John David Blankenship, D.O.
Family Practice
New Patient Packet

Patient Name: _____ Date: _____
(Preferred to be called: _____) Cell Phone #: _____
Sex: _____ DOB: _____ Social Security #: _____
Race: Caucasian _____ African-American _____ American-Indian _____ Asian _____ Hispanic_____ Other _____
Current Address: _____ City: _____
State: _____ Zip Code: _____ Home Phone #: _____
eMail Address: _____
Employer: _____ Business Phone #: _____
Marital Status: Never Married: _____ Married: _____ Widowed: _____ Divorced: _____
Name of your Spouse: _____ Cell Phone #: _____
Spouses Employer: _____ Employer Phone #: _____
Emergency Contact: _____ Cell Phone #: _____
What is their relationship to you? _____

Primary Insurance: _____ Policy #: _____
Secondary Insurance: _____ Policy #: _____
Who is financially responsible for your visits with us: SELF Spouse Parent

Payment Policy:

Payment for services must be made at the time of your visit. Our office is an accredited user of the Visa, MasterCard, Discover, American Express and Health Care Programs. We also accept cash and checks.
SELF-PAY patients will be charged $150.00 per visit, plus any fees relating to additional in-office testing that may be required. Patients with a HIGH DEDUCTIBLE INSURANCE PLAN, will be charged $150.00 until your deductible is met.

I, _____ have read Dr. Blankenship's payment policy and understand that payment is expected at the time of my visit.

_____ Date: _____
Signature of Patient or Representative

Privacy Rights
HIPAA

This notice describes how medical information about you may be used and disclosed and how you can access this information. Please review it carefully.

This is a summary of our Notice of Privacy Practices or Privacy Rights, which describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of this Notice of Privacy Practices, or Privacy Rights. We may change the terms of our notice at any time and reserve the right to do so. The new notice will be effective for all protected health information that we maintain at that time.

We will use your protected health information as part of rendering patient care, including treatment, payment and healthcare operations.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has acted in reliance on the use or disclosure indicated in the authorization.

We may use or disclose your protected health information in certain situations without your authorization or opportunity to agree or object.

You have the right to request restriction of your protected health information.

You have the right to request to receive confidential communications of your protected health information.

You have the right to inspect and copy your protected health information.

You have the right to amend your protected health information.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

You have a right to obtain a copy of this notice from us.

You may complain to the Secretary of Health and Human Services if you believe we have violated your privacy rights. You may file a complaint with us by notifying our privacy contact. No retaliation will occur if a complaint is filed.

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Name: _____ DOB: _____ Date: _____

Notification of Privacy Rights

I, _____ acknowledge that I have been advised of my privacy rights and the notice of Privacy Practices has been made available to me.

_____ Date: _____
Signature of Patient or Representative

Permission to Discuss My Medical Concerns

John David Blankenship, D.O., LLC, or his affiliates can discuss my medical information or needs with the following individuals:

_____	_____	_____
Name	Relationship	Phone #
_____	_____	_____
Name	Relationship	Phone #

_____ _____
Signature of Patient or Representative Date

YES NO
I give Blankenship Family Medicine and its affiliates permission to leave voicemail messages on any phone number listed within your New Patient Packet Paperwork regarding appointments, medication refills, or any other medical information.

YES NO
I only want a voicemail message requesting to return your phone call. (No other information will be provided).

Specialists Involved With My Healthcare Needs, (include mental health)

Specialists	**Specializing In**	**Last Visit Date**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

BLANKENSHIP FAMILY MEDICINE
John David Blankenship, D.O. – 204 Lowe Ave SE, Bldg 1, Suite 2, Huntsville, AL 35801
Office Phone: 256-534-7235 / Office Fax: 256-534-7268

Authorization to Release Protected Health Information

Date: _____

REGARDING YOUR CURRENT/PREVIOUS PATIENT:	**DOB:**
_____	_____

RELEASE INFORMATION FROM:	**RELEASE INFORMATION TO:**
_____	**BLANKENSHIP FAMILY MEDICINE**
_____	**204 Lowe Ave SE, Bldg 1, Suite 2**
Phone: _____	**Huntsville, AL 35801**
Fax : _____	**FAX: 256-534-7268**

INFORMATION REQUESTING TO BE RELEASED: ANY AND ALL

History & Physical	EKG's	Lab Reports	Hospital Notes	Immunization Records
Pathology Reports	Radiology	Operative Reports	Billing	Clinic Notes/Encounters

I understand the information to be released may include records related to behavior and/or mental healthcare, alcohol and drug abuse treatment, HIV/AIDS, and genetics. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. The provider/facility will not condition treatment on whether I sign the authorization. I may be charged for copies in accordance with state law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law. This authorization will expire one year from the date of signing unless I indicate an earlier date or event here: _____.

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form. If the patient is 18 years of age or older, the patient must sign and date the form. If the patient is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship:

__Legal Guardian or Conservator __Healthcare Agent (Healthcare Power of Attorney)

If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date the form, unless an exception exists under the state or federal law. Please indicate your relationship to the patient.

__Parent __Legal Guardian

Signature (Required)	**Date Signed (Required)**
_____	_____
Printed Name of Person Signing	**Mailing Address**
_____	_____

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Family Practice

Name: _____ DOB: _____ Date: _____

Preferred Pharmacy Name	Phone	Location

MEDICATION ALLERGIES

MEDICATION		REACTION
NO MEDICATION ALLERGIES: _____		

FOOD/ENVIRONMENTAL ALLERGIES, (i.e., bee sting)

TYPE	REACTION
NO FOOD/ENVIRONMENTAL ALLERGIES: _____	

MEDICATIONS

PRESCRIPTION MEDICATION	X PER DAY	DOSAGE AMOUNT	OVER THE COUNTER MEDICATION/SUPPLEMENTS
NO MEDICATIONS: _____			

LIFESTYLE PREVENTATIVE HEALTH

QUESTION	ANSWER
How many hours of sleep do you get per night?	
How often do you exercise per week?	
What is the duration of time?	
What type of exercise?	
What type of foods do you regularly eat? (i.e. low carb, plant-based, KETO, Mediterranean, or other)	
What do you do for your mental health, stress, and anxiety prevention? (i.e., exercise, yoga, counseling, meditation, prayer, other)	
How much water do you drink a day?	
If comfortable, describe any religious faith you may have, (Christian, Jewish, Muslim, atheist, non-religious, other, etc).	

If additional space is needed, please provide a separate list.

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Name: _____ DOB: _____ Date: _____

FAMILY HISTORY (Please Circle) **All Immediate Family Members**
Total Number of Biological Siblings: _____

Are You Adopted? _____

CONDITION	FATHER	MOTHER	SISTER	SISTER	BROTHER	BROTHER
Alive or Deceased	A D	A D	A D N/A	A D N/A	A D N/A	A D N/A
Alcohol Addiction	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Anxiety	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Asthma	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Cancer (list type)	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Clotting Disorder	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Depression	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Diabetes	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Drug Addiction	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Heart Disease	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
High Blood Pressure	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
High Cholesterol	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Stroke	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No

SOCIAL HISTORY
(Please answer each question, even if the answer is "0", "No", or "None")

Marital Status	Number of Children	Pets	
Are You a Current Smoker	Number of Packs Per Day	Are You a Previous Smoker	When Did You Start/Quit
Other Tobacco Products	What Kind of Tabacco	Amount Per Day	When Did You Start/Quit
Do You Drink Alcohol	How Often and How Much	Do You Use Recreational Drugs	What Type of Drugs

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Name: _____ DOB: _____ Date: _____

TESTING		
TEST	**YEAR**	**N/A**
AAA Screen		
Bone Density		
Fasting Cholesterol Panel		
Colonoscopy		
Cologuard		
Fasting Glucose		
Heart Cath		
Lung CT		
Men: PSA		
Stress Test		
Upper Endoscopy		
Women: Pap Smear		
Women: Mammogram		

IMMUNIZATIONS		
VACCINE	**YEAR**	**UNKNOWN**
FLU		
HEP B		
PNEUMONIA		
TETANUS		
WHOOPING COUGH		
SHINGLES		

BIRTHS	
Pregnancies	
Term	
Preterm	
Miscarriage	
Termination	
Living	
Menopause	

MEDICAL HISTORY			
Anemia		Anxiety	
Arthritis		Asthma	
Back Problem		BPH	
CAD		Cancer*	
CHF		COPD	
Diabetes		Dementia	
Depression		Dermatitis	
Epilepsy		Gerd	
Glaucoma		Gout	
Headache		Heart Attack	
Hepatitis		High Cholesterol	
HIV		Hypertension	
Hypothyroid		IBS	
Migraines		Nasal Allergies	
Pneumonia		Renal Stone	
Stroke		Ulcer (GI	
If you have cancer, please list the type:			

SURGERIES			
ABG		Aortic Aneurysm	
Appendectomy		Breast Augment	
Breast Reduction		C-Section	
Carotid Endarterectomy		Cataract Extract	
Colectomy		Ectopic Pregnancy	
ESWL		Partial Hysterectomy	
Hysterectomy		Gallbladder	
Gastric Banding		Heart Valve	
Hernia		Hip – R L BIL	
Hip Fracture – R L BIL		Intestinal By-Pass	
Knee Arthroscopy – R L BIL		Knee Replacement - R L BIL	
Knee Surgery - R L BIL		Shoulder – R L BIL	
LS Spine Surgery		Mastectomy	
Oophorectomy		Pacemaker	
Prostatectomy		PTCA	
Lasik		Sinusectomy	
Splenectomy		Thyroidectomy	
Tonsillectomy		Tubal Ligation	
Vasectomy		No Surgeries	

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Family Practice

Name: _____ DOB: _____ Date: _____

REVIEW OF SYSTEMS			
GENERAL	**CARDIOVASCULAR**	**GENITOURINARY**	**SKIN**
Fatigue/Daytime Sleepiness Y N	Chest Pain Y N	Frequent Urination Y N	Rash Y N
Weight Loss/Gain Y N	Palpitations Y N	Discomfort/Pain/Burning with Urination Y N	Change in Skin Lesions Y N
Fever, Night Sweats Y N	Shortness of Breath with Exertion Y N	Women: Hot Flashes, Irregular Periods Y N	New Skin Lesions Y N
		Men: Decreased Urine Stream, Dribbling Urine, Multiple Need to Urinate at Night Y N	
EYE	**RESPIRATORY**	**NEUROLOGIC**	**ENT**
Eye Pain Y N	Wheezing Y N	Dizzy Spells Y N	Hearing Problems Y N
Vision Change Y N	Cough Y N	Speech Problems Y N	Sore Throat Y N
	Excessive Snoring Y N	Memory Problems Y N	Runny Nose Y N
		Headaches Y N	
ENDOCRINE	**GASTROINTESTINAL**	**MUSCULOSKELETAL**	**PSYCHIATRIC**
Excessive Thirst Y N	Heartburn Y N	Joint/Bone Pain Y N	Sad Y N
Swelling in Neck Y N	Abdominal Pain Y N	Back Pain Y N	Irritable Y N
Easy Bleeding/Bruising Y N	Blood in Stool Y N	Neck Pain Y N	Suicidal Y N
OTHER			

John David Blankenship, D.O.
Family Practice

Name: _____ DOB: _____ Date: _____

Patient Rights & Responsibilities

You and your family are our number one concern during your visit with us. The following statement of your Rights and Responsibilities is presented as the policy of this facility but does not presume to be a complete representation of all-mutual rights and responsibilities.

____ **YOU HAVE THE RIGHT TO:**
Initial

- Receive considerate, respectful care, which always recognizes your personal dignity, under all circumstances.
- Participate in decisions involving your care. Except in an emergency, you shall not be subjected to any procedure without your voluntary, competent, and understanding consent or the consent of your legally authorized representative.
- Refuse treatment to the extent permitted by law and be informed of the consequences of that refusal.
- Information about Advance Directives, such as a Living Will or Durable Power of Attorney for Health Care, that would allow you to make your own healthcare decisions for the future and to have your chosen representative exercise these rights for you if you are not able to do so.
- Instructional and educational information about your medical treatment in a language and terms that you understand.
- The confidential treatment of and personal access to your medical record.
- Know who is responsible for providing your direct care and receive information concerning your continuing healthcare needs and alternatives for meeting those needs.
- Have access to interpreter services, free of charge, to the patient.

___ **YOU HAVE THE RESPONSIBILITY TO:**
Initial

- Give Dr. Blankenship and the staff of Blankenship Family Medicine complete and accurate information about your condition and your care.
- Follow the instructions of Dr. Blankenship and the staff of Blankenship Family Medicine and keep appointments relative to your care.
- Make it known whether you clearly understand planned actions and treatment and what is expected of you.
- Accept responsibility for his/her actions should he/her refuse treatment or not follow Dr. Blankenship's orders.
- Report unexpected changes in your condition to Dr. Blankenship and the staff of Blankenship Family Medicine.
- Know your health insurance guidelines and accept any financial obligations associated with your care.
- Be considerate of other patients in the waiting area. Be considerate of Dr. Blankenship and his staff.
- Follow the policies and procedures of our Practice Information for Patients.
- Bring a current copy of any Advance Directives to be scanned in your medical chart.
- Notify Blankenship Family Medicine of a request for interpreter services required.
- Arrive for your scheduled appointment on time. Call reminders are a courtesy and are completed by a third party. We have no control over their system and if they experience any downtime or service interruptions. It is your responsibility to know the date and time of your scheduled appointments and to arrive on time for your scheduled appointments.

Practice Information for Patients

Welcome to the family practice of John David Blankenship, D.O. We are truly honored and grateful that you have chosen to trust us with your medical care. Blankenship Family Medicine was established to provide individualized care for families.

Dr. Blankenship was raised in Huntsville, AL. However, he has lived in various locations since leaving for college in Nashville in 1988. He graduated from Kirksville College of Osteopathic Medicine in 1997 and finished his Family Practice Residency in Montgomery, AL in 2001. After eight years in a family practice group in Corbin, Kentucky, he moved his family back to Huntsville in 2009. He spent three years working in emergency medicine and urgent care clinics in North Alabama. His experiences motivated him to open a family practice that combines the best of modern technology with a comprehensive, individualized approach to care in July 2012. By putting relationships at

Name: _____ DOB: _____ Date: _____

the forefront of the healthcare experience, BFM strives to produce high-quality integrative healthcare with measurable results and improved patient satisfaction. In order to provide this type of healthcare, it is essential that the practice limits cost, maintains a manageable volume of patients, and empowers patients to participate in all aspects of their healthcare.

APPOINTMENTS:

_____ Initial — It is important that you bring all your medicine bottles with you to each visit. All refills of daily medications should be handled at your visit. Please make your appointments 2 weeks prior to running out of your medications.

_____ Initial — To remain a patient at BFM, you must have an annual well visit at our office. Most insurances will pay for a yearly well visit, however, we encourage you to check with your insurance. Each insurance company has the right to deny services at any time, leaving the financial responsibility to the patient.

_____ Initial — Payment – Your co-pay or self-pay payments are expected at the time of your visit. For patients without insurance, you are considered a "Self-Pay" patient, and your office visit fee is $150.00 for each visit, plus any additional charges.

_____ Initial — For sickness or urgent complaints – We will try to see patients within 24 hours.

_____ Initial — Telemedicine – Will be performed phone visits when necessary, and standard co-payments will be required. It is your responsibility to verify with your insurance company regarding telemedicine coverage. You are financially responsible for any charges your insurance company does not cover. Self-pay patients will be charged $150.00 for telemedicine visits.

_____ Initial — Routine Visits for Chronic Problems – Are scheduled in a 3-6 month window.

_____ Initial — Cancelation/No Show – Please provide at least a 24-hour notice if you need to cancel your appointment. Failure to do so will results in a $50.00 fee. We have a 24/7 answering service that you can call and cancel your appointment.

_____ Initial — Please Be On Time – When an appointment is made for you, that slot is reserved for your health care. Being on time is crucial for the courtesy of our other patients and for Dr. Blankenship and his staff. If you are 15 minutes late for your scheduled appointment, we will ask that you reschedule. You will incur a $50.00 fee for a missed visit which will need to be paid prior to rescheduling your appointment.

_____ Initial — Please Silence Your Cell Phones – If you need to make or receive a call, please step outside for the courtesy of our other patients and the staff. Please do not partake in cell phone conversation, or speak on your speaker function, in the lobby, lab, exam rooms, or restrooms while you are in the clinic.

OFFICE HOURS: _____ Initial — Our Office Hours are as follows: (We are CLOSED for lunch daily from 12:00-1:00)
Monday's – 8:00 am – 5:00 pm
Tuesday's – 10:00 am – 12:00 pm, (our phones are on at 8:00 am, but we do not start seeing patients until 10:00 am. The second Tuesday of every month we are closed).
Wednesday's – 8:00 am – 5:00 pm
Thursday's – 8:00 am – 5:00 pm
Friday's – 8:00 am – 5:00 pm

John David Blankenship, D.O.
Family Practice

Name: _____ DOB: _____ Date: _____

MEDICINE POLICY: _____
Initial
If possible, generic medicines will be prescribed. Medications that require prior authorization or higher co-pays will be avoided. unless they are deemed necessary for your well-being.

If a medication needs to be changed for any reason, (i.e., a cost increase, insurance change, pharmacy transfer, etc.), an appointment will be required.

Your medication refills should be requested at your office visit. You will need to schedule an appointment to receive a refill(s) of your medication. Please do not wait until you are out of medication to contact us. Phone calls will be returned within a 24-hour period.

Dr. Blankenship will not call-in antibiotics, pain, sleep medications or refills of routine medications after our normal daily business hours.

FORMS: _____
Initial
Please advise us if you will be bringing a form to be filled out prior to your appointment. Please bring all forms that need to be completed by Dr. Blankenship, preferably before your appointment. Fees for forms vary from $50.00 - $150.00. This includes, but is not limited to, short-term disability, life insurance, insurance applications, sports physical, college physicals, FMLA, subpoenas for lawsuits, free medicine applications, auto insurance, etc. Please contact the office for specific charges.

PATIENT PORTAL: _____
Initial
Take control of your health information with our Patient Portal. The Patient Portal allows us to communicate more effectively with our patients. To set up your Patient Portal, we will provide you with a temporary username and password. Please go to www.yourhealthfile.com to begin setting up your Patient Portal. Your Patient Portal allows you to have access to your important medical information such as, lab results, test results, appointment date/time, etc. New Patients will be sent a Registration Link to set up your Patient Portal. Please contact us if you do not have a computer or internet access and we will provide you with the necessary paperwork to be completed.

SOCIAL MEDIA: _____
Initial
For the privacy of all our patients and staff, please do not take any photos while in the clinic and post them on any social media platform.

Please follow us and like us on Facebook: Blankenship Family Medicine.

Our website is always open! Please visit our website for current information and important notifications: www.blankenshipfamilymedicine.com.