SHOALS
FAMILY CLINIC

Medical History

Name: ____

DOB: ______________________ Date: __________________

Phone number: _________________________________ Home/Cell

Address: ____

____

Allergies: ____

____

Email address (to access patient portal): ______________________

Who is your primary care provider? __________________________

Please list any other physicians you see _______________________

____

Preferred Pharmacy: __________________________________

How did you hear about us?: ____ Billboard _____ Radio _____Friend _____ Other: ________

____

Current Medications: ________________________________

____

____

____

Social History: Smoking ____ Vape ____ Smokeless Tobacco ____

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Personal History:

__ Anemia	__ Hepatitis	__ Seizures
__ Allergies	__ High Cholesterol	__ Stroke
__ Asthma	__ High Blood Pressure	__ Substance Abuse
__ Cancer	__ HIV	__ Thyroid Disorder
__ Diabetes	__ Migraines	__ Abnormal Menstruation
__ Eczema	__ Peptic Ulcers	__ Sleep Apnea
__ Heart Disease	__ Psychiatric Disorders	

Other: ____

____

Family History:

__ Cancer	__ Stroke	_____ Other ____________________
__ Diabetes	__ Thyroid Disorder	____________________
__ Heart Disease	__ Psychiatric Disorder	____________________

Surgical History (list):

____

____

____

Please provide date of your last exam (month/year):

Eye Exam ____________________ Colonoscopy ____________________

Prostate Exam/PSA ____________________ Foot Exam ____________________

Mammogram ____________________ Pap Smear ____________________

Last Menstrual Period: ________________________

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Shoals Family Clinic to use and disclose my protected health information to perform treatment, payment and operations of healthcare. The Notice of Privacy Practices provided by Shoals Family Clinic describes such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Shoals Family Clinic reserves the right to revise its notice of privacy at any time and may be obtained by written request.

With this consent, Shoals Family Clinic, may call my residence and speak to me or leave a message via test or voice and/or mail to my residence regarding any items that may assist the practice with healthcare operations such as appointment reminders, insurance, patient statements, lab/test results and any items pertaining to my clinical care. I also understand that Shoals Family Clinic uses electronic health records. By signing this form, I am consenting Shoals Family Clinic to use and disclose my protected health information to perform healthcare operations. I may revoke my consent in writing except to the intent that the practice has already made disclosures in reliance to my prior consent.

Patient's Representative/Patient's Signature ______________________________

Date ______________________

Consent for Treatment

Name: ______________________________ DOB: _______________ Date: _______________

I, the undersigned, hereby voluntarily consent to outpatient care at Shoals Family Clinic encompassing routine diagnostic procedures, examinations and medical treatment including but not limited to routine laboratory work, radiological studies, referrals to specialists and administration of medications prescribed by the provider. I further consent to the performance of those items listed above by the staff and assistants.

Deductibles/Percentage Pays/Co-Payments/Self Pay

Co-payments are due at the time of service. Deductibles and percentage payment amounts will be billed at the time payment is received from the Insurance Company. Payment is due within 30 days of invoice from the Billing Department. Self-Pay patients are required to pay the office visit and any additional costs (injections, testing, etc) at time of service. Any questions regarding billing should be directed to the biller.

Cancellations/Late Arrivals

Cancellations should be made greater than 24 hours before appointment time unless extenuating circumstances. Being more than 15 minutes late for an appointment may necessitate rescheduling your appointment.

Patient's Representative/Patient's Signature____

Date : ___________________________

Relationship to Patient : ____