Premier FAMILY CARE
First in Convenience… First in Compassion

DEMOGRAPHIC

Patient Information- As Listed on Your Insurance

Preferred Pharmacy _____ **Pharmacy Address** _____

Last Name _____ **First Name** _____ **Middle Initial**_____

Preferred Name _____ **DOB** _____ **Gender: M F SS #** _____ | _____ | _____

Race _____ **Ethnic Group** _____ **Language** _____ **Marital Status: M S W D**

Home Address _____

Zip _____ **City** _____ **State** _____

Phone (Home) _____ **(Work)** _____ **(Cell)** _____ **Preferred Contact Method** _____

Employer _____ **Email** _____

Primary Insurance Policy Holder

Insurance Company _____

Policy Holder's Name _____

Date of Birth _____ **SSN#** _____-____-_____

Secondary Insurance Policy Holder

Insurance Company _____

Policy Holder's Name _____

Date of Birth _____**SSN#**_____-____-_____

Parent or Guardian of Minor Child/Children

Name _____ **Date of Birth** _____

SS # _____ **Mailing Address** _____

City _____ **State** _____ **Zip** _____ **Phone** _____

In Case of an Emergency

Emergency Contact _____

Phone _____ **Relationship** _____

Permission to Disclose Health and Billing Information

I, (**Print Name**) _____, hereby grant permission for Premier Family Care to discuss or release information concerning my medical diagnosis, or information relating to or in my medical records, or any medical information that the aforementioned entity may have on file as it concerns me including but not limited to billing, benefit inquiries, claims, appeals and complaints, to the following individual(s) in compliance with the required HIPAA guidelines:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

- ☐ I decline to have my medical information shared with any individual. I understand that I have the right to change this decision at any time.
- ☐ By checking here, I acknowledge the medical staff may review my medication/prescription history.

Signature: _____ **Date** _____

Staff Witness: _____ **Date** _____

Premier FAMILY CARE
First in Convenience… First in Compassion

Medical Profile **Patient ID:_____**

Patient Name:	**DOB:**

Review of Systems

Review the list below. Check each item to show if you now have recently had any of these problems (Yes or No). If you need help with this form our staff will be happy to assist you.

Date of last Colonoscopy: _____ Date of last Eye Exam: _____

Date of last EKG: _____ Date of last Stress Test: _____

Y	N	**Constitutional:**	Y	N	**Gastroenterology:**	Y	N	**Musculoskeletal:**
		Fatigue			Frequent heartburn or indigestion			Joint pains
		Fever			Frequent nausea			Joint swelling
		Chills			Frequent or recurrent vomiting			Frequent backaches
		Sweats			Vomiting blood			History of fractures
		Night sweats			Constipation	**Y**	**N**	**Neurologic:**
		Weight Change			Hemorrhoids			History of seizures
Y	**N**	**Eyes:**			Blood in stools			History of fainting
		Glaucoma			Frequent or recurrent diarrhea			History of stroke (CVA)
		Cataracts			Use of laxatives frequently			History of temporary paralysis
		Corrective eyeglasses	**Y**	**N**	**Genitourinary:**	**Y**	**N**	**Cardiovascular:**
		Recent visual changes			Painful urination			Chest, tightness, pressure, or pain
Y	**N**	**ENT:**			Get out of bed at night to urinate			Swelling in feet or legs
		Allergic rhinitis			How many times? ___			Sleep on more than 1 pillow
		Frequent sore throat			History of kidney stones			Awaken at night to catch breath
		Recent hearing changes	**Y**	**N**	**Women Only:**			Pounding heart beats (palpitations)
		Hearing aids			History of breast lumps			Rapid heartbeats for no reason
		Ringing in ears			Nipple discharge			Light headedness
		Dentures			Change in periods			History of a heart murmur
Y	**N**	**Respiratory:**			Hot flashes			Leg cramps when walking
		Frequent cough			Hormonal medications	**Y**	**N**	**Psychiatric:**
		Cough up sputum	**Y**	**N**	**Men Only:**			Depression
		Cough up blood			Difficulty with erection			Anxiety
		Short of breath on exertion			Dribbling urine			Crying spells
		Wheezing			Decreased urine stream size			Change in personality
		Excessive snoring			Difficulty starting urination	**Y**	**N**	**Hematologic/Lymphatic**
Y	**N**	**Skin (Integumentary):**	**Y**	**N**	**Endocrine:**			Easy bruising
		Skin lesions			History of thyroid problems			History of Anemia
		Skin rash			Difficulty tolerating heat or cold			History of blood transfusion
Y	**N**	**Allergic/Immunological:**			Recent changes in skin or hair			Swollen lymph glands
		History of hives						
		Frequent pneumonia						
		Removal of spleen						
		Frequent use of steroids						

Patient Signature: _____ Date: _____

Premier FAMILY CARE
First in Convenience… First in Compassion

Medical Profile

Name _____ Date of Birth _____

Past Medical History *Check all that apply. Describe details of medical conditions in the space provided.*

- ☐ NONE
- ☐ Alcohol/Drug Addiction
- ☐ Allergies
- ☐ Anemia
- ☐ Angina (Chest Pain)
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ BPH (Enlarged Prostate)
- ☐ Cancer: _____
- ☐ COPD
- ☐ CVA (Stroke)
- ☐ Depression
- ☐ Diabetes (Adult Onset)
- ☐ Diabetes (Child Onset)
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Heartburn/GERD
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ IBS (Irritable Bowel)
- ☐ Inflammatory Bowel Disease (Crohn's or UC)
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Health Disorder: _____
- ☐ Migraine
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Ulcers
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ Thyroid Disease

☐ Other/Details:

Past Surgical History *Check all that apply. Describe details of surgery in the space provided.*

- ☐ NONE
- ☐ Angioplasty
- ☐ Appendectomy
- ☐ Back Surgery
- ☐ Carpal Tunnel
- ☐ Cataract
- ☐ Colon Surgery
- ☐ Coronary Bypass
- ☐ Coronary Stent
- ☐ Gallbladder
- ☐ Gastric Bypass
- ☐ Hernia Repair
- ☐ Hip Replacement
- ☐ Knee Replacement
- ☐ Pacemaker or Defibrillator
- ☐ Small Bowel Surgery
- ☐ Thyroid Surgery
- ☐ Tonsillectomy

** Males**
- ☐ Prostate Biopsy
- ☐ TURP (Prostate Surgery)
- ☐ Vasectomy

Females
- ☐ Breast Biopsy
- ☐ Breast Implants
- ☐ Breast Reduction
- ☐ C-Section
- ☐ D&C
- ☐ Hysterectomy
- ☐ Ovaries Removed
- ☐ Tubal Ligation

☐ Other/Details:

Medications *Please list prescription or over-the counter medications you are currently using.*

	Drug Name	Dosage/Strength	How Many Times Per Day?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Allergies *Check the box below if No Allergies*

☐ **NO KNOWN DRUG ALLERGIES**

	Drug Name/Food	Reaction
1.		
2.		
3.		
4.		

Women's Health History

Age of first menstrual period _____
Last menstrual period _____
Age of onset of Menopause _____

Are you currently Pregnant? Yes No Possibly
What type of Birth Control do you use? _____

Pregnancy History *List the number of each type in the box below.*

Full Term	Premature	C-Section	Vaginal	Live Birth	Ectopic	Miscarriage	Abortion

Premier FAMILY CARE
First in Convenience… First in Compassion

Medical Profile

Name _____ Date of Birth _____

Social History *Your answers help determine your risk for certain diseases. Responses are confidential.*

Tobacco Use: Yes No
- ☐ Chew Tobacco
- ☐ Cigarettes
- ☐ E-Cigarettes

How many per day? _____
For how long? _____
If you quit, what year? _____

Medical Marijuana: Yes No

Do you drink Alcohol? Yes No
If yes, what type? _____
How Much? _____
How Often? _____
If you quit, what year? _____

Do you use *illegal* drugs? Yes No
If yes, what type? _____
How Much? _____
How Often? _____
If you quit, what year? _____

Preventive Care *List dates of the most recent preventative services that you've received.*

Test Performed	Date Performed	Results		Never Performed
Abdominal Aortic Aneurysm Test		Normal	Abnormal	☐
Bone Density Test		Normal	Abnormal	☐
Colonoscopy		Normal	Abnormal	☐
Complete Physical		Normal	Abnormal	☐
Eye Exam		Normal	Abnormal	☐
HIV Test		Normal	Abnormal	☐
Mammogram		Normal	Abnormal	☐
PAP Smear (Females Only)		Normal	Abnormal	☐
Prostate Exam (Males Only)		Normal	Abnormal	☐
PSA (Males Only)		Normal	Abnormal	☐

Immunizations *List dates of most recent immunizations.*

IMMUNIZATION	DATE	IMMUNIZATION	DATE

If under 18, are immunizations current? Yes No

Family Medical History *Check all that apply to your IMMEDIATE relatives. (Parents, Grandparents, or Siblings)*

☐ Alzheimer's	☐ Cancer – Breast	☐ Depression	☐ Kidney Disease
☐ Anemia	☐ Cancer – Colon	☐ Diabetes (Adult Onset)	☐ Liver Disease
☐ Anxiety	☐ Cancer – Ovarian	☐ Diabetes (Child Onset)	☐ Migraine
☐ Arthritis	☐ Cancer – Prostate	☐ Glaucoma	☐ Osteoporosis
☐ Asthma	☐ Cancer – Stomach	☐ Heart Disease	☐ Seizures
☐ Atrial Fibrillation	☐ Cancer – Other	☐ High Blood Pressure	☐ Thyroid Disease
☐ Bleeding Disorder	☐ CVA (Stroke)	☐ High Cholesterol	☐ Ulcers
☐ Blood Clots	☐ COPD	☐ Inflammatory Bowel Disease (Crohn's or UC)	

☐ Other/Details:

I certify that the information provided above has been answered to the best of my knowledge. I understand that this information will be kept confidential and will only be used for my medical care.

Patient Signature _____ Date _____

Premier FAMILY CARE
First in Convenience… First in Compassion

Financial Policy

Thank you for choosing Premier Family Care as your health care provider. Please understand that payment of your bill is considered your responsibility. We require all patients complete our forms before seeing the doctor.

Insurance (Other than Managed Care)

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Payment is due at the time services are rendered. If your insurance has not been paid on your account within 45 days, you will be asked to pay for your services even though your insurance is pending. This can be paid with cash, check, Visa, MasterCard, Discover, or American Express.

Managed Care Insurance

We file for all office visits with PPO's and HMO's in which we participate. Copays are due at the time of service. If you do not have your insurance card with you at the time of your visit, you will be expected to pay for your visit at the time of service.

Medicare

Premier Family Care participates in the Medicare program. We will file the claim with Medicare and will accept Medicare's allowable payment. You will be billed for the 20% coinsurance and any deductible. If you have a secondary insurance, we will file your secondary insurance for you after the Medicare payment has been received.

Usual and Customary Fees

We charge what we consider is usual, customary and reasonable. You are responsible for payment regardless of any insurance company's arbitrary determination of another usual, customary and reasonable fee.

No Insurance Coverage

If you do not have insurance, your payment is due at the time of service unless prior arrangements have been made. We accept cash, check, Visa, MasterCard, Discover or American Express.

I UNDERSTAND THAT I AM RESPONSIBLE FOR THE PAYMENT OF ANY SERVICES AT TIME OF VISIT.

- Please note: you may incur separate charges for laboratory and orthopedic services or supplies.
- I understand that I am responsible for all charges including deductible, co-pay's, etc. that are not covered by my insurance plan including Medicare.
- I authorize transfer of medical benefits to undersigned physician for services rendered.
- I authorize release of any medical information necessary to process this claim.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: A DETAIL OF YOUR RIGHTS AND HOW YOUR MEDICAL INFORMATION WILL BE USED AND DISCLOSED IS SET FORTH IN THE NOTICE OF PRIVACY PRACTICES. A COPY HAS BEEN FURNISHED TO ME AND IS POSTED IN THE CLINIC.

_____ _____

PATIENT SIGNATURE **DATE**