

Patient Information

Please fill out this page in its entirety. Thank you!

Name: _____ Preferred Name: _____
Last, First, Middle Initial

Date of Birth: _____ Age: _____ Sex: M F Marital Status: M S D W

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Cell: _____ Home: _____

Employer: _____ Work: _____

Email: _____

Local Pharmacy Information

Please include a local pharmacy; if you do not have one, please let the front office staff know.

Pharmacy Name: _____

Pharmacy Address: _____ Pharmacy Phone: _____

Guarantor/Guardian (For patients UNDER 18 years of age)

Name: _____ Phone: _____

Relationship to Patient: _____ Date of Birth: _____

Legal Guardian? YES NO (Guardianship documentation is **required** at time of check-in.)

Emergency Contact Information

Name: _____ Phone: _____

Relationship to Patient: _____

Insurance Information

Primary: _____

Secondary: _____

Policyholder Information

Please make sure to fill out this portion if the patient is not the policyholder. We need this information in the event we have to schedule surgeries or procedures and to obtain billing benefits.

Name: _____ Phone: _____

Relationship to Patient: _____ Date of Birth: _____

Signature: _____ Date: _____

Or Signature of Parent/Guardian if Under 18 Years of Age

Patient Medical History Questionnaire

Name: _____ Date: _____

Medical History

Please list all illnesses (e.g., cancer, diabetes, high blood pressure, stroke, heart attack, etc.).

Surgical History

Please list all of the surgeries that you have had and the approximate date performed.

Family History

Please list all illnesses that run in your immediate family. List maternal or paternal, including grandparents.

Social History

Do you currently smoke or use tobacco products: Y N

If yes, age started? _____ How much per day? _____

If you are a former smoker, at what age did you start/stop? _____ / _____

Do you drink alcoholic beverages? _____ How much in an average week? _____

Allergy History

Please list all allergies (both to medications and environmental allergens) that you have.

Current Medications

Please list all current medications and their dosages if known, or allow us to copy your list.

**Include over-the-counter medications.*

*** Please complete the backside of this form. ***

Is there a possibility that you may be pregnant? Y N

Have you had or do you have hepatitis? Y N

Have you had or do you have HIV? Y N

Review of Systems: Please answer the following questions regarding how you feel currently.

Do you or have you recently had any of the following?

EYES

Visual changes in the past year? Y N

Glaucoma? Y N

Double or blurred vision? Y N

Pain, redness or dryness? Y N

EARS

Do you currently wear hearing aids? Y N

Date of purchase? _____

Hearing problems? Y N

Ringing in the ears? Y N

Discharge from the ears? Y N

Loss of balance/vertigo? Y N

Ear pain? Y N

Pressure in the ears? Y N

Frequent ear infections? Y N

History of loud noise exposure? Y N

NOSE

Nasal congestion? Y N

Nasal discharge? Y N

Post-nasal drip? Y N

Loss of smell? Y N

Frequent nosebleeds? Y N

Snoring? Y N

Injury to the nose? Y N

Nasal or sinus surgery? Y N

Frequent sinus infections? Y N

THROAT

Sore throat? Y N

Frequent throat infections? Y N

Painful or difficult swallowing? Y N

Hoarseness? Y N

HEART

Heart problem? Y N

High blood pressure? Y N

Angina/chest pain? Y N

Swelling in the ankles? Y N

CHEST

Asthma? Y N

Bronchitis? Y N

Shortness of breath? Y N

Wheezing? Y N

Chronic cough? Y N

Cough up blood? Y N

History of tuberculosis? Y N

DIGESTIVE

Stomach problems? Y N

Heartburn/ulcers? Y N

Gallstones? Y N

Vomited blood? Y N

Chronic constipation/diarrhea? Y N

Blood in the stool? Y N

Liver problems? Y N

GENITOURINARY

Kidney stone? Y N

Frequent urination? Y N

Bladder infections? Y N

Painful urination? Y N

INTEGUMENT

Previous skin cancer? Y N

Changes to existing skin lesions? Y N

Previous melanoma? Y N

Changes to moles? Y N

New skin lesions? Y N

History of prolonged sun exposure? Y N

NEUROLOGICAL

Frequent severe headaches? Y N

Weakness/paralysis? Y N

Tremors? Y N

Convulsions/seizure? Y N

Stroke? Y N

Loss of consciousness? Y N

MUSCULOSKELETAL

Severe back pain? Y N

Joint pain? Y N

ENDOCRINE

Heat intolerance? Y N

Excessive sweating? Y N

Thyroid condition? Y N

Diabetes? Y N

Hypoglycemic? Y N

Hyperglycemic? Y N

PSYCHIATRIC

Difficulty sleeping? Y N

Difficulty staying asleep? Y N

Excessive daytime sleepiness? Y N

BLOOD

Anemia? Y N

Easy bruising? Y N

Received transfusions? Y N

Office Use Only

Height _____ Temp _____

Weight _____ Pulse _____

B/P _____

The above information is true and correct to the best of my knowledge.

Signature: _____ **Date:** _____

Authorization for Release of Information

Patient Name: _____ Date of Birth: _____

CCOA is authorized to release protected health information about the above-named patient to the entities listed below.

Entity(ies) to Receive Information

Spouse

Name: _____ Phone: _____

This entity may receive health information about:

Clinical information Billing information All

Parent

Name: _____ Phone: _____

This entity may receive health information about:

Clinical information Billing information All

Other

Name: _____ Phone: _____

This entity may receive health information about:

Clinical information Billing information All

Information is not to be released to anyone but me.

Voicemail

Please call: Home Cell Work

If unable to reach me:

You may leave a detailed message. Please leave a message asking to return your call only.

I understand that I have the right to revoke this authorization at any time. I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will be in effect until revoked by the patient.

Signature: _____ Date: _____

Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name: _____

Address: _____

(Street)

(City)

(State)

(Zip)

I have received a copy of the Notice of Privacy Practices for the above-named practice.

(Signature)

(Date)

For Office Use Only

We were unable to obtain a written acknowledgment of receipt of the Notice of Privacy Practices because:

An emergency existed, and a signature was not possible at the time.

The individual refused to sign.

A copy was mailed with a request for a signature by return mail.

Unable to communicate with the patient for the following reason: _____

Other: _____

Prepared by: _____

Signature: _____

Date: _____

Financial Policy

If you are covered by health insurance, please provide your insurance information to the front office staff, and we will be happy to bill your insurance. Accepting your insurance information does not place any financial responsibilities onto this practice, and you will be held accountable for any unpaid balances.

Based on the limits of your insurance plan benefits, not all diagnostic tools and procedures performed by our practice may be considered inclusive with the office visit. You, the patient, would be financially responsible for any amount applied to your deductible, out-of-pocket expense, coinsurance amount or noninclusive amount. Co-payments are collected at the time of service. Any other balances are due upon receipt of a statement from our office.

No-show appointments are subject to a \$35 missed appointment fee.

Completing insurance forms, copying medical records, etc., requires office staff time and physician time away from patient care, so we require payment for completing forms or copying medical records. The charge is determined by the complexity of the form, letter or communication.

I authorize the release of medical or other information necessary to process insurance claims, and I authorize payment of the medical benefits directly to this practice for services rendered.

Patient Name: _____ Date of Birth: _____

Parent or Responsible Party (if patient is under 18 years old): _____

Signature: _____ Date: _____