Partners In Health
Family Medicine

PATIENT DEMOGRAPHIC FORM

Would you like to sign up for Patient Portal? Yes__ No __

PATIENT INFORMATION

Patient Name: _____ Sex: ☐M ☐F Social Security #: _____/_____/_____

Marital Status: ☐Single ☐Married ☐Widow/er ☐Divorced ☐Partner Date of Birth: _____/_____/_____ Age: _____

Race: _____ Ethnic Group: ☐African American ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Other: _____

Language if not English: _____ Other Communication issues: ☐Yes ☐No Detail: _____

Mailing Address: _____
Street Apt No. City State Zip

Physical Address (if not the same as mailing): _____
Street Apt No. City State ZIP

Home Phone: (_____) _____-_____ Cell/pager: (_____) _____- _____ Work phone: (_____) _____-_____

Email Address: _____ Preferred Contact Method: ☐Text ☐Mail ☐E-Mail ☐Phone

Reminder method: ☐Work Phone ☐Home Phone ☐Cell Phone ☐E-Mail Driver License No: _____ _____ Expires: _____
Number State

Spouse/Partner Name: _____ Date of Birth: ___/___/___ Social Security No: ___/___/_____

Address: _____ Work Phone: (____) _____ - _____
Street Apt No City State Zip

Emergency Contact Name: _____ Emergency Contact No: (_____) _____ - _____

Address: _____ Relationship: _____
Street Apt No City State Zip

GUARANTOR/PARENT INFORMATION

Responsible Party Name: _____ Date of Birth: ___/___/___ Sex: ☐M ☐F Social Security No: _____/_____/_____

Marital Status: ☐Single ☐Married ☐Widow/er ☐Divorced ☐Partner Driver's License No: _____ _____ Expiration Date: _____
Number State

Home Phone: (_____) _____-_____ Cell/pager: (_____) _____- _____ Work phone: (_____) _____-_____

Employer: _____ Occupation: _____

Address: _____ Relationship to Patient: _____

PATIENT'S INSURANCE INFORMATION (PLEASE PROVIDE INSURANCE CARD AND PHOTO ID TO RECEPTIONIST)

Primary Insurance Company's Name: _____

General Phone: (_____)_____-_____ Claims Phone: (_____)_____-_____ Office fax: (_____)_____-_____

Insurance Address: _____
Street Apt No City State Zip

Policy Holder: _____ Date of Birth: _____/_____/_____ Social Security No: _____/_____/_____

Insurance ID No: _____ Insurance Group No: _____

Secondary Insurance Company's Name: _____

General Phone: (_____)_____-_____ Claims Phone: (_____)_____-_____ Office fax: (_____)_____-_____

Insurance Address: _____
Street Apt No City State Zip

Policy Holder: _____ Date of Birth: _____/_____/_____ Social Security No: _____/_____/_____

Insurance ID No: _____ Insurance Group No: _____

(Please Read And Sign)

I herby authorize my insurance benefits to be paid directly to *Partners in Health Family Medicine, PLLC* and I realize I am responsible for paying for non-covered services. I understand that I am responsible for all charges incurred on my behalf, including any added costs incurred due to any effort to collect for services rendered. I hereby authorize the release of pertinent medical information to insurance carriers.

Patient/Guardian Signature: _____ **Date:** _____

Partners In Health
Family Medicine

FINANCIAL POLICY

Our goal is to provide you excellent medical care in a comfortable, personal and cost effective manner. Our financial policies have been developed to help keep the cost of "doing medicine" down, which means lower fees for you. You can help by paying for your care in a timely manner.

Patient Name: _____ DOB: _____/_____/_____ Account No: _____

ASSUMPTION OF RESPONSIBILITY

Payments to Partners In Health, PLLC may be made by cash, check, VISA or MasterCard. Patients are expected to pay all co-pays, deductibles and/or coinsurance at the time of service. We do our best to include all charges at the time of service but occasionally; charges may be added or modified after the visit. (For example: an additional blood or urine test may be ordered or the level of service may be modified per AMA guidelines).

Partners In Health, PLLC reserves the right to charge a fee for delinquent accounts. If ongoing medical care is needed, you are expected to pay on your old balance as well as payment in full for new charges at the time of service. Accounts with balances over ninety (90) days may be turned over to a collection agency unless you are making monthly payments on an approved payment plan.

Please check each box.

☐ By signature below, I/we, whether signing as guarantor or as patient, understand and hereby agree that in consideration of services to be rendered to the patient named above, assume the obligation, the financial responsibility and agree to pay upon demand to Partners In Health, PLLC all fees for such services and incidentals incurred by named patient. Should the account be referred to an attorney for collection or to a collection agency, the undersigned shall pay reasonable attorney fees, collection fees and other expenses as a court may determine proper.

☐ By signature below, I/we understand that in connection with collection procedures Partners In Health, PLLC has the right to request, receive and review all credit information as provided by a licensed and duly operated credit bureau.

☐ By signature below, the undersigned understands that all bills are payable upon presentation and that the guarantor and **NOT** the insurance is responsible for the payment of all services. If the undersigned disagrees with any charges, they will contact this office in writing within thirty (30) days of the billing date.

ASSIGNMENT OF INSURANCE BENEFITS

☐ I/we understand that insurance billing is a courtesy to our patients. Once my annual deductible has been met, PIH will bill my insurance company.

☐ I/we understand that I am expected to pay for any co-payment and any non-covered services at the time of my visit.

☐ I/we understand it is my responsibility to pay any balance older than sixty (60) days (even if my insurance company has not paid) and to follow up with my insurance company for reimbursement.

A refund will be issued if PIH receives a payment from your insurance company after your balance is paid. If we have made an error we will gladly submit a corrected claim.

☐ By signature below, I/we hereby guarantee payment of all charges as outlined above and incurred for the account of the above named patient from the date of first treatment until final date of discharge or termination of treatment.

☐ By signature below, I/we hereby assign direct payment of any hospital insurance benefits, medical insurance benefits (including major medical benefits, insurance sick benefits or injury benefits) payable of the liability of a third party or organization, and so forth, payable to or for the above named patient be paid in full.

NO SHOW AND CANCLELLED APPOINTMENTS

Partners In Health, PLLC reserves the right to charge a fee for "no show" appointments with less than 24 hours' notice. Our policy requires: (1) receiving a 24 hour notice if the patient is unable to keep an appointment; (2) applying a fee for missed appointments; and (3) discharging a patient when three appointments are missed without prior notice. There is a 10-minute grace period for all appointments before we mark them as a no show and you will need to reschedule.

No-Show Appointment Fees: 1st and 2nd = $25 each missed visit 3rd = $25 and discharge from practice. All No-Show fees must be paid prior to next scheduled office visit.

AUTHORIZATION TO RELEASE INFORMATION

The undersigned hereby authorizes said Partners In Health, PLLC to release sociological and medical information officially acquired in the course of examination and treatment for the purpose of filing for insurance benefits and other financial coverage.

This authorization to release information shall remain in place until all claims have been paid.

NOTICE: DO NOT SIGN THIS AGREEMENT BEFORE YOU READ, UNDERSTAND AND AGREE TO THE CONDITIONS AS SET OUT ABOVE. YOU SHOULD KEEP A COPY OF THIS AGREEMENT IN YOUR RECORDS.

BY SIGNATURE BELOW I ACKNOWLEDGE THAT I HAVE READ, I UNDERSTAND AND I APPROVE ALL OF THE ABOVE.

Signature: _____ Date: _____

Partners In Health
Family Medicine

PERMISSION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: ____/____/____ Account No: _____

Patient Address: _____
Street Apt No City State Zip

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

I give permission to Partners In Health, PLLC to **VERBALLY** discuss the following medical and billing information about me (check all that apply):

- ☐ Appointment information.
- ☐ Medical information including my symptoms, diagnosis, medications and treatment plan.
- ☐ Behavioral health information including my symptoms, diagnosis, medications and treatment plan.
- ☐ Chemical dependency information including my symptoms, diagnosis, medications and treatment plan.
- ☐ Lab/test results.
- ☐ Billing and payment information.
- ☐ Other: _____

Partners In Health, PLLC has my permission to discuss the above information with:

Name: _____ Relationship: _____

Address: _____
Street Apt No City State Zip

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Name: _____ Relationship: _____

Address: _____
Street Apt No City State Zip

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Name: _____ Relationship: _____

Address: _____
Street Apt No City State Zip

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

I understand that I have the right to revoke my permission at any time except where PIH has already made disclosures in reliance upon this request. I understand I must notify PIH in writing if I revoke my permission.

_____ _____
Signature of Patient/Authorized Representative Date

If authorized representative please attach copies of supporting legal documentation.

Reason patient is unable to sign: _____

_____ _____
Signature of Partners In Health, PLLC Representative Date

Partners In Health
Family Medicine

PERSONAL AND FAMILY MEDICAL HISTORY

NAME: _____ DATE OF BIRTH: _____

Personal Medical History Check all that apply:

___NONE
___ADD/ADHD
___AIDS/HIV
___Allergies/Hay Fever ___Alzheimer's/Other Dementia
___Anemia
___Anxiety
___Arthritis - Type: _____
___Asthma
___Bladder Problems
___Blood Disorders
___Cancer - Type: _____
___Congestive Heart Failure
___Constipation
___COPD
___Depression
___Diabetes - Type I____ or Type II___
___Diverticulosis/Diverticulitis
___Fibromyalgia
___Gout
___Heartburn/GERD
___Headaches: ___check if migraines
___Hearing loss
___Heart Disease/Coronary Artery Disease
___Hepatitis
___High Cholesterol
___High Blood Pressure/Hypertension
___Joint or Bone Problems - Type: _____
___Kidney Disease
___Kidney Stones
___Liver Disease
___Lung Disease - Type: _____
___MRSA/Staph Infection
___Obesity
___Osteoporosis
___Prostate Problems
___Seizures
___Stroke
___Urinary Tract Infections
___Other: Please List:
_____
_____
_____
_____

Family Medical History
Grandparents (GP), Parent (P) Siblings (S)
Check all that apply:

	GP	P	S
___Unknown	____	____	____
___AIDS	____	____	____
___Alcoholism	____	____	____
___Alzheimer's	____	____	____
___Asthma	____	____	____
___Blood Disorders	____	____	____
___BPH (enlarged prostate)	____	____	____
___Breast Cancer	____	____	____
___Stroke	____	____	____
___Colon Cancer	____	____	____
___COPD	____	____	____
___Depression	____	____	____
___Diabetes	____	____	____
___Gout	____	____	____
___Heart Problems	____	____	____
___High Blood Pressure	____	____	____
___High Cholesterol	____	____	____
___HIV	____	____	____
___Hypothyroid	____	____	____
___Hypothyroid	____	____	____
___Kidney Stones	____	____	____
___MI (Heart Attack)	____	____	____
___Osteoarthritis	____	____	____
___Osteoporosis	____	____	____
___Prostate Cancer	____	____	____
___Rheumatoid Arthritis	____	____	____

___Other: _____
___Other: _____
___Other: _____

SURGICAL HISTORY: List all surgeries you have had, including date:

_____
_____
_____
_____
_____
_____

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Name: _____ Date of Birth: _____

Preferred Pharmacy: _____ Location: _____

Allergies: Allergic to any medications? ___Yes or ___No
If yes, please list below:

ALLERGY TO THIS MEDICATION: REACTION TO MEDICATION:

_____
_____
_____
_____
_____
_____
_____
_____

MEDICATION LIST: Please include dosage and frequency.

MEDICATION	**DOSAGE**	**FREQUENCY**

Specialists you see:

Doctor:	**Specialty:**

Tobacco Use: ___Yes ___No ___Former

	How Many?	**How Long?**
___Cigarettes:	_____	_____
___Cigars:	_____	_____
___Vape:	_____	_____
___Smokeless:	_____	_____

Alcohol Use: ___Yes or ___No

	How Much?	**How Often?**
___Beer:	_____	_____
___Wine:	_____	_____
___Liquor:	_____	_____

Illicit Drug Use: ___Yes or ___No

HEALTH MAINTENANCE:
Last Colonoscopy Date: _____

Last Mammogram Date: _____

Last Pap Smear Date: _____

Last Tetanus Shot: _____

Last Flu Shot: _____

Last Pneumonia Shot: _____

Last Shingles Shot: _____

Exercise Level: ___ None ___ Some ___ Moderate ___ Heavy

Do you have any of the following?

___ Living Will ___ Power of Attorney

___ Health Care Proxy

Occupation: _____

Place of Employment:

_____

Partners In Health
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NAME: _____ DATE OF BIRTH: _____

I have received a copy of the Privacy Act of Partners in Health Family Medicine, PLLC, and I understand that the providers and staff at Partners in Health Family Medicine will not discuss my health information with my family, friends, or other non-authorized persons unless I expressly authorize them to do so as indicated below.

_____ _____

Signature *Date*