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: ______________________________

PREMIER
INTERNISTS

PREMIER
FAMILY
PHYSICIANS

PREMIER
PHYSICIANS

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: _____________________

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)

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 ______/______/______