Primary Care Internists of Montgomery, P.C.
PATIENT REGISTRATION

Welcome to our office. In order to serve you properly, we will need the following information. **(Please Print) Doctor:** _____
All information will be strictly confidential.

Patient's Name (As it appears on insurance cards)	Sex M F	Birth Date ____/____/_____ Age_____	Marital Status Single [ ] Married [ ] Widowed [ ] Divorced [ ]
Residence address City State Zip		Home Phone:	Patient's Social Security #
If the patient is under 19 who is the *Responsible Party*? **(Signature must be at bottom of page)**	Self Spouse Parent	Patient Email Address:	*Responsible* Party's SS#
Responsible Party/Patient's Drivers License # State:	*Responsible* Party's Email:		How Long at current Employer?
Address of Responsible Party if different from patient:		Retired? YES [ ] NO [ ]	Cell Phone Number:
Name of employer Address		Business Phone	Occupation
Name of Spouse/Parent	Birth date	Social security #	Business phone
Preferred Pharmacy and phone number:	Referred by: (include address and phone)		
Person to contact in case of emergency(listed on HIPAA form):	Relationship to patient	Phone	
Medicare Yes [ ] No [ ]	Please Provide Copy of Card	BCBS Yes [ ] No [ ]	Please Provide Copy of Card / Effective Date
Medicare Secondary insurance name Please Provide Copy of Card			
Workers' Compensation? Yes No Motor Vehicle? Yes No **If Yes-put W/C or MVA carrier below**	Date of Accident	Treatment authorized by	Claim # / W/C or MVA Insurance Phone #
If not Medicare or BCBS – Primary Insurance Company Please Provide Copy of Card			Is insurance through your employer? YES NO
Subscriber Name	**Subscriber birth date**		
Patient's Race:	Patient's Ethinicity: Hispanic OR Non-Hispanic		Preferred Language:

Medicare Lifetime Signature on File:

I request that payment of authorized Medicare benefits be made on my behalf to Primary Care Internists of Montgomery Center, PC for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services

_____ _____
Patient Signature Date

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to PCI for any services furnished me by the physician. I understand that I **am financially responsible for any amount not covered by my contract**. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits. **AGREEMENT TO PAY:** The undersigned accepts the fees charges as a lawful debt and promises to pay said fee including the cost of collection, attorney fees, and court costs if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama, or any other state.

_____ _____
Patient **or** Resposible PartySignature (if child is under 19 years old) Date

1/1/16

PRIMARY CARE INTERNISTS OF MONTGOMERY
1722 Pine Street • Suite 309 • Montgomery, Alabama 36106
(334) 262-0342 • Fax (334) 262-0390

New Patient Health Questionnaire

Date _____ Age _____ Race _____ Sex _____ Marital Status _____
Name _____ Date of Birth _____

A. (leave blank) CC: _____
HPI: _____

B. Circle any of the following conditions you have had:

High Blood Pressure	Diabetes
Heart Disease	High Cholesterol
Rheumatic Fever	Depression
Emphysema	Tuberculosis

C. List all operations and injuries you have had:

Part of Body	Year	Explain

D. List other illnesses and hospitalizations you have had:

Illness/Hospitalization	Year	Explain

E. 1. List all prescription and non-prescription medicines and any supplements or vitamins you take regularly and their doses.

2. List all other medicines you remember taking in the past 6 months:

3. Medications you are allergic to and type of reactions:

4. What other doctors do you see regularly? (ob gyn, ophthalmologist, etc.)

F. 1. Do you consider your health... Good Fair Poor (circle one)

2. Your present weight _____ lbs Your usual weight _____ lbs Your weight one year ago _____ lbs

3. Do you exercise regularly? Yes No Describe _____

4. What is your usual bedtime? _____ Time you arise _____

5. List all tobacco use, past and present, and what type: _____

_____

6. How much/many do you drink daily of: Coffee _____ Tea _____ Soft drinks _____

7. Do you drink alcoholic beverages? Yes No

Estimate how much you drink per week _____ Bottles of beer _____ Ounces of beer or wine _____ Other

8. Do you use any illicit drugs? No Yes

9. Describe your job _____

Exposure to chemicals or fumes at work or at home _____

10. Who lives with you? _____

11. How far did you go in school? _____

12. Do you follow any special diet? Explain _____

13. Year of immunizations: Tetanus _____ Pneumonia _____ Hepatitis _____ Other _____

When have you last had a TB skin test? _____ Positive Negative (circle one)

Did you ever live with anyone who had TB? Yes No Who? _____

14. Have you had a colonoscopy or sigmoidoscopy (procto)? Yes No When? _____

15. Have you had a stress (treadmill) test? Yes No When? _____

16. Do you usually wear seatbelts when in your car? Yes No

G. Family History

	Alive or Dead	Sex	Current age or age at death	Significant diseases and/or causes of death
Father	❒ A ❒ D	[redacted]	_____	_____
Mother	❒ A ❒ D		_____	_____
Brother	❒ A ❒ D		_____	_____
Brother	❒ A ❒ D		_____	_____
Sister	❒ A ❒ D		_____	_____
Sister	❒ A ❒ D		_____	_____
Children	❒ A ❒ D	_____	_____	_____
(list in	❒ A ❒ D	_____	_____	_____
order of	❒ A ❒ D	_____	_____	_____
age).	❒ A ❒ D	_____	_____	_____

Circle any of the following illnesses which have affected any near blood relatives (parental or siblings)

High cholesterol	Cancer	Diabetes
Stroke	High blood pressure	Emphysema
Gout	Migraine	Easy bleeding
Stomach ulcers	Heart attack	Hyperthyroidism (or goiter)

H. Mark X to all that apply to you

1. ❒ Wake up tired ❒ Fever ❒ Poor sleep
   ❒ Weight loss ❒ Weight gain ❒ Excessive daytime drowsiness

2. ❒ Problems with your eyes ❒ Temporary loss of vision ❒ Double vision

3. ❒ Hard of hearing ❒ Constant noises in your ears ❒ Chronic sinus congestion
   ❒ Sore throat ❒ Change in your voice during the past 6 months
   ❒ Constant running nose ❒ Excessive snoring ❒ Bad nosebleeds

4. ❒ Tightness, pressure, squeezing or burning in the chest during exertion or after meals
   ❒ Racing or irregularity in your heartbeat ❒ History of a heart murmur ❒ Pain or discomfort in the heart or chest
   ❒ Easily get short of breath with exertion ❒ Feet swelling ❒ Pain in lower legs when walking
   ❒ Sit up at night to breathe ❒ Frequent leg cramps ❒ Varicose veins

5. ❒ Suffer from frequent heavy chest colds ❒ Asthma or wheezing ❒ Frequent shortness of breath
   ❒ Chronic coughing ❒ Phlegm or sputum with your cough
   ❒ Severe soaking sweats at night ❒ Cough up blood

6. ❒ Normal appetite ❒ Excessive appetite ❒ Poor appetite
   ❒ Difficulty swallowing ❒ Frequent heartburn ❒ Nausea or vomiting
   ❒ Bloated after eating ❒ Abdominal pain ❒ Vomited blood
   ❒ Stomach ulcers ❒ Stools black or bloody ❒ History of colon polyps
   ❒ Frequent loose bowel movements ❒ Bad constipation ❒ History of diverticulosis
   ❒ Recent change in bowel habits ❒ Hemorrhoids (plies)
   ❒ History of jaundice (yellow eyes & skin) ❒ History of serious liver or gallbladder trouble

7. ❒ Get up more than once during the night to urinate ❒ Weak or slow urinary stream
   ❒ Pain, burning or stinging when urinating ❒ Lose control of bladder ❒ History of kidney stone
   ❒ History of bladder infection ❒ Urine ever brown, black or bloody ❒ Urinate frequently during the day
   ❒ Ever treated for a sexually transmitted or vinereal disease ❒ Problems with sexual function
   ❒ May be at risk for HIV or AIDS (IV drug use, multiple sex partners, homosexual)

8. ❒ Stiff painful muscles ❒ Back pain ❒ Swollen painful joins List:

9. ❒ Changing moles ❒ Skin rash ❒ Breast lumps
   ❒ Other changing skin spots ❒ Severe itching

10. ❒ Frequent severe headaches ❒ Severe dizziness ❒ Burning or poor sensation in feet
    ❒ Fainted more than twice ❒ History of seizures ❒ Weakness on one side
    ❒ Poor sensation on one side

11. ❒ Recent personal or family tragedy ❒ Major life change ❒ Excessive fatigue
    ❒ Feel depressed ❒ Feel hopeless ❒ Feel lonely
    ❒ Worry to excess ❒ Feel worthless ❒ Thoughts out of control at times

12. ❒ Tendency to be too hot ❒ History of goiter (an enlarged thyroid gland)
    ❒ Tendency to be too cold ❒ Breast discharge ❒ Change in hair or nails

13. ❒ History of severe anemia (low blood) ❒ History of a blood transfusion ❒ Enlarged glands
    ❒ Bleeding problems after tooth extraction or surgery ❒ Excessive bruising

14. ❒ Hayfever ❒ History of hives ❒ Severe allergies

Women Only:
❒ Vaginal bleeding after menopause ❒ Hot flashes ❒ Menopausal symptoms
❒ Excessive discomfort with periods ❒ Excessive menstrual bleeding ❒ Vaginal bleeding between periods
❒ Vaginal itching or discharge ❒ Irregular periods
What was the date of your last period? _____ Was it normal? ❒ Yes ❒ No _____
When was your last pelvic exam? _____ By whom? _____
Have you taken female hormones? ❒ Yes ❒ No What type? _____
When was your last mammogram (breast x-ray)? _____
Times pregnant? _____ Children delivered _____ Abortions _____ Miscarriages _____
Are you and your spouse practicing birth control? ❒ Yes ❒ No What method? _____

I. Physical Examination: (circle positive items, line through if negative)

Weight _____ Temp _____ Pulse _____ Resp _____ BP (R. Arm) _____ BP (L. Arm) _____

Constitutional: General Appearance: (nutrition, deformities, development, distress)

Eyes: Conj. and lids Pupils Fundi

ENT: Ext(E&N) Otoscopic Hearing Nose Lips, Teeth, Gums Oropharynx

Neck: Neck (JVD, masses,...) Thyroid

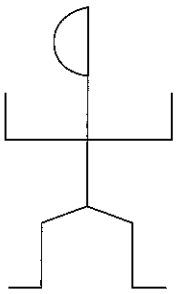
Chest/Breasts: Inspection Palpation of breasts & axillae

Resp: Resp. effort Aust Percuss Palpation

CV: Palpation Ausc: (gallop, rub, rhythm, PC's, murmur)

Carotids AA Femoral Pedal Edema/varicosiles

Pulses:



GI: Abdomen Liver/Spleen Hernia Rectal Hemoccult +/-

GU: (M) Scrotum Penis Prostate

GU: (F) Ext. gen. Urethra Bladder Cervix Uterus Adnexa

Lym: Neck Axillia Groin Other (SC fossa...)

MS: Digits and nails For joints/bones/muscles of neck, back, arms or legs

Inspection ROM Stability Muscle strength/tone

Skin: Palpation Inspection: (rash, lesions)

Neuro: Cr. N's DTRs Sensation

Psy: Judgment/Insight Orientation Memory Mood and Affect

CXR:

EKG:

Abnl. lab:

Pending lab:

Dictated HPI, Assessment, Plan:

PRIMARY CARE INTERNISTS OF MONTGOMERY, P.C.
Consent and Conditions for Treatment
PAYMENT IS DUE AT THE TIME OF SERVICE

PRINT NAME: _____ DOB: _____

In order to reduce confusion and misunderstanding between our patients and the practice we have adopted the following financial and office policies. If you have any questions about the policy, discuss them with our Practice Manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibility as an essential element of your care and treatment.

PAYMENTS ACCEPTED – For your convenience we accept Debit Cards, Visa, MasterCard, Discover, American Express, checks or cash as method of payment. Unless you have health insurance that can be verified prior to your visit, or other arrangements have been made in advance full payment is due at the time of service. For all services rendered to minor patients we will look to the adult (parent or guardian) accompanying the patient for payment.

HEALTH INSURANCE: PRIMARY INSURANCE - Insurance companies where we have a Participating Provider agreement, we will accept assignment of benefits. We will require, as does your insurance contract in most cases, to pay your co-payments or deductibles prior to your visit. Primary insurance plans where we do not participate will be billed, as a courtesy, by our office and we will require assignment, so that the payment will be made directly to us. We will attempt to verify your insurance coverage and benefits prior to you being seen by the provider and collect the amount that is deemed correct by them for the services that we provide. If we are unable to verify your coverage you will be responsible for payment in full. If this causes a credit balance, we will refund this balance with 90 days of notification from your insurance company that you have met your deductible obligation.

SECONDARY OR SUPPLEMENTAL INSURANCE – We will file your secondary or supplemental insurance for you one time as a courtesy to the patient. It will be the patient's responsibility to make sure that we receive payment.

We have no way of knowing in advance the total amount of your visit today. Your office visit charge (time the Provider spent with you, only) will run between $50.00 - $300.00 depending on whether you are a new patient or already an established patient with us. Lab work and all other procedures performed here in the office will have separate billable charges that will be added to your final office bill. If your insurance company refuses to pay today's charges for any reason, you will be held responsible. **Payment is due at the time of service with our office.**

OTHER OFFICE POLICIES -

Missed Appointments – In order to provide the best possible service and availability to all of our patients, it is our policy that we may charge $25.00 for a missed office visit. (Note: we cannot bill your insurance company for this charge).

Late Arrivals – To respect the needs of all of our patients, if you are more than 15 minutes late for your appointment you may be asked to reschedule your appointment.

Returned checks – Our fee for returned checks is $30.00. This fee is to be paid in the form of a money order or cash in order for you to pick up the returned check.

Forms that need to be filled out – If you need a form filled out and signed by your provider and do not wish to have an appointment there will be a $25 fee for filling out that form for you. This payment will be required before the completed form is release back to you.

Consent for Treatment – I present myself for treatment and in doing so I hereby consent to the rendering of such care, which may include routine diagnostic procedures, and or other medical and surgical procedures, by the providers of Primary Care Internists, as may in their professional judgment be deemed necessary or beneficial. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks. I acknowledge that no guarantees have been made to me as to the result of any examination or treatment. I further understand that I have the right, in collaboration with my physician, to make decisions involving my health care to accept or refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.

ASSIGNMENT OF BENEFITS/INFORMATION RELEASE: I, the undersigned authorize payment of medical benefits to Primary Care Internists of Montgomery for any services furnished me by the provider. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

AGREEMENT TO PAY: For Primary Care Internists of Montgomery, I the undersigned accept the fees charged as a lawful debt and promise to pay said fees including the collection agency fees (33.33%), attorney fees, and court costs if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama, or any other state.

EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE: You agree, in order for us to service your account or to collect monies you may owe, Primary Care Internists and/or agents may contact you by telephone at any number associated with your account, including wireless numbers, which may result in charges to you. We may also contact you by sending text message or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice message and/or use of automatic dialing devices, as applicable.

I have read this disclosure and agree that Primary Care Internists, its employees and/or agents my contact me as described above, and I understand the financial policy of the practice and I agree to be bound by its terms.

_____ _____

Signature of the Patient or Responsible Party Date

*Because the patient is an authorized minor, or physically or mentally incapacitated, this consent is given on behalf of the patient.

By: _____ as: _____

PRIMARY CARE INTERNISTS OF MONTGOMERY, P.C.

HIPAA- Medical Information Release

Due to **federal privacy guidelines under HIPAA (required April 2001)** we are required to have a medical release of information on file for each patient. This authorizes our office to release medical information to your designated family members, caregivers, and friends, as well as, pharmacists, hospitals, emergency medical personnel, and referral specialists about you or your minor (under 14 yrs of age) children's PROTECTED HEALTH INFORMATION (PHI). Included would be all health and identifiable information. This authorizes us to share your health information, after proper identification, by verbal or written communication, telephone, cell phones, answering machine, fax, mail or e-mail as needed for your care to only those you have identified below. Power of Attorney's would be listed separately. By your signature below you also acknowledge that you have read the Notice Of Privacy Practices.

In order for us to do this please list names, relationship to you and phone numbers of the authorized individuals below. Do not list anyone who has not agreed to provide us with their date of birth for identification purposes.

****PLEASE PRINT****

I _____(patient name or child's name) DOB: _____ give my authorization to the following individual(s) listed below to discuss my medical care with you and or your staff on my behalf.

Names	**Relationship**	**Phone #**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any health information you do not wish to be given out please list below.

_____ _____
_____ _____
_____ _____

The above information is private and confidential and will be placed in your medical record. This authorization will expire 12 months from the date signed.

Signature _____(Relationship)_____Date_____

DISCLAIMER (Complete only if you want ***no one*** else to have any access to information, including family members.)

____I do not want you to discuss my medical care with anyone other than myself.

Patient Name: _____ DOB: _____

Medicare Wellness Exam

Today you are offered a Medicare Wellness Exam. This exam is covered at no additional expense to you. It is paid for by Medicare so your doctor and his staff can have the time to review items that Medicare has found important to your health. This does not substitute your "yearly physical" which is designed to review your current and treat possible health problems. There will be a separate charge for that, subject to the usual co-pay and/or deductible.

Please answer the following questions as part of the exam:

1. Have you had a Medicare Wellness Exam outside of this office in the past year? Yes No
2. Do you have an advanced directive or living will? Yes No
3. Would you like to discuss an advance directive or living will? Yes No
4. Do you or your family and friends feel that you have a problem with thinking or memory? Yes No

The following questions are required as a part of your first Medicare Wellness Exam. Otherwise, they are optional.

5. Do you have little interest or pleasure in doing things? Yes No
6. Do you feel down, depressed or hopeless? Yes No
7. Is help needed with the phone, transportation, shopping, preparing meals, housework, laundry, medications or managing money? Yes No
8. Have you had any falls or accidents in the past year? Yes No
9. Do you have trouble hearing? Yes No