PATIENT HISTORY FORM

Patient Name: ________________________________ Date of Birth___________________________

Today's Date__________________________________ Social Security Number___________________

PAST MEDICAL HISTORY

Previous Physician's name:________________________ Date of last exam:________________________

Have you ever been hospitalized? Yes____ No_____ If yes, what for?_____________________________

Have you ever been tested for hepatitis A, B or C? Yes____ No______ Which Hepatitis virus?____________

Vaccines: **Hepatitis B:** Yes___ No___ If yes, date:____________ **Influenza:** Yes___ No___ If yes, date:____________

Tetanus: Yes___ No___ If yes, date:____________**Pneumonia:** Yes___ No___ If yes, date:____________

Have you had a sexually transmitted disease? Yes_____ No_____ Diagnosis_______________________

Which of the following conditions are you currently being treated or have been treated for in the past?

Heart disease/Murmur/Angina___ Shortness of breath___ Eye Disorder/glaucoma___ Diabetes_____

High cholesterol_____ Asthma_____ Seizures_____ Kidney/Bladder problems_____

High blood pressure_____ Lung problems/cough_____ Stroke_____ Liver problems/Hepatitis____

Low blood pressure______ Sinus problems_____ Neurological problems_____ Cancer______

Anemia or blood problems_____ Tonsillitis______ Depression/Anxiety______ Ulcers/colitis______

Swollen ankles_______ Ear problems_______ Psychiatric care______ Thyroid problems________

Please describe any current or past medical treatment not listed above:

____

____

Please list your past surgeries:

____

____

Allergies

Are you allergic to penicillin or any other drugs? Yes ________ No ___________

Please list :____ reaction: ________________________________

Medications:

Please list: ____

____

PLEASE COMPLETE REVERSE SIDE

Family History

	Living	Age	List serious illnesses
Father:	Yes___ No___	______	________________
Mother:	Yes___ No___	______	________________
Sisters :	Yes___ No___	______	________________
	Yes___ No___	______	________________
	Yes___ No___	______	________________
Brothers:	Yes___ No___	______	________________
	Yes___ No___	______	________________
	Yes___ No___	______	________________

Has any member of your family (including children and parents) had any of the following illnesses?

Illness	Which family member? (Mother or father's side?)	
Anemia or blood disease	________________	**Living Yes _____No_____**
Cancer (which kind?)	________________	**Living Yes _____No_____**
Diabetes	________________	**Living Yes _____No_____**
Glaucoma	________________	**Living Yes _____No_____**
Heart disease	________________	**Living Yes _____No_____**
High blood pressure	________________	**Living Yes _____No_____**
HIV disease/ AIDS	________________	**Living Yes _____No_____**
Mental Illness/ Depression	________________	**Living Yes _____No_____**
Stroke	________________	**Living Yes _____No_____**
Other serious illness	________________	**Living Yes _____No_____**

Social and Preventative History:

Do you drink alcohol, beer, or wine? Yes ___ No ___ if no, have you in the past? Yes _____ No _____

How many drinks per week? ___________

Do you currently drink coffee and/or tea? Yes ___ No ___ If yes, how many cups per day? ______________

Do you exercise daily/weekly? Yes ___ No ___

Do you currently smoke or chew tobacco? Yes____No ___ if no, have you in the past? Yes_____ No ______

Do you wear seatbelts while driving? Yes __ No __ Do you wear a helmet while riding a bike? Yes ___ No ____

Females: Gynecological History:

How many times have you been pregnant? ____________ How many children do you have ________________

Date of last Pap Smear? _______________ Have you ever had an abnormal Pap Smear? Yes___ No___

Diagnosis: ___________ Follow up: ____________________________

Date of last Mammogram? _______________________ Mammogram results? _____________________________

Have you ever had a breast biopsy? Yes ___ No ___ Biopsy results: ___________________________________

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient/Legal Guardian Signature ____Date: ____________

PATIENT INFORMATION

Name: ________________________________Date of Birth:_____/_____/_____ Age: ____ Sex_____

SSN: _______________________________ Home Phone: (_____)__________________________

Cell Phone: (_____) _________________ E-Mail:____

Address: ____ Nick Name: ____________

City: ____________________ State: ____________ Zip Code: _______________________

Employer: _______________________________ Work Phone :(________) __________

Employer Address: ______________________________ Emergency Contact (name/#):_____________________

INSURANCE INFORMATION -PRIMARY INSURANCE INFORMATION

Subscriber Name: ___________________________________ Subscriber DOB: ___________________

Policy #:____________________________________ Group #________________________________

Subscriber SSN: ______________________________ Relation to Patient:_______________________

Subscriber Employer: _________________________ Insurance Co. Name: ____________________

Effective Date of Insurance: ________________________

SECONDARY INSURANCE INFORMATION

Subscriber Name: ___________________________________ Subscriber DOB: ___________________

Policy #:____________________________________ Group #________________________________

Subscriber SSN: ______________________________ Relation to Patient:_______________________

Subscriber Employer: _________________________ Insurance Co. Name: ____________________

Effective Date of Insurance: ________________________

PLEASE INCLUDE COPY OF INSURANCE CARD FRONT AND BACK

I agree to promptly pay for the services rendered for me or the patient named above. I authorize Family First Medicine to test my blood for hepatitis and/or HIV if in their opinion an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration. INSURED or AUTHORIZED PERSON"S SIGNATURE: I authorize payment of medical benefits directly to Family First Medicine on my behalf for services rendered.

Signature:____ Date:____________________

Office Policies

(Please initial each line)

_____**CO-PAYS:** Co-pays must be paid prior to every office visit upon check-in.

_____**INSURANCE CARDS:** Please bring your insurance card to every visit.

_____**LATE TO APPOINTMENTS**: If you are more than 5 minutes late to your appointment, you may be asked to reschedule.

_____**NO SHOW TO APPOINTMENTS**: Failure to show up for a scheduled appointment is not acceptable. Each offense will result in a $50 fee. The second time you fail to come to an appointment you will receive a warning letter in addition to the $50 fee. The third time you will be dismissed from the practice.

______**MEDICATION REFILL REQUESTS:** Please contact your pharmacy if a refill is needed and then allow 48 hours for all medication refill requests.

______**TELEPHONE MESSAGES:** Please allow 48 hours for a returned phone call from a telephone message unless it is an emergency.

______**FEES FOR FORMS:** There is a $10 per page form fee for all forms to be filled out. FMLA is a flat $50 fee.

______**TEST RESULTS:** Any time a test or procedure has been ordered for you, the results should come within 2 weeks. Any time you have not been notified of a test result within 2 weeks, please call for the results.

______**PATIENT RESPONSIBILITY FOR BILLING:** It is the patient's responsibility to be aware of their current insurance plans and provide that information for us to bill. It is also the patient's responsibility to know their plan and what types of coverage they have. All outstanding bills not paid by the insurance carrier will become patient responsibility.

______**NON-COMPLIANCE WITH PROVIDER PLAN OF TREATMENT:** We require that you comply with your provider's plan of treatment 100% of the time. If you question an ordered test or procedure, please communicate that concern to your provider at an appointment. Non-compliance with the plan of treatment including lab work and testing is grounds for immediate dismissal.

Thank you for your cooperation with these office policies.

BILLING AND PAYMENT AGREEMENT

Welcome to Family First Medicine. We are happy that you have chosen us as your primary care medical office. Finances are always a sensitive subject to address; however, we believe that it is important to address insurance and payment issues at the onset of our relationship so that there are no issues for either of us once we begin.

- Most people chose a doctor who is approved by their insurance company. Therefore, all initial paperwork must be completed correctly in order for us to receive third party insurance payment so that you do not incur any unnecessary costs.

- Your individual insurance company sets your co-pay. You may also have a deductible that has to be met before the insurance will begin to pay for services. You pay this directly to your doctor's office and then when the deductible, (if any) is met, the insurance will begin to pay. This varies from company to company, so it is to your advantage to check with your company's benefit coordinator before you come in for your visit.

- We cannot charge the insurance company for missed appointments; therefore it is our policy to charge $25.00 for cancellations of less than 24 hours prior to a scheduled appointment and $50.00 for no call no show. Remember that you have committed for that time and have blocked out a physician's time to others. There will also be a $45.00 service charge for all returned checks.

- If you should change insurance companies, let us know so that we can check to see if your coverage is the same. Should you change insurances and not inform us, you may become individually liable for visits that could have otherwise been covered under your new insurance. It is important that you let us know whether more than one insurance company covers you, and if so which insurance is primary and secondary so that we can bill the primary company first or your second insurance will be null and void.

- We hope that this will clear up any questions you may have about the clerical end of your visit with us. Please feel free to ask any questions you have. By your signature it is understood and agreed that you are directly responsible for payment for the services rendered whether or not your insurance is involved. If it becomes necessary to go outside of the office to any agency for the collection of fees, you will be charged for the additional expenses.

- Signature:______________________________ Date:_______________

INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), ________________________have insurance

coverage with:____,

and assign directly to Family First Medicine all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named health facility may use my health care information and may disclose such information to the above-named insurance company (-ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

The above named health facility may also disclose my health care information to my referring doctor and/or other doctors who will help in providing care for me. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____________________________________ _________________

Signature of Patient, Guardian, or Personal Representative Date

_____________________________________ _________________

Printed name of Patient, Guardian, or Personal Representative Relationship to Patient

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct and indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- Day-to-day health care operations of the practice.

I have also been informed of, and given the right to review and secure a copy of your Statement of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry our treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Exceptions to Protected Health Information

I wish to be contacted in the following manner (check all that apply)

Home Telephone # ______________________________

◊ Ok to leave message with detailed information

◊ Leave message with call-back number only

Work Telephone # __________________________

◊ Ok to leave message with detailed information

◊ Leave message with call-back number only

Cell Phone # ______________________________

◊ Ok to leave message with detailed information

◊ Leave message with call-back number only

Email Address ______________________________@____________

◊ Ok to send message with detailed information

I authorize the release of medical information to the following people:

____

____

____

Patient Signature and Date

Family First Medicine

1140 Charles Lane Marysville, Ohio 43040
937-578-4291 (P) 937-578-4294 (F)

Authorization for Disclosure of Health Information

Patient Name: ________________________________ ________________________________ _________________

Date of Birth: _________________________________ Phone: ________________________________ __________

Address: ________________________________ ________________________________ _____________________

City: _______________________________________ State: ______________________ Zip: __________________

1. *I authorize the use or disclosure of the above named individual's health information as described below.*
2. *The following individual or organization is authorized to make the disclosure:*

Name: (physician or facility transferring from): ________________________________ ________________________

Address: ________________________________ ________________________________ _____________________

City: _______________________________________ State: ______________________ Zip: __________________

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

_____ Complete health records
_____ Lab results/X-ray reports
_____ Physical exam
_____ Consultation reports
_____ Immunization record
_____ Other (please specify: ________________________________ ______________________________

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

5. *This information may be disclosed to and used by the following individual or organization.*

Name: Family First Medicine, Dr. Anna Clem-Badhwar D.O.

Address: 1140 Charles Lane

City: Marysville State: Oh Zip: 43040

For the purpose of: ________________________________ ________________________________ _____________

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ________________________________ ________________________.

7. If I fail to specify an expiration date, event or condition, this authorization will expire in sixty days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

________________________________ ________________________________ _________________________,

________________________________ ________ ________________________________ _____________

Signature of patient or legal representative Signature of witness

Date:________________________________ ___ Date: ________________________________ ________