WILSON FAMILY PRACTICE

899 AIGNER DRIVE
BOONVILLE, IN 47601
PHONE (812)641-0262
FAX (812)641-0557

PATIENT INFORMATION

First Name:_____ **Middle Initial**:_____ **Gender: M F**

Last Name:_____ **SSN:**_____

DOB:_____ **Home Phone**:_____

Cell Phone:_____ **Work Phone:** _____

Mailing Address:_____

City:_____ **State**:_____ **Zip Code**:_____-

Email Address:_____

Allow Text and Email reminder? YES NO

EMERGENGY CONTACT INFORMATION

Contacts Name:_____ **Relationship**:_____

Contact Phone:_____

PAYMENT RESPONSIBILITY

THIS SECTION MUST BE FILLED OUT WITH PARENT INFORMATION FOR ALL PATIENTS UNDER 18

First Name:_____ **Last Name**:_____

INSURANCE INFORMATION

Insurance Company:_____ **Policy #**:_____

Policy holder:_____ **Relationship to patient**:_____

Policy holder's SSN:_____ **DOB**:_____

Street Address:_____ **City**:_____

State:_____ **Zip Code**:_____

Home phone:_____ **Cell Phone**:_____

PRIMARY CARE PHYSICIAN

THIS SECTION MUST BE FILLED OUT IF RICHLAND MEDICAL IS THE PRIMARY CARE

Name of Family Physician:_____

Street Address:_____ **City:**_____

State:_____ **Zip Code:**_____

Phone:_____ **Date of Last Visit:**_____

Please list all current medications with dosage and how often it is taken. Be sure to include over-the-counter medication, prescription drugs, and any supplements and vitamins:

Medication Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Preferred Pharmacy:_____

ALLERGIES

PLEASE INCLUDE ALL FOOD, DRUG AND INVIRONMENTAL ALLERGIES

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SURGICAL HISTORY

PLEASE LIST ALL PAST SURGERIES

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PAST MEDICAL HISTORY

Heart Disease	yes	no	Hyperthyroid	yes	no
Heart Attack	yes	no	Kidney stones	yes	no
Heart Arrhythmia	yes	no	Kidney Disease	yes	no
Atrial Fibrillation	yes	no	Stroke	yes	no
Congestive Heart Failure	yes	no	Gallbladder Disease	yes	no
Hypertension	yes	no	Anemia	yes	no
Vascular Disease	yes	no	Chronic Back Pain	yes	no
Diabetes	yes	no	Lyme Disease	yes	no
*Insulin Dependent	yes	no	Psoriasis	yes	no
* Non Insulin Dependent	yes	no	Depression	yes	no
High Cholesterol	yes	no	Osteoporosis	yes	no
Lung Disease	yes	no	Neuropathy	yes	no
Asthma	yes	no	Hypothyroidism	yes	no
Reflux Diseas (GERD)	yes	no	Fibromyalgia	yes	no
Ulcers	yes	no	Colitis	yes	no
Cancer (location)_____	yes	no	Blood Clots (DVT or PE)	yes	no

FAMILY MEDICAL HISTORY

***PLEASE SPECIFY THE RELATION BETWEEN PATIENT AND FAMILY MEMBER**

MATERNAL:

Heart Disease: _____
Heart Attack: _____
Heart Arrhythmia: _____
Atrial Fibrillation: _____
Congestive Heart Failure: _____
Hypertension: _____
Vascular Disease: _____
Diabetes: _____
High Cholesterol: _____
Lung Disease: _____
Asthma: _____
Reflux Disease (GERD): _____
Ulcers: _____
Cancer (specify): _____
Blood Clots: _____
Neuropathy: _____
Osteoporosis: _____
Depression: _____
Psoriasis: _____
Arthritis (specify): _____
Chronic Back Pain: _____
Anemia: _____
Gallbladder Disease: _____
Stroke: _____
Kidney Disease: _____
Kidney Stones: _____
Hypothyroid: _____
Hyperthyroid: _____

Paternal:

Heart Disease: _____
Heart Attack: _____
Heart Arrhythmia: _____
Atrial Fibrillation: _____
Congestive Heart Failure: _____
Hypertension:_____
Vascular Disease:_____
Diabetes: _____
High Cholesterol: _____
Lung Disease: _____
Asthma: _____
Reflux Disease (GERD) _____
Ulcers: _____
Cancer (specify): _____
Blood Clots: _____
Neuropathy: _____
Osteoporosis: _____
Depression: _____
Psoriasis: _____
Arthritis (specify): _____
Chronic Back Pain: _____
Anemia: _____
Gallbladder Disease: _____
Stroke: _____
Kidney Disease: _____
Kidney Stones: _____
Hypothyroid: _____
Hyperthyroid: _____

TOBACCO/ALCOHOL/RECREATIONAL DRUG USE

Smoking Status:

Current smoker: yes no
***If yes, how many packs per day:*_____**
Previous smoker: yes no
***If yes, specify when you quit:* _____**
Chewing Tobacco: yes no

Alcohol Use: *(circle the answer)*

Occassional Daily None

Recreational Drug Use: yes no

If yes, please specify which drugs are used:

_____

I hereby authorize my insurance benefits to be paid directly to my physician. I understand that I am financially responsible for non-covered services. I also authorize the physician to release any information required for processing my insurance claim.

Signature _____ **Date** _____

PROTECTED HEALTH INFORMATION

I ,_____, hereby authorize my personal health information may be release to the following people.

1.) **Name:**_____ **Phone**:_____
Relationship: _____
2.) **Name**:_____ **Phone**:_____
Relationship:_____
3.) **Name**:_____ **Phone**:_____
Relationship:_____
4.) **Name**:_____ **Phone**:_____
Relationship:_____

Signature _____ **Date** _____

General Consent to Treat

I consent to medical care of a routine/emergency nature from the authorized professional staff of Wilson Family Practice for myself or the above-mentioned minor for whom I am the parent/guardian. I authorize the release of any and all medical records and information obtained through my medical evaluation to those individuals that my doctor feels appropriate for my continued medical care.

I understand that I have the right to a full disclosure of the nature of any medical treatment received or proposed to be rendered and the risks, if any, involved and alternative means available.

It is understood that I may withdraw this consent at any time by contacting any member of the professional staff in writing.

Financial Agreement

I authorize payment to Wilson Family Practice of any medical benefits, which would otherwise be payable to me and which were established by my insurance company. The amount paid to Wilson Family Practice shall not exceed the practice's regular charges for the services.

I also authorize the release of my medical records to my insurance company/companies or other third-party payers or my employer as required for the collection of payments. I understand that I am responsible for the payment of charges that are not paid by my insurance company.

Medicare Agreement

The information provided by me in the applying for payment of Social Security benefits is try and correct. I also authorize the physician to initiate a complaint to the insurance commissioner for any reason on my behalf.

I request that the payment of benefits be made for me. The benefits due to me for services provided by my physician shall be paid directly to Wilson Family Practice. In the event the physician does not receive such payment, I authorize such physician to submit a claim to Medicare on my behalf.

If my current policy prohibits direct payment to Wilson Family Practice, I hereby direct the check made out to me and mail to: Wilson Family Practice, 899 Aigner Dr, Boonville, IN 47601.

Payment Agreement

Wilson Family Practice requests that you read your insurance policy and be fully aware of any limitations of the benefits provided. You should be aware that this insurance agreement is between you and the insurance company. We will gladly help you, but it is your responsibility to know the limitations of your policy. Any charge incurred beyond the reimbursement of your policy will be your financial responsibility.

Collection Fee Agreement

I understand that if any unpaid balance is assigned to a third-party collection agency for collection or placed with an attorney to obtain judgement or otherwise satisfy payment of my account, a collection fee **equal to 33%** of the unpaid balance will be added to my account. I agree to pay that fee. I further agree to pay reasonable attorney fees and court costs if a judgement is granted against me.

I have read the above and understand my financial obligation.

Patient Signature:_____

Date:_____

Signature of Responsible Party:_____

Relationship to Patient:_____ **Date:**_____

MRI/CT Procedure Questionnaire

Please provide a "yes" or "no" answer for every item below.

	Yes	No
Cardiac pacemaker or any other cardiac implants	◯	◯
Internal electrodes or wires (pacing wires, DBS or VNS wires)	◯	◯
Artificial heart valve, coil, filter, and/or stent	◯	◯
Aneurysm clips	◯	◯
Neurostimulator-TENS unit, Biostimulator, bone growth stimulator	◯	◯
Implanted drug pump (for chemotherapy medicine or pain medicine)	◯	◯
External drug pump (for insulin or other medication)	◯	◯
IV access port	◯	◯
Implanted post surgical hardware (pins, rods, screws, plates, wires)	◯	◯
Artificial joint and/or limb	◯	◯
Artificial eye and/or eyelid spring	◯	◯
Ear implant	◯	◯
Any type of implant held in by a magnet	◯	◯
Shunt or Sophy adjustable and programmable pressure valve	◯	◯
Spinal fixation device, spinal fusion, halo vest, or spinal cord stimulator	◯	◯
Surgical clips, staples, or mesh	◯	◯
Tissue expander (breast implants)	◯	◯
IUD, diaphragm, pessary	◯	◯
Radiation seeds	◯	◯
Kidney Disease	◯	◯
Diabetes	◯	◯
Liver Disease	◯	◯
Claustrophobia	◯	◯
Allergy to Contrast dye	◯	◯