



PREMIER
INTERNISTS



PREMIER
FAMILY
PHYSICIANS



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PHYSICIANS

PATIENT INFORMATION

Preferred Provider: Dr. _____ Preferred Pharmacy: _____

Patient Name: _____
Last First Middle "Nickname"

DOB: _____ Sex: _____ SSN: _____ Marital Status: _____ Drivers Lic #: _____

Ethnicity (circle one): African American American Indian Asian Primary Language: _____
Caucasian/White Hawaiian Hispanic/Latino Other

Address: _____
Street Apt # City State Zip Code County

Phone #: _____
Home Work Cell/Other Primary

Email Address: _____

Emergency Contact: _____
Name Relationship DOB Phone #

Insurance Information: Insurance Company Name: _____

Insurance ID #: _____ Group #: _____

Insurance Claim Address: _____

Policy Holder: _____
Last First Middle DOB

Address: _____ SAME?
Street Apt # City State Zip Code (check here)

Phone #: _____
Home Work Cell/Other

SSN: _____ Employer: _____

How did you hear about us?

- Word of Mouth
- Facebook
- Insurance Company
- Yelp
- Health Grades
- Radio
- Web Search
- Community Newsletter
- Other: _____

Preferred Method of Communication: Mail - Fax - Patient Portal - Cellphone - Home Phone - Work Phone

PATIENT AGREEMENT

Payment is due at time services are rendered. By signing below, you agree to and understand the following policies:

HIPAA – Privacy Notice

I am aware that I may review Premier Family Physicians (PFP) HIPAA privacy notice at any time and understand that I may request a copy.

Initials

PFP Medical Care Agreement

I authorize the physicians of PFP to administer medical treatment as deemed necessary. I understand that there will be a \$25.00 charge for appointments not cancelled 24 hours in advance. I understand that the primary insured is financially responsible for any balance not covered by my insurance, including co-pay, deductible/co-insurance, and any services excluded by my policy. I also understand that PFP will not verify insurance coverage. I also understand the primary insured will be held responsible for any and all charges incurred by myself or covered dependents should there be no coverage on the date of service. Furthermore, I hereby authorize release of medical information necessary to file a claim with my insurance and assign benefits to otherwise payable to me to Premier Family Physicians, LLP.

Initials

Medical Care Agreement

I authorize the physicians of PFP to instruct their Physician Assistant/Nurse Practitioner and Physical Medicine Providers to assist in certain aspects of my medical care.

I understand that a Physician Assistant/Nurse Practitioner is not a licensed physician and may not treat or diagnose any illness or medical condition except under the supervisions/direction of a licensed physician. I understand that each time I make an appointment, if my physician is not available in a timely manner, I will be given the choice to be seen by the Physician Assistant/Nurse Practitioner. I acknowledge it is my responsibility to inform the staff of PFP if I wish not to see the Physician Assistant/Nurse Practitioner and be scheduler with my assigned physician accordingly. I understand that I may revoke this authorization at any time.

Initials

Electronic Communication

By supplying my home/mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach & messaging system to use my personal information., the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, **for the purpose of notifying me of a pending appointment, missed appointment, overdue wellness visit, or any other reasonable healthcare related communication.** I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information regarding healthcare events, unpaid balances, missed appointments, and to leave a reminder message on my voice mail or answering system if I am unavailable at the number provided by me.

Initials

Signature: _____

Date: _____



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In order to help you clearly understand our policies and services, please read the following statements, and sign the bottom indicating you accept these rules:

- I understand the clinic normally uses Clinical Pathology Laboratories (CPL). If I or my insurance company prefers another lab, it is my responsibility to inform a medical staff member before the specimen is being taken so I am not billed for having lab work processed by CPL, instead of another lab.
- I understand there can be a fee for controlled substance prescriptions written without an appointment.
- I understand there may be a fee for missed appointments or appointments not cancelled within 24 hours. Please notify us as soon as possible if you cannot make your scheduled appointment.
- I understand there is a \$35 fee for bounced checks and an additional \$20 processing fee for balances that go in to collections.
- I understand a fee may be assessed for any paperwork or forms to be completed without an appointment and that it may take up to 10 days to be completed.
- I understand prescription renewals are to be processed through the requested pharmacy. If the prescription is mail order and requires a written prescription, it may take 3-4 business days to be processed.
- I understand that labs, x-ray reports, and other test results need to be reviewed and it may take between 3-4 business days to be reviewed by the physician/PA. A staff member will contact you sooner if the results are urgent; otherwise, you will be contacted by phone, mail or via our secure patient web portal with the results.

Fees for Services:

- \$12 Controlled substance prescriptions without an appointment
- \$15 Transfer of entire medical record, notary service, school forms with an appointment, disability forms
- \$25 Medical Records (purpose of life/medical insurance, attorney requests)
- \$35 Attending physician statement
- \$50 Physician dictated letter
- \$75 Physician narrative

Thank you for your cooperation.

Patient Name (please print): _____

DOB: _____

Patient Signature: _____

Date: _____



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CONSENT FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

Cell Phone#: _____ Email: _____

Please check the sections that apply, then sign at the bottom of the page:

_____ **I do not give PFP permission** to release my information to anyone other than myself.

or

_____ **I give PFP permission** to release my information that includes:

_____ Entire Medical Record

_____ Blood Tests

_____ X-rays

_____ Cultures, including throat, urine and genital

_____ Appointment Details

_____ Billing Information

with

_____ My spouse or significant other (Name _____)

_____ Other family member (Name _____)

_____ On home answering machine or cell phone # _____

_____ On office/work voice mail # _____

I also give permission to receive all information by mail to address:

Signature: _____ Date: _____

(A signature is required for this form to be considered valid)



Patient Auto-Payment Agreement

For your convenience we are offering a patient balance payment option. This option is designed to help you pay your bill on time every time. You are not required to fill this form out if you do not wish to participate in our Auto-Payment program.

If after a claim has been submitted to my insurance company:

- 1) the claim is denied as a non-covered service; or
- 2) the charges deemed a patient responsibility by your insurance company Premier Family Physicians has my permission to charge my credit card/ debit card on file for services provided to me or my dependent.

I understand that in the event my credit card or debit card has been charged for medical services, and then my insurance company makes payment to Premier Family Physicians for those charges, the office will issue a refund or credit to my credit or debit card in the amount received from my insurance company.

I hereby authorize Premier Family Physicians and its designated payment system to charge my credit or debit card the full amount of charges for medical services provided. The amount charged will be reflected on my credit / debit card statement.

If payment is denied by my payment card company or bank, I agree to pay the entire amount promptly via another form of payment.

Patient Name:

Patient Date of Birth:

Dependent Name:

Dependent Date of Birth:

Signature: _____

Date: _____

(you will receive an electronic receipt via text or email for any transactions processed, provided we have your contact information)

Your Family. [Our Team](#). Good Health.



FEMALE HEALTH HISTORY FORM

Today's Date: _____

Name: _____ DOB: _____

Previous Primary Care Physician: _____

Other physicians (specialists) involved in your care: _____

Preferred pharmacy: _____

MEDICAL HISTORY:

Have you been diagnosed with any of the following?

- Alcoholism, Allergies, Anemia, Anxiety, Arthritis, Asthma, Back pain, Blood clots, Cancer, Crohn's / Ulcerative colitis, Depression, Diabetes, Emphysema / Lung disease, Endometriosis, Eye disease, Fractures, Gout, Migraines, Hearing loss / Ear problems, Heart attacks, Heart disease, Hepatitis, Hernia, High blood pressure, High Cholesterol, HIV, HPV infection, Incontinence, Insomnia, Kidney disease, Kidney stones, Osteoporosis, PCOS, Stomach Reflux, Seizures, Sleep apnea, STDs, Stroke, Stomach ulcers, Thyroid disease, Tuberculosis, Urinary tract infections

Other medical history? _____

SURGICAL HISTORY:

Have you had any of the following?

- Abdominal surgery, Appendectomy, Brain surgery, Back surgery, Bladder surgery, Breast biopsy, Breast surgery, C-Section, Cosmetic surgery, Eye surgery, Gallbladder removal, Heart surgery, Hysterectomy, Hernia repair, Ovarian Cyst removal, Thyroid surgery, Tubal ligation

Other surgical history? _____

OBSTETRIC / GYNECOLOGIC HISTORY:

- Age of first period, Period cycle, Period duration, Pattern, Flow, Have you ever been pregnant?, # Full term, # Preterm, # Miscarriages, # Abortions, # Ectopic, # Multiple (twins, triplets), # Living children, Did you have any complications during pregnancy and/or delivery?, If yes, please explain, Are you currently sexually active?, Partner(s), Method of birth control, If postmenopausal: Age of last normal period, Are you / have you taken hormone replacement?, If yes, for how long?

ALLERGIES:

Are you allergic to any medications? Yes No

If yes, please list the name(s) and type of reaction

NAME	REACTION

MEDICATIONS:

Do you currently take any prescription medications: Yes No

MEDICATION NAME	STRENGTH & DOSE	FREQUENCY
		<input type="checkbox"/> Daily <input type="checkbox"/> 2xdaily <input type="checkbox"/> 3xdaily <input type="checkbox"/> 4xdaily <input type="checkbox"/> As needed
		<input type="checkbox"/> Daily <input type="checkbox"/> 2xdaily <input type="checkbox"/> 3xdaily <input type="checkbox"/> 4xdaily <input type="checkbox"/> As needed
		<input type="checkbox"/> Daily <input type="checkbox"/> 2xdaily <input type="checkbox"/> 3xdaily <input type="checkbox"/> 4xdaily <input type="checkbox"/> As needed
		<input type="checkbox"/> Daily <input type="checkbox"/> 2xdaily <input type="checkbox"/> 3xdaily <input type="checkbox"/> 4xdaily <input type="checkbox"/> As needed
		<input type="checkbox"/> Daily <input type="checkbox"/> 2xdaily <input type="checkbox"/> 3xdaily <input type="checkbox"/> 4xdaily <input type="checkbox"/> As needed
		<input type="checkbox"/> Daily <input type="checkbox"/> 2xdaily <input type="checkbox"/> 3xdaily <input type="checkbox"/> 4xdaily <input type="checkbox"/> As needed

Do you take any over-the-counter supplements? (Calcium, multivitamins, sleep aids, other supplements)

No Yes - _____

FAMILY HISTORY:

Unknown / Adopted

Family Member	Alcoholism	Breast Cancer	Bleeding Problems	Colon cancer	COPD	Crohn's/ Ulc Colitis	Diabetes	Glaucoma	Heart attack	Heart failure	High cholesterol	High blood pressure	Kidney disease	Lung cancer	Lupus	Mental illness	Ovarian cancer	Pancreatic cancer	Prostate cancer	Rheum. arthritis	Stroke	Thyroid disease	Tuberculosis
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maternal grandfather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mat. grandmother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paternal grandfather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pat. grandmother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aunt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uncle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other relatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SOCIAL HISTORY:

Marital status: _____
 Occupation: _____
 Current tobacco use Yes No
 Previously but quit: (date) _____
 Packs per day _____
 Years of use: _____ yrs
 Type: Cigarettes Cigars Chewing
 Dip Pipe E-cigarettes
 Exposure to second hand smoke? Yes No
 Alcohol use Yes No
 If yes: # drinks / week _____

Type of alcohol _____
 Are you or others concerned about your drinking? Yes No
 Drug use Yes No
 If yes: type _____
 Do you practice any religion Yes No
 If yes, which one? _____
 Do you exercise? Yes No
 How often? _____ times/week
 What type of exercise? _____

HEALTH MAINTENANCE:

If you've had any of the following please specify date last performed:

- Pap smear _____/_____/_____
- Have you ever had an abnormal pap smear: No Yes: when? _____/_____/_____
- How was it treated? _____
- Mammogram _____/_____/_____
- Have you ever had an abnormal mammogram? No Yes: _____
- If yes, how long ago? _____
- Colonoscopy _____/_____/_____
- Result: Normal Polyps Diverticula Hemorrhoids Other: _____
- Bone density scan _____/_____/_____
- Result: Normal Osteopenia Osteoporosis
- CT for lung cancer screening _____/_____/_____
Dental exam _____/_____/_____
Eye exam _____/_____/_____
Tetanus shot _____/_____/_____
HPV series (3) _____/_____/_____
Flu shot _____/_____/_____
Pneumonia shot: Pneumovax _____/_____/_____ Prevnar 13 _____/_____/_____
Shingles vaccine _____/_____/_____
Hepatitis A vaccine _____/_____/_____
Hepatitis B vaccine series _____/_____/_____
Meningitis vaccine _____/_____/_____
MMR (measles, mumps, rubella) _____/_____/_____
Varicella vaccine _____/_____/_____