐ Shortness of breath with walking or lying flat
- ☐ Swelling of feet, ankles or hands

## RESPIRATORY

- ☐ Chronic or frequent coughs
- ☐ Spitting up blood
- ☐ Shortness of breath
- ☐ Wheezing

## GASTROINTESTINAL

- ☐ Loss of appetite
- ☐ Change in bowel movements
- ☐ Nausea or vomiting
- ☐ Frequent diarrhea
- ☐ Painful bowel movements or constipation
- ☐ Rectal bleeding or blood in stool
- ☐ Abdominal pain or heartburn

## GENITOURINARY

- ☐ Frequent urination
- ☐ Burning or painful urination
- ☐ Blood in urine
- ☐ Change in force of stream when urinating
- ☐ Incontinence or dribbling
- ☐ Sexual difficulty
- ☐ Male - testicle pain or lump
- ☐ Female- pain with periods
- ☐ Female- irregular periods
- ☐ Female- vaginal discharge
- ☐ Female - # pregnancies __ # miscarriages __

## MUSCULOSKELETAL

- ☐ Joint pain
- ☐ Joint stiffness or swelling
- ☐ Muscle pain or cramps
- ☐ Back pain
- ☐ Cold extremities
- ☐ Difficulty in walking

## INTEGUMENTARY (skin, breast)

- ☐ Rash or inching
- ☐ Change in skin color
- ☐ Change in hair or nails
- ☐ Breast pain
- ☐ Breast lump
- ☐ Breast discharge

## NEUROLOGICAL

- ☐ Frequent or recurring headaches
- ☐ Light headed or dizzy
- ☐ Convulsions or seizures
- ☐ Numbness or tingling sensations
- ☐ Tremors
- ☐ Paralysis

## PSYCHIATRIC

- ☐ Memory loss or confusion
- ☐ Nervousness
- ☐ Depression
- ☐ Insomnia

## ENDOCRINE

- ☐ Glandular or hormone problem
- ☐ Excessive thirst or urination
- ☐ Heat or cold intolerance
- ☐ Skin becoming dryer
- ☐ Change in hat or glove size

## HEMATOLOGICAL- LYMPHATIC

- ☐ Slow to heal after cuts
- ☐ Bleeding or bruising tendency
- ☐ Past transfusion
- ☐ Enlarged glands

## ALLERGIC- IMMUNOLOGIC

History of skin reaction or other adverse reaction to:

- ☐ Penicillin other antibiotics
- ☐ Morphine, Demerol or other narcotics
- ☐ Novocaine or other anesthetics
- ☐ Aspirin or other pain remedies
- ☐ Tetanus antitoxin or other serums
- ☐ Iodine, Merthiolate or other antiseptic
- ☐ Other drugs / medications (list below)
- ☐ Known food allergies (list below)

| HEALTH HISTORY | |
|---|---|
| PAST MEDICAL HISTORY: Please describe conditions you have or have had in the past | |
| 1 | |
| 2 | |
| 3 | |
| 4 | |
| 5 | |
| 6 | |
| 7 | |
| 8 | |
| 9 | |

| Other Serious Illnesses or Injuries: | |
|---|---|
| | |
| | |

| SOCIAL HISTORY | | | | | |
|---|---|---|---|---|---|
| Number of Children: | | Marital Status: | | Occupation: | |

| FAMILY HISTORY | | |
|---|---|---|
| DISEASE | | RELATIONSHIP TO YOU |
| ☐ | CANCER | |
| ☐ | DIABETES | |
| ☐ | EPILEPSY | |
| ☐ | HEART DISEASE | |
| ☐ | HIGH BLOOD PRESSURE | |
| ☐ | HIGH CHOLESTEROL | |
| ☐ | MIGRAINE | |
| ☐ | STROKES | |
| ☐ | OTHER | |

| MEDICAL INFORMATION RELEASE FORM / HIPAA RELEASE FORM | | | |
|---|---|---|---|
| Name | | Date of Birth | |

## RELEASE OF INFORMATION

| | | | |
|---|---|---|---|
| ☐ | I authorize the release of information that may include protected health information under HIPAA<br>This information may be released to: | | |
| ☐ | Spouse | Name | |
| ☐ | Child(ren) | Name | |
| ☐ | Other | Name | |
| ☐ | Information is not to be released to anyone | | |
| This release of Information will remain in effect until terminated by me in writing. | | | |

## MESSAGES

| | | | | |
|---|---|---|---|---|
| Please call | ☐ My home | ☐ My work | ☐ My cell | ☐ Call this number (        ) _ _ _ - _ _ _ _ |
| If you are unable to reach me | | | | |
| ☐ You may leave a detailed message | | | | |
| ☐ Please leave a message asking me to return your call | | | | |
| ☐ Other (please describe) | | | | |

| The best time to reach me is | Day(s) | | Between (time) | from          to |
|---|---|---|---|---|

| Signature | | Date | |
|---|---|---|---|

## FINANCIAL POLICY

We are pleased you chose Patient First MD for your healthcare needs. Our goal is to provide you with the highest quality healthcare services possible. In choosing our services, you have accepted the financial responsibility to ensure full payment.

**Copayments:** Your copayment, as stated on your insurance card, will be collected from you prior to your visit. You may pay by cash, check, or credit card. We gladly accept Visa, MasterCard, and Discover cards for payment.

**Private Pay:** The patient agrees to pay Patient First MD at the time of treatment for services rendered. We will provide a statement that can be used to submit claims for reimbursement or kept for personal records.

**Medicare:** Patient First MD Is a participating Medicare Part B program provider. We will bill Medicare directly for services rendered. You will be responsible for any deductibles and coinsurance.

**HMO/PPO/POS:** Our office participates in most HMO, PPO, and POS plans. You are responsible at the time of service for any copayment stated on your insurance identification card. Any additional amounts due by you will be billed to you once your Insurance processes the bill.

**Major Medical:** Your major medical insurance coverage Is a contract between you and your insurer. Patient First MD will bill your insurance carriers directly as a courtesy to you. You are responsible for any deductible, copayments, or coinsurance your insurance carrier determines.

**Out of Network Carrier**: The undersigned agrees to remit payment for all items and/or services provided. Any estimated coinsurance is due at the time of service. The balance due will be that portion of Provider's applicable charges not paid by insurance or any other payer including self-funded plans and may be more than and include the coinsurance, co-payment and deductible amounts, as well as amounts due for non-covered items/ services. The undersigned agrees to pay the balance due in full upon receipt of an invoice from Provider. If prompt payment is not made, Provider may pursue its standard collection policy or other applicable remedies at Provider's sole discretion. Under the Providers standard collection policy, all legal fees including attorney and court fees will be the responsibility of the undersigned. The undersigned agrees that an interest of 1 % monthly will be due for all outstanding payment and will be added to the total outstanding amount due. The undersigned agrees that the services rendered by Provider, whom I have been advised does not participate in and will be billed to third party payers including self-funded plans at an out of network level. If you have any questions you should contact the health care professional ordering the services to be provided or consult your health benefits plan / self-funded administrator for information regarding copayment, deductible and or coinsurance amounts.

**Assignment of Benefits:** The undersigned requests that payment of authorized benefits be made to Provider, and authorizes Provider to collect directly all public and private insurance coverage benefits due, for any items/services furnished to Patient by Provider. In the event benefit payments due Provider are paid directly to Patient or the undersigned, the payee shall immediately and without request from Provider, endorse and remit to Provider all such benefit payment checks. If payment is not remitted in full within 30 days upon receipt from the insurance provider, Provider will pursue its standard collection policy. On assigned Medicare claims, Provider agrees to accept the applicable Medicare allowable amount (including deductibles and co-payments paid by the undersigned) as payment in full for covered items/services

**Workers' Compensation/Motor Vehicle Accident:** Patient First MD will bill your insurance carrier for you directly. Should your claim be found non-compensable, we will bill your private insurance. You will be responsible for paying for patient responsibility as stated by your health insurance. It is not our policy to await the results of your litigation to receive payment; we will not hold a Letter of Protection or Lien on your account. We do not waive any financial responsibility in litigation cases.

**Referrals/Authorization:** You are responsible for obtaining a referral or authorization as required by your insurance for our services. You may be financially responsible for any charges denied due to the absence of a referral or authorization. Your scheduled visit may also be rescheduled due to the absence of a referral or authorization.

**Cancellation Policy:** If you fail to call and cancel your appointment, you will be billed a cancellation fee of $25.00, which your insurance company will not pay.

**Returned Checks:** If your personal check is returned to us by your bank for any reason, you will be charged a fee of $25.00. Both your original payment and check fee are payable In cash or credit card. Any future payments you must make to our office must be cash or credit card.

I have read the above policy regarding my financial responsibility to Patient First MD for providing medical care to me or the below-named patient. I understand that my failure to comply with the financial policies of Patient First MD may cause Interruptions in my medical care. I understand that it is my responsibility to inform this office of any correspondence that I received from my Insurance company notifying me of a change or cessation of my insurance coverage.

| Patient Name | | Patient Signature | | Date | |
|---|---|---|---|---|---|
| Patient Legal Guardian | | Guardian Signature | | Date | |
| Relationship to Patient | | | | | |

## RECORDS RELEASE AUTHORIZATION

| Patient Name | | DOB | |
|---|---|---|---|
| Address | | | |

Please release my medical records to:

Patient First MD
1000 State RT 35
Suite 101
Middletown, NJ 07748

Ph: 732.629.9699   Fax: 732.724.9802

I authorize the release of my medical records or other health care information, including intake forms, chart notes, reports, correspondence, and other written information concerning my health and treatment during the period of

_______________________________________ to _______________________________________

| Signature of Patient or Patient Representative | |
|---|---|

## NOTICE OF NO AFTER-HOURS COVERAGE

| Patient Name | | DOB | |
|---|---|---|---|

Please be aware that we do NOT have after-hours coverage for phone messages. Any messages left on our voicemail will not be received or returned until the next business day.

In case of a medical emergency, you should call emergency services.

If an urgent medication refill is needed after-hours, your pharmacist should be able to supply an emergency refill.

I acknowledge the above statements.

| Signature of Patient or Patient Representative | | Date | |
|---|---|---|---|