ORCHARD HEALTH
Primary & Express Care

Thank you for choosing Orchard Health Centers, PLLC (OH) for your health and wellness needs!

EXPRESS CARE PATIENT INFORMATION

Demographic Information:

Full Legal Name:_____ Age:_____

Date of Birth:_____ Social Security #:_____ ☐ Male / ☐ Female

Phone #:_____ Email Address:_____

By providing your phone number and email address, you agree to receive appointment reminders and other necessary communications.

Preferred method of communication: ☐ Phone/Text ☐ E-mail ☐ Both

Mailing Address:_____

_____

Height:_____ Weight:_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Engaged ☐ Separated ☐ Widow/Widower

Race: ☐ White ☐ Black ☐ Asian ☐ Hispanic ☐ American Indian

Sexual Orientation: ☐ Straight/Heterosexual ☐ Gay/Lesbian/Homosexual ☐ Bisexual ☐ Other:_____

Are you currently sexually active? ☐ Yes / No ☐ Current Contraceptive Method:_____

Insurance Company:_____ Insurance ID #:_____ Group #:_____

Effective Date:_____ Insurance Policy Holder:_____ Policy Holder SSN:_____

Policy Holder DOB:_____ Relation to Patient:_____

Guarantor (person responsible for bill or parent if different from patient):_____

Relationship to patient: ☐ Self ☐ Spouse ☐ Parent Phone #:_____ Date of Birth:_____

Adress:_____

Social Security #:_____ Employer:_____

Preferred Pharmacy:_____

Current/Recent Primary Care Provider:_____

How did you hear about Orchard Health?_____ If referred, by whom?_____

Do you have or have you had and of the following: Please check all that apply.

☐	High Blood Pressure	☐	High Cholesterol	☐	Fibromyalgia	☐	Schizophrenia	☐	Cancer Type:
☐	Diabetes	☐	Asthma	☐	Lupus	☐	Chronic Back Pain		
☐	Glaucoma	☐	Allergies	☐	Hypothyroid	☐	Injury of Large Joint	☐	Cancer Type:
☐	TIA (mini stroke)	☐	GERD / Reflux	☐	Hyperthyroid	☐	Drug Addiction		
☐	CVA (stroke)	☐	Irritable Bowel	☐	Heart Valve Issues	☐	Alcohol Addiction	☐	Use Marijuana
☐	Angina (chest pain)	☐	COPD/Emphysema	☐	Depression	☐	Tobacco Addiction	☐	Smoke Cigarettes
☐	Heart Attack	☐	Osteoarthritis	☐	Anxiety	☐	Nicotine Dependence		Packs per day:
☐	Atrial fib / flutter	☐	Rheumatoid Arthritis	☐	Bipolar Disorder	☐	DUI / DWI	☐	Vape

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Do you use tobacco?	☐ Yes, everyday	☐ Yes, on occasion	☐ No, former user	☐ No, never
Do you drink alcohol?	☐ Yes, everyday	☐ Yes, socially	☐ No, former user	☐ No, never
Do you use illegal drugs?	☐ Yes, everyday	☐ Yes, socially	☐ No, former user	☐ No, never
Are you currently employed?	☐ Yes, full time	☐ Yes, part time	☐ No, retired	☐ No, other

Current Employer:_____ Hrs. per week:_____

Medication Allergies:

Name:	Reaction:

Environmental / Food Allergies:

Allergen:	Reaction:

Current Medications: Please be thorough and accurate. If more space is needed, please let the staff know. Include vitamins and supplements.

Name of Medication	Strength (mg)	Frequency of Use	Reason for Use	Prescribing Provider

Surgeries:

Type:	Date:	Hospital:

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Hospitalizations:

Reason:	Date:	Hospital:

Total # of siblings (including yourself): _____

Family History:

Does any of your immediate blood relatives (grandparents, parents, siblings) have any of the following conditions?

Condition	Yes	No	Relative	Condition	Yes	No	Relative
Diabetes	☐	☐		Osteoarthritis	☐	☐	
High Blood Pressure	☐	☐		Rheumatoid Arthritis	☐	☐	
Heart Disease	☐	☐		Heart Attack/ Murmurs	☐	☐	
Cancer	☐	☐		Thyroid Disease	☐	☐	
Type	☐	☐		High Cholesterol	☐	☐	
Kidney Disease	☐	☐		Liver Disease	☐	☐	
Dementia	☐	☐		Stroke	☐	☐	

PLEASE CHECK ALL THAT APPLY:

General:	When:	**Eyes:**	When:
☐Good Health Lately	_____	☐Eye disease or injury	_____
☐Recent unexplained weight loss or gain	_____	☐Wear glasses or contacts	_____
☐Fever/Chills/Sweats	_____	☐Blurred Vision/Glaucoma/Cataracts	_____
☐Fatigue	_____	☐Flashing Lights/Floaters	_____
☐Headaches		☐Watery/Itchy/Discharge from eyes	
Ears, Nose, Throat, Mouth	When:	**Cardiovascular:**	When:
☐Hearing loss or ringing	_____	☐Heart Problems	_____
☐Earache or drainage	_____	☐Chest pain	_____
☐Chronic sinus problems/head congestion	_____	☐Palpitations	_____
☐Swollen glands in neck	_____	☐Shortness of breath	_____
☐Sore throat or voice changes	_____	☐Swelling of ankles/hands/feet	_____
☐Environmental Allergies		☐Passing out spells	
Respiratory	When:	**Gastrointestinal**	When:
☐Chronic or frequent coughs	_____	☐Loss of Appetite	_____
☐Spitting/coughing up blood	_____	☐Heartburn	_____
☐Asthma or wheezing	_____	☐Nausea/Vomiting/Diarrhea/Constipation	_____
☐Shortness of breath		☐Change in Bowel Movements	
Musculoskeletal	When:	**Skin**	When:
☐Joint pain/stiffness/swelling/warmth	_____	☐Rash or itching	_____
☐Weakness of muscles or joints	_____	☐Sunburns as a child	_____
☐Muscle pain or cramps	_____	☐Change in skin color/moles	_____
☐Back pain	_____	☐Change in hair or nails	_____
☐Difficulty walking		☐Varicose Veins	

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Neurological	When:	**Psychiatric**	When:
☐Light-headed or dizziness		☐Memory Loss or confusion	
☐Convulsions or seizures		☐Difficulty with anger	
☐Numbness or tingling sensations		☐Nervousness	
☐Tremors		☐Depression	
☐Stroke/TIA		☐Trouble Sleeping	
☐Head Injury		☐Hospitalized for emotional problems	
Endocrine	When:	**Hematologic/Lymphatic**	When:
☐Gland or hormonal problems		☐Slow healing cuts or bruises	
☐Thyroid Disease		☐Anemia	
☐Problems with blood sugar/diabetes		☐Past blood transfusions	
☐Frequent Thirst for no reason		☐Enlarged lymph nodes in groin/armpits	
☐Heat or cold intolerance		☐Easier bruising than usual for you	
FOR WOMEN:	When:	**FOR MEN:**	When:
Genitourinary		**Genitourinary**	
☐Frequent Urination		☐Frequent Urination	
☐Burning/Painful Urination		☐Burning/Painful Urination	
☐Frequent urination at night		☐Frequent urination at night	
☐History of kidney infections/stones		☐History of kidney infections/stones	
☐Blood in urine		☐Blood in urine	
☐Vaginal discharge/odor/itching		☐Erectile dysfunction	
☐Pain during sex		☐Testicular pain	
☐Lack of sexual desire		☐Lack of sexual desire	
☐Painful/heavy periods		☐Discharge from penis	
☐PMS or Menopausal symptoms		☐Pain during sex	

Additional health concerns:_____

_____

_____

Emergency Contact Information:

Non-HIPPA – this means we can't share medical information about you.

Name:_____ **Relation to Patient**: _____ **Phone #**: _____

HIPPA Contact – this person will have access to your medical information.*

Name:_____ **Relation to Patient**: _____ **Phone #**: _____

*HIPPA Release: The Health Insurance Portability and Accountability Act (HIPPA) provides safeguards to protect privacy. Implementation of HIPPA requirements officially began on April 14, 2003.

What this means: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPPA provides certain rights and protections to you as the patient. Orchard Health Centers PLLC. balances these needs with the goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

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THIS STUFF IS IMPORTANT:

_____ Orchard Health Centers PLLC. utilizes their affiliate practice, Ashe Family Healthcare, and their medical insurance billing and coding specialist to process insurance claims and debit/credit card payments. As such, you will see Ashe Family Healthcare (AFH) listed on many billing and statement notices. If you have any questions about your billing/insurance statements, please contact Orchard Health at 336-990-9540.

Payment Policy
We require payment of all balances related to your services, including co-pays, deductibles, coinsurance, non-covered service fees, etc. at the time of your visit.
Cash, personal checks, money orders, debit/credit cards, and HSA cards are accepted.

Payment Plans
A **minimum of 30%** must be paid upfront.
Payment of the remainder of balance must be made within 30 days of the rendered service.
A valid credit or debit card must be on file with us to ensure your payment.
In the event of financial hardship, a modified payment plan can be arranged on a case-by-case basis after discussing it with our financial counselor.

Billing Statement and Invoices
We submit claims to your insurance company on your behalf. We also send you an itemized billing statement listing each service and associated charges. Upon receipt of payments from your insurance carrier, any services, or portion of services not covered by your insurance plan will be billed to you. This includes unsatisfied deductible and any out-of-pocket expenses not covered by your carrier.
Full payment is due within 15 days of receipt.
Your account is considered past due 30 days from the date of the first statement.
You will receive a maximum of 3 statements (Initial, Past Due, and Final Notice).
If your account is over 90 days past due and you have not made a payment arrangement, your account may be turned over to a collection agency, including the fees charged by the agency for collection purposes.
Failure to pay the remaining balances can result in the termination of your care from our practice.

_____ I have completed this form to the best of my knowledge and attest to the validity of the information contained herein. I have read and understand all policies above and further understand it is my responsibility to maintain awareness of the most up-to-date policies and requirements to maintain compliance with being a patient of Orchard Health Centers, PLLC. I further agree to keep my demographic and health information current with Orchard Health. I will keep my account in good standing and maintain financial responsibility with appropriate accountability.

Patient Name (Printed):_____

Patient Signature: _____ **Date**:_____

If patient is under the age of 18:

Parent/Legal Guardian Name (Printed): _____

Parent/Legal Guardian Signature: _____ **Date**: _____