

How did you hear about us? Internet/Friend/Other \_\_\_\_\_ INSURANCE/COPAY \_\_\_ SELF PAY \_\_\_

**PATIENT HISTORY FORM**

**DATE:** \_\_\_\_\_

**PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **AGE:** \_\_\_\_\_

Note to return to work/school (circle one) Yes No

**REASON FOR VISIT:** \_\_\_\_\_

**MEDICATIONS (PRESCRIPTION AND OVER THE COUNTER):**

\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES (INCLUDES MEDICATIONS, TYPE OF REACTION):**

\_\_\_\_\_

**IMMUNIZATIONS (YEAR):** TDAP \_\_\_\_\_ FLU \_\_\_\_\_ PNEUMOVAX \_\_\_\_\_ SHINGLES \_\_\_\_\_

**PAST MEDICAL HISTORY: (LIST ALL CONDITIONS):**

\_\_\_\_\_

**SCREENINGS (YEAR COMPLETED):** MAMMO \_\_\_\_\_ PAP \_\_\_\_\_ BONE DENSITY \_\_\_\_\_ COLONOSCOPY \_\_\_\_\_

**FAMILY MEDICAL HISTORY:** \_\_\_\_\_

**CARDIAC HISTORY UNDER THE AGE OF 55: YES/NO** \_\_\_\_\_

**SMOKING: YES / NO / FORMER**      **ALCOHOL: YES / NO**      **LMP (Female Only):** \_\_\_\_\_

-----**OFFICE USE ONLY BELOW**-----

**VITAL SIGNS:** Height \_\_\_\_\_ Weight \_\_\_\_\_ Temp \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ HR \_\_\_\_\_ RR \_\_\_\_\_ SPO2 \_\_\_\_\_

**REVIEW OF SYSTEMS:** N, V, D, fever, weight loss, night sweats, travel, sexually active

\_\_\_\_\_

**PHYSICAL EXAM:** \_\_\_\_\_

**TESTS ORDERED/RESULTS:** \_\_\_\_\_ In lab book

**DIAGNOSIS:** \_\_\_\_\_

**TREATMENT:** \_\_\_\_\_

**FOLLOW UP:** \_\_\_\_\_

**PHARMACY INFORMATION:**

**NAME** \_\_\_\_\_ **ADDRESS** \_\_\_\_\_ **ZIP** \_\_\_\_\_ **PHONE** \_\_\_\_\_

**PRIMARY CARE PROVIDER NAME:** \_\_\_\_\_ **PHONE #:** \_\_\_\_\_

Room \_\_\_\_\_

Student \_\_\_\_\_

Time \_\_\_\_\_

Patient Name: \_\_\_\_\_

### CONTRACT TERMS

In order to protect our patients from outstanding debt and the risk of collections, an agreement has been made to improve the processing methods once insurance liabilities have been determined. This is not a receipt. This is a contract agreeing to pay for services once patient liability has been determined. The terms of this contract are as follows:

**X** \_\_\_\_\_ (guarantor initials) I agree to allow the practice to charge my credit card for the balance due, as determined by the final adjudication of this and all other claims included under this contract. I agree to the final adjudication amount as defined by my insurance company, with exceptions as noted below. I agree to these charges under the following conditions:

- a) The charges will take place upon receipt, or within a few days of the final explanation of benefits from my insurance company
- b) The amount charged to my card will not exceed \$200.00
- c) I will receive a bill from the practice for any balance greater than \$200.00 for which I am liable.
- d) I will receive a receipt for any amount charged to my card once the transaction has been executed

Signature: **X** \_\_\_\_\_

(Cardholder signature) I agree to pay the above total amount according to the card issuer agreement.