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| **Patient Information** |
| Date: |  |  |  |  |
| Patient: |  |  |  |  |  |  |
|  | Last | First | MI | Preferred | Title |  |
|  | [ ] Male [ ] Female | [ ] Child\* [ ] Student\*\* | [ ] Single [ ] Married [ ] Divorced [ ] Widowed |
| \*If Child, provide parent/guardian name(s) below: | \*\*If Student, please complete: [ ] Full-time [ ] Part-Time |  |
|  |  |  |  |  |  |
|  | Parent/Guardian Name(s) |  |  | School/Location |  |
| Patient Date of Birth: |  | Patient SSN: |  |  |
| Address: |  |  |  |
|  | Address Line 1 |  |  |  |
|  |  | Home: |  |  |
|  | Address Line 2 | Cell: |  |  |
|  |  |  |  | Other: |  |  |
|  | City | ST | ZIP Code | Pager: |  |  |
| E-Mail: |  | Fax: |  |  |
| Referral? | [ ] Yes [ ]  No | Referred by: |  |  |
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| **emergency Information** |
| In case of emergency, please provide information for the nearest relative or designated contact person not at the patient’s address: |
|  |  |  | Tel: |  |  |
|  | Name | Relationship |  |  |  |

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| **employment Information** |
| Employer: |  | Occupation: |  |  |
| Address: |  |  |  |
|  | Address Line 1 | Work: |  X |  |
|  |  | Direct: |  |  |
|  | Address Line 2 | Other: |  |  |
|  |  |  |  | Pager: |  |  |
|  | City | ST | ZIP Code | Fax: |  |  |
| E-Mail: |  |  |  |  |
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| **insurance Information** |
| Subscriber: |  |  |  |  |  |  |
|  | Last | First | MI | Preferred | Title |  |
| Subscriber Date of Birth: |  | Subscriber SSN: |  |  |
| Subscriber Employer: |  |  |
| Patient Relationship to Subscriber: | [ ] Self [ ] Spouse [ ] Child [ ] Other       |  |
| **Primary Insurance Carrier:** |  |  |
| Group/Policy No.: |  | ID No.: |  |  |
| Address: |  | Tel: |  |  |
|  |  | Toll-free: |  |  |
|  |  |  |  | Fax: |  |  |
|  | City | ST | ZIP Code |  |  |  |
| **Secondary Insurance Carrier:** |  |  |
| Group/Policy No.: |  | ID No.: |  |  |
| Address: |  | Tel: |  |  |
|  |  | Toll-free: |  |  |
|  |  |  |  | Fax: |  |  |
|  | City | ST | ZIP Code |  |  |  |

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| **Previous physian Information** |
| Doctor: |       | Telephone: |       |  |
| Clinic/Facility: |       |  |
| Address: |       |  |
|  |       |       |       |  |
|  | City | ST | ZIP Code |  |
| Reason for changing: |       |  |
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| **mEDICAL history** |
| Oral Health: [ ] Excellent [ ] Good [ ] Fair [ ] Poor |
| Date of Last Dental Visit: |       | Treatment Type:  |       |  |
|  |  |  |  |  |
| Would you like a referral to a dentist? [ ] Y[ ] N  |
|  |
| [ ] Y[ ] N | Have you ever had an X-ray? If yes, explain: |       |  |
| [ ] Y[ ] N | Have you ever had a CT scan? If yes, explain: |       |  |
| [ ] Y[ ] N | Have you ever had an MRI? If yes, explain: |       |  |
| [ ] Y[ ] N | Are you allergic to any medications? If yes, please list: ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Family History: Please check if a blood related member of your family has had any of the following:□TB □Heart Disease □Bleeding Tendency □Rheumatic Fever □High Blood Pressure □Anemia□Diabetes □Strokes □Arthritis □Thyroid Disease □Lung Disease □Mental Disease □Cancer□Kidney Disease □Glaucoma other disease:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_What factors are most important for your satisfaction with our office? |  |
|  |       |  |
| Any additional concerns/comments? |  |
|  |       |  |
|  |  |  |

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| **primary physician Information** |
| Physician: |       | Telephone: |       |  |
| Clinic/Facility: |       |  |

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| **Medical History** |
| General Health: [ ] Excellent [ ] Good [ ] Fair [ ] Poor |
| [ ] Y[ ] N | Under a physician’s care now? |  |
| [ ] Y[ ] N | Any hospitalization in the past 5 years? |       |  |
| [ ] Y[ ] N | Any serious illnesses/surgeries? |       |  |
| [ ] Y[ ] N | Use tobacco in any form? If Yes, Type: |       |  |
| [ ] Y[ ] N | Do you drink alcoholic beverages? If so what kind and how often: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| [ ] Y[ ] N | Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.* |  |
| Female Patients: | [ ] Y[ ] N Currently nursing? | [ ] Y[ ] N Currently pregnant? | Due Date: |       |  |
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| Is there anything important about your medical condition we have not asked? [ ] Y[ ] N If yes, please describe: |
|  |       |  |
|  |
| All Patients: Do you have, or have you ever had any of the following? (Check all that apply): | [ ] None |  |
| [ ] Acid Reflux | [ ] Bulimia | [ ] Hearing Problems | [ ] Psychiatric Treatment |
| [ ] ADHD | [ ] Cancer/Malignancy | [ ] Heart Attack | [ ] Radiation/Chemo |
| [ ] AIDS/HIV | [ ] Cerebral Palsy | [ ] Heart Disease | [ ] Respiratory Disease |
| [ ] Anemia | [ ] Chemical Dependency | [ ] Heart Murmur | [ ] Rheumatic Fever |
| [ ] Anorexia | [ ] Chicken Pox | [ ] Hepatitis | [ ] Sinus Problems |
| [ ] Anxiety | [ ] Convulsions | [ ] High Blood Pressure | [ ] Stroke |
| [ ] Artificial Heart Valve | [ ] Depression | [ ] Kidney Disease | [ ] Thyroid Condition |
| [ ] Artificial Joints | [ ] Diabetes | [ ] Liver Problems | [ ] Tuberculosis |
| [ ] Arthritis | [ ] Dizziness/Fainting | [ ] Mitral Valve Prolapse | [ ] Ulcers |
| [ ] Asthma | [ ] Epilepsy/Seizures | [ ] Mononucleosis | [ ] Venereal Disease |
| [ ] Autism/Asperger’s | [ ] Frequent Ear Infections | [ ] Pacemaker |  |
| [ ] Bleeding Disorder | [ ]  Frequent Headaches | [ ] Other – please list: |       |  |
|  |
| All Patients: Are you ALLERGIC to or have you ever had any reaction to the following? (Check all that apply): |
| [ ] Aspirin | [ ] Codeine | [ ] Lactose Intolerance | [ ] Sleeping Pills | [ ] None |  |
| [ ] Anesthetic – Local | [ ] Dairy | [ ] Metal Sensitivity | [ ] Sulfa Drugs |
| [ ] Barbiturates | [ ] Latex | [ ] Nitrous Oxide Sedation | [ ] Penicillin/Other Antibiotics |
| [ ] Other – please list: |       |  |
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| **medication information** |
| All Patients: Are you currently taking any of the following? (Check all that apply): | [ ] None |  |
| [ ] Antibiotics/Sulfa Drugs | [ ] Antihistamines/Allergy | [ ] Daily Aspirin | [ ] Blood pressure Medications |
| [ ] Blood thinners | [ ] Cancer/Chemo Medications | [ ] Cortisone/Steroids | [ ] Heart Medication/Digitalis |
| [ ] Insulin | [ ] Nitroglycerin | [ ] Oral Contraceptives | [ ] Osteoporosis Medications |
| [ ] Other Diabetic Medications | [ ] Recreational Drugs | [ ] Thyroid Medications | [ ] Tranquilizers |
| [ ] Other (please list below) |  |  |  |
| **Drug Name** | **Dosage** | **Reason Prescribed** |
|       |       |       |
|       |       |       |
|       |       |       |
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**Financial Guidelines**

*We are committed to providing you with the best care possible to achieve total health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.*

**Insurance**

**We accept most major insurance payments, however we may not be an in network provider for your plan**. If we are not an in network provider, review your plan details, as in many cases insurance reimbursement may differ.

* **No estimate is a guarantee of payment.** Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding procedures or downgrading procedures to a lesser reimbursement level; in which case, you would be responsible for the difference.

**Payments**

* **Patient portion or** **patient co-pay is due at** **the time services are rendered**
* **Payment Information:**
	+ All major credit cards are accepted (Visa, MasterCard, Discover, American Express, Apple Pay, Etc.)
	+ $130 office visit charge for self pay: this does not include any procedures, tests, or blood work which will be provided at an additional reasonable charge.

* **Balances left over 90 days will incur an 18% or $10 minimum monthly finance charge.** We encourage you to contact us promptly for assistance in the management of your account.

**Missed Appointments**

* **Please give 24 hours notice** if you are unable to keep your reserved time, otherwise, a $40.00 cancellation fee will be assessed.

 **By signing below I acknowledge I have read and understand the guidelines above.**

|  |  |
| --- | --- |
| Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

# ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Updated 2018

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my primary care provider’s *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my primary care provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

**Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to Patient**: [ ] Adult Patient [ ] Parent [ ] Guardian [ ] Other

**Please list any dependent children under the age of 18 also covered by this acknowledgement:**

|  |
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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

[ ]  I give permission for the following communications to be used by Dr. Janis Anthony-Wade, D.O. and or FLPC Staff **(please check all that apply)** :

 [ ]  Cell phone: [ ] Text Message reminders permitted
 [ ]  Home phone [ ]  Work [ ]  E-Mail:

[ ]  I am granting permission for Dr. Janis Anthony-Wade, D.O. and or FLPC Staff to leave a message with any person who may answer my phone or on my voicemail of the following numbers **(please check all that apply)**:

 [ ]  Home Phone [ ]  Cell Phone [ ]  Work Phone [ ]  None- please just ask for a call back

 [ ]  Other (Please explain):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **For Office Use Only:** |
| We were unable to obtain the patient’s written acknowledgement of our Notice of Privacy Practices due to the following reason:[ ]  The patient refused to sign[ ]  Communication barriers [ ]  Emergency situation |
| [ ]  Other – please list:       |

|  |
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| **Patient consent- payment authorization – signature on file** |
|  |
| To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medication changes, I shall inform the primary care provider and staff at the next appointment without fail.I hereby authorize payment directly to Dr. Janis Anthony-Wade and/or First Look Primary Care, P.C. of the medical benefits otherwise payable to me.I hereby authorize Dr. Janis Anthony-Wade to release any information concerning my health or medical care, advice, treatment or supplies provided. This information is to be used in administering medical claims and/or discussing treatment options with other medical professionals.I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. **By signing below, I acknowledge that I have read and understand the statements mentioned above.** Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |