PREMIER INTERNISTS

PREMIER FAMILY PHYSICIANS

PREMIER 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 □ Yelp □ Web Search
□ Facebook □ Health Grades □ Community Newsletter
□ Insurance Company □ Radio □ 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
$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

PREMIER FAMILY PHYSICIANS

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)

PREMIER FAMILY PHYSICIANS

MALE 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	☐ Yes	☐ No
Allergies	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Back pain	☐ Yes	☐ No
Blood clots	☐ Yes	☐ No
If yes: where?_____		
Cancer	☐ Yes	☐ No
If yes: what type?_____		
Chrohn's / Ulcerative colitis	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
If yes: what type?	☐ 1	☐ 2
Emphysema / Lung disease	☐ Yes	☐ No
Eye disease	☐ Yes	☐ No
If yes: what type?_____		
Fractures	☐ Yes	☐ No
If yes: where?_____		
Gout	☐ Yes	☐ No
Migraines	☐ Yes	☐ No
Hearing loss / Ear problems	☐ Yes	☐ No
Heart attack	☐ Yes	☐ No
Heart disease	☐ Yes	☐ No
If yes: what type?_____		
Hepatitis	☐ Yes	☐ No
If yes: what type? (A, B, C)_____		
Hernia	☐ Yes	☐ No
If yes: what type?_____		
High blood pressure	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No
HIV	☐ Yes	☐ No
HPV infection	☐ Yes	☐ No
Incontinence	☐ Yes	☐ No
Insomnia	☐ Yes	☐ No
Kidney disease	☐ Yes	☐ No
Kidney stones	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No
Prostate enlargement	☐ Yes	☐ No
Stomach Reflux	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Sleep apnea	☐ Yes	☐ No
STDs	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Stomach ulcers	☐ Yes	☐ No
Thyroid disease	☐ Yes	☐ No
If yes: what type?_____		
Testicular torsion	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Urinary tract infections	☐ Yes	☐ No

SURGICAL HISTORY:

Have you had any of the following?

Abdominal surgery	☐ Yes	☐ No
Appendectomy	☐ Yes	☐ No
Brain surgery	☐ Yes	☐ No
Back surgery	☐ Yes	☐ No
If yes: what type?_____		
Bladder surgery	☐ Yes	☐ No
Cosmetic surgery	☐ Yes	☐ No
If yes: what type?_____		
Eye surgery	☐ Yes	☐ No
If yes: what type?_____		
Gallbladder removal	☐ Yes	☐ No
Heart surgery	☐ Yes	☐ No
If yes: what type? _____		
Hernia repair	☐ Yes	☐ No
If yes: what type? _____		
Prostate surgery	☐ Yes	☐ No
Thyroid surgery	☐ Yes	☐ No
If yes: what type? _____		
Vasectomy	☐ Yes	☐ No

Other surgical history?_____

_____

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
		☐ Daily ☐ 2xdaily ☐ 3xdaily ☐ 4xdaily ☐As needed
		☐ Daily ☐ 2xdaily ☐ 3xdaily ☐ 4xdaily ☐As needed
		☐ Daily ☐ 2xdaily ☐ 3xdaily ☐ 4xdaily ☐As needed
		☐ Daily ☐ 2xdaily ☐ 3xdaily ☐ 4xdaily ☐As needed
		☐ Daily ☐ 2xdaily ☐ 3xdaily ☐ 4xdaily ☐As needed
		☐ Daily ☐ 2xdaily ☐ 3xdaily ☐ 4xdaily ☐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	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal grandfather	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mat. grandmother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal grandfather	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pat. grandmother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Aunt	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Uncle	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other relatives	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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? _____

Are you currently sexually active? __Yes __ No
Partner (s): __Male __Female __Both
Do you use protection? __Yes __No

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

Prostate exam _____/_____/_____
PSA _____/_____/_____
Colonoscopy _____/_____/_____
- Result: ☐ Normal ☐ Polyps ☐ Diverticula
☐ Hemorrhoids ☐ Other: _____
Aortic aneurysm screening _____/_____/_____
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 _____/_____/_____