Primary Care
INTERNISTS
MONTGOMERY

NEW PATIENT INFORMATION

Today's Date_____

Name_____ DOB_____

Address_____

Cell Phone_____ Home Phone_____

Insurance_____

Current Primary Care Physician_____

Reason for **NEW** Primary Care Physician_____

_____

Please be advised no physician at Primary Care Internists of Montgomery will prescribe any type of pain, anxiety or controlled substance medication.

You will be required to have an Annual Wellness Visit yearly.

We will mail you a new patient information packet and you will need to return it to our office ten (10) days before your scheduled appointment or your appointment will be canceled.

You will need to confirm your appointment with our office.

PRIMARY CARE INTERNISTS OF MONTGOMERY

Primary Care Physicians

11123 Chantilly Parkway Court Unit L, Pike Road, AL 36064

334.262.0342

NEW PATIENT HEALTH QUESTIONNAIRE

Date: _____ Age: _____ Race: _____ Sex: _____ Marital Status: _____

Name: _____ Date of Birth: _____

Health History

A. CC: _____

HPI: _____

B. Circle any of the conditions you have had:

High Blood Pressure		Diabetes
Heart Disease		High Cholesterol
Rheumatic Fever		Depression
Emphysema		Tuberculosis
Tightness, pressure, squeezing or burning in the chest during exertion or after meals		
Racing or irregularity in your heartbeat	History of 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
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
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	Recent change in bowel habits
History of diverticulosis	Hemorrhoids	History of jaundice (yellow eyes/skin)
History of serious liver or gallbladder trouble		
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 stones
History of bladder infection	Urine ever brown, black or bloody	Urinate frequently during the day
Ever treated for a sexually transmitted or venereal disease		Problems with sexual function
May be at risk for HIV or AIDS (IV drug use, multiple sex partners, homosexual)		
Stiff painful muscles	Back pain	Swollen painful joints
Changing moles	Skin rash	Breast lumps
Other changing skin spots		Severe itching
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		
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
Tendency to be too hot		Tendency to be too cold
History of goiter (enlarged thyroid gland)	Breast discharge	Change in hair or nails
History of severe anemia (low blood)		History of a blood transfusion

Enlarged glands	Bleeding problems after tooth extraction	Excessive bruising
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 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?_____

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 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 reaction:

4. What other doctors do you see regularly? (OB/GYN, Ophthalmologist, etc.)

Family History

FAMILY HISTORY (Mark "X" if positive and list approx. age if known.)					
	Mother	Father	Sister	Brother	Child
Breast Cancer					
Ovarian Cancer					
Colon Cancer					
Prostate Cancer					
Heart Attack, stent, or bypass surgery					
Stroke					
High cholesterol					
High blood pressure					
Diabetes					
Dementia					
Aneurysm					
Sudden death or died in sleep <55 yrs old					

Social History

SOCIAL HISTORY						
TOBACCO?	Never	Current smoker	*No. years smoked?*	*Packs per day*	Year Quit	Other tobacco
ALCOHOL?	Never	Few times/year	1-2 per day	3 or more per day	Past history of abuse...Year quit:	
CAFFIENE?	Never	Occasional	Daily	**DIET:**		
DESCRIBE ANY HISTORY OF DRUG USE OR ABUSE			EXERCISE ROUTINE			
Marital Status (Circle one) S M W D			Number of pregnancies: _____ Sexual partner preference: M F		Number of children _____ Living _____ Deceased	
Highest level of education completed		Current occupation			If retired, what type of work did you do?	
HOME ENVIRONMENT	Private home	Assisted Living	Nursing Home	Other		

Review of Systems

Use checkboxes or circle applicable conditions. Cardiovascular, Respiratory, Gastrointestinal, Genitourinary, Musculoskeletal, Skin, Neurologic, Psychiatric, Endocrine, Hematologic, Allergy and Women's Health history sections as reflected in the original questionnaire.

Additional notes:_____

Physical Examination

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 Auso: (gallop, rub, rhythm, PC's, murmur)
	Carotids AA Femoral Pedal Edema/varicosiles
GI:	Abdomen Liver/Spleen Hernia Rectal Hemoccult +/-
GU:	(M) Scrotum Penis Prostate
	(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:

Abn lab Pending lab

Provider Assessment

Dictated HPI, Assessment, Plan:

Primary Care INTERNISTS MONTGOMERY

PATIENT REGISTRATION

Today's Date_____

Welcome to our office. In order to serve you properly, we will need the following information. All information is strictly confidential.

Patient Name Last, First, Middle Initial	SEX [ ] Male [ ] Female	Date of Birth | |	Marital Status [ ] Single [ ] Married [ ] Widowed [ ] Divorced
Address	Telephone Number	Social Security Number	

If patient is under 19, who is responsible?	Self Spouse Parent	Email address	Responsible party SSN
Responsible party's DL#	Responsible Party's email address	How long at current employer	
Address of Resp Party if different from patient	Retired: [ ] Yes [ ] No	Cell Phone Number	
Employer Name/Address	Employer Telephone	Occupation	
Name of Spouse/Parent	Date of Birth	Social Security Number	Business Phone
Preferred Pharmacy & Phone number	Referred by: include address & phone		
Person to contact in case of emergency	Relationship to patient	Contact Number	

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		
Work Comp Yes No MVA Yes No If yes, put WIC or MVA carrier below	Date of accident	Treatment authorized by	Claim #	WIC or MVA Insurance phone
If not Medicare or BCBS – Primary Insurance Company		Is Insurance through your employer? Yes No		
Subscriber Name		Subscriber Date of Birth		
Patient's Race:	Patient's Ethnicity: 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 Physicians 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 account not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning healthcare, advice, treatment or supplies provided to me. This information will be sued 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 Responsible Party Signature (If child is under 19 years old) Date

Primary Care Internists of Montgomery

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CONSENT AND CONDITIONS FOR TREATMENT
PAYMENT IS DUE AT THE TIME OF SERVICE

PRINT NAME: _____ DOB: _____

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 provide 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. 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.

HEALTH INSURANCE - PRIMARY INSURANCE: Participating provider benefits will be billed according to your plan. Co-payments and deductibles are due prior to your visit. If coverage cannot be verified, payment in full may be required.

SECONDARY OR SUPPLEMENTAL INSURANCE: We will file your secondary or supplemental insurance one time as a courtesy. It remains the patient's responsibility to ensure payment is received.

OTHER OFFICE POLICIES:

- Missed Appointments: A $25.00 fee may be charged.
- Late Arrivals: Patients more than 15 minutes late may be asked to reschedule.
- Returned Checks: A $30.00 returned check fee applies.
- Forms: Forms completed without an appointment may incur a $25.00 fee.

CONSENT FOR TREATMENT: I consent to the rendering of medical care, diagnostic procedures, and treatments deemed necessary by the providers of Primary Care Internists. I understand that no guarantees have been made regarding the outcome of treatment.

ASSIGNMENT OF BENEFITS / INFORMATION RELEASE: I authorize payment of insurance benefits directly to Primary Care Internists and authorize release of information necessary for processing claims.

AGREEMENT TO PAY: I accept responsibility for all charges not covered by insurance, including collection costs, attorney fees, and court costs when applicable.

EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE: I authorize contact by telephone, text message, or email regarding my account and services.

I have read this disclosure and understand the financial policy of the practice and agree to be bound by its terms.

Signature of Patient or Responsible Party: _____ Date: _____

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

By: _____ As: _____

Primary Care INTERNISTS MONTGOMERY

HIPAA – Medical Information Release

Patient Name_____ DOB_____

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 designed family members, caregivers, and friends, as well as, pharmacists, hospitals, emergency medical personnel, and referral specialists about you or your minor (under 14 years 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. With 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 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 does not expire. I may change or revoke this authorization at any time by completing a new authorization.

Signature_____Relationship_____Date_____

***DISCLAIMER** (Complete only if you want **<u>someone</u>** else to have access to your information, including family members.)

_____I <u>do not</u> want you to discuss my medical care with **<u>anyone</u>** other than myself.

Signature_____Relationship_____Date_____