MAIN STREET MEDICAL CENTER

Jessica Cross, FNP

What is the purpose of your visit today? ______________________

Please complete <u>all</u> <u>sections</u> of this form. If a section is not applicable, please mark as N/A to acknowledge you have reviewed that section. <u>Sign</u> all indicated areas.

PATIENT INFORMATION

Name: First ______ Middle ______ Last ______

DOB: ______ ☐ Male ☐ Female SS: ______

Height ______ Ft ______ In Weight ______

We are required by the Federal Government to ask and collect information on race, ethnicity, employment status and language preferences. You may select "decline to respond" if you do not wish to provide this information.

Race – Ethnicity

- ☐ American Indian or
- ☐ Alaska Native
- ☐ Asian
- ☐ Black / African American
- ☐ Native Hawaiian or
- ☐ Other Pacific Islander
- ☐ White / Caucasian
- ☐ I decline reporting
- ☐ Other: ______

Work Status

- ☐ Employed Full Time
- ☐ Employed Part Time
- ☐ Student
- ☐ Retired
- ☐ Unemployed

INSURANCE

Please proved a copy of your insurance card and your identification card (photo id). If you do not have a copy of your card we cannot bill your insurance. You may reschedule your appointment or elect to pay as a "non-insured" patient. A photocopy is acceptable and can be emailed to <u>RedRiverClinic@gmail.com</u> BEFORE your visit. ***WE DO NO ACCEPT MEDICAID FROM OTHER STATES!***

- ☐ I **don't have** health insurance and will provide payment for services rendered <u>today</u>.
- ☐ I **have** insurance and I am the <u>Primary</u> (main person) Insured
- ☐ I **have** insurance and I am a <u>dependent</u> (not the main person) on this policy

PRIMARY INSURANCE

Carrier (Aetna, BCBS, Medicare, ect) ______ ID# ______ Group # ______

Primary insured Name ______ Date of Birth ______ Relationship ______

☐ Self ☐ Other:

SECONDARY INSURANCE

Carrier (Aetna, BCBS, Medicare, ect) ______ ID# ______ Group # ______

***Please make sure your primary and secondary are in correct order! Having this information entered incorrectly will delay payment from insurance, and possibly cause you to be financially responsible for the bill (see our Financial Responsibility Statement).*

I certify that I am presenting a VALID, <u>active</u> coverage insurance card. I understand that if my insurance is not in effect at the time of the visit, or if Insurance fails to pay for my visit within 3 month, I will be financially responsible.

______ Print Name ______ Date ______ Signature

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PATIENT CONTACT INFORMATION

Primary Address [mailing address, must be same address you receive information about insurance plan]

Address	City	State	Zip

Secondary / Alternative Address

Address	City	State	Zip

Phone & Email

Home (______) ______________________ Cell (______) ______________________

Work (______) ______________________ Other (______) ______________________

Email ____

Emergency Contact

Name ______________________ Relationship ______________________

Phone (______) ______________________ Other (______) ______________________

COMMUNICATION PREFERENCE

- ☐ I agree to receiving text, phone calls, and / or email alert reminders for upcoming appointment.
- ☐ Cell phone ☐ Work phone ☐ email
- ☐ Home phone ☐ Other phone
- ☐ I OPT OUT of receiving any text, phone calls, and/or email alert reminders.

PATIENT HEALTH HISTORY INFORMATION

Social History

- ☐ Never smoker
- ☐ Never Smoker but live in smoking home ☐ previously ☐ currently
- ☐ Former Smoker Quit ______ yrs ago
- ☐ "Some-day" smoker # per day: __________
- ☐ Smoke daily # per day: ______ # of years:
- ☐ Other Nicotine use ☐ Pipe ☐ Vape ☐ Cigars ☐ Chewing tobacco/snuff

Do you drink alcohol? ☐ No ☐ Yes

☐ Beer ☐ Wine ☐ Liquor # ______ ☐day ☐week ☐month

- ☐ No use of street drugs, illicit drugs, or other's prescriptions.
- ☐ History of substance use. Type: ______________________
- ☐ Current substance use. Type: ______________________
- ☐ Medical Cannabis use. ☐ I have my NM card.

- ☐ I have smoke alarms in my home ☐ I have carbon monoxide detectors in my home
- ☐ I wear my seat belt ☐ I use safety gear when participating in sports activities

IMMUNIZATIONS

Please mark the immunizations you have had and enter dates [knows or approximate dates received]

	Immunization	Date		Immunization	Date
☐	Influenza		☐	Pneumonia PPV23	
☐	Hepatitis A series		☐	Shingles Vaccine	
☐	Hepatitis B series		☐	Tetanus-Diptheria	
☐	Pneumonia PPV13		☐	Tetanus-Diptheria-Whopping	

☐ All immunizations are current.

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MEDICAL HISTORY

Please mark any items *you* have been diagnosed with.

- ☐ Alcoholism
- ☐ Allergies / hayfever
- ☐ Anxiety
- ☐ Asthma
- ☐ Anemia, type:
- ☐ Arthritis
- ☐ Atrial fibrillation
- ☐ Arthritis
- ☐ Blindness
- ☐ Bipolar disorder
- ☐ Blood Clots (DVTs)
- ☐ Cataracts
- ☐ Chronic pain
- ☐ Cancer, type:
- ☐ Celiac disease/gluten sensitive
- ☐ Chronic bronchitis
- ☐ COPD (obstructive lung issues)
- ☐ CHF (congestive heart failure)
- ☐ Chronic sinus infections
- ☐ Diabetes type 1 (childhood)
- ☐ Diabetes type 2 (adult)
- ☐ Depression
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Gall stones
- ☐ GERD (gastroesophagus reflux)
- ☐ Gout
- ☐ Hearing aids
- ☐ Hepatitis, type:
- ☐ Hernia, location:
- ☐ HIV
- ☐ Headache(s)
- ☐ Head injury
- ☐ Heart attack
- ☐ Herniated disc
- ☐ Hearing loss
- ☐ Heartburn
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hypothyroid (underactive)
- ☐ Hyperthyroid (overactive)
- ☐ Insomnia
- ☐ Irritable bowel syndrome
- ☐ Kidney failure / kidney disease
- ☐ Lung disease
- ☐ Migraine(s)
- ☐ Osteoarthritis (large joints)
- ☐ Osteoporosis (brittle bones)
- ☐ Skin disorder
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Seizures
- ☐ Stomach ulcer
- ☐ TIAs
- ☐ UTIs
- ☐ Wears corrective lenses
- ☐ NO SIGNIFCANT HISTORY

Additional medical history not covered above: ____________________

____

____

____

SURGICAL HISTORY

	Surgery	Date
☐	Adenoidectomy [adenoids]	________
☐	Appendectomy [appendix]	________
☐	Breast Implants	________
☐	Cesarean section	________
☐	Cholecystectomy	________
☐	Coronary artery bypass	________
☐	Discectomy	________
☐	Ear tubes	________
☐	Hernia repair, location:	________
☐	Heart valve replacement	________
☐	Hip replacement	________
☐	Hysterectomy	________
☐	Knee replacement	________
☐	Laminectomy	________
☐	Tonsillectomy	________
☐	Prostate	________

- ☐ Other: ____________________
- ☐ No surgical history

FAMILY HISTORY

Mark M=mother, F=father, S=sibling, C=child, GM=grandmother, GF=grandfather

M	F	S	C	GM	GF	
☐	☐	☐	☐	☐	☐	Alcoholism
☐	☐	☐	☐	☐	☐	Allergies/hayfever
☐	☐	☐	☐	☐	☐	Anxiety
☐	☐	☐	☐	☐	☐	Asthma
☐	☐	☐	☐	☐	☐	Anemia
☐	☐	☐	☐	☐	☐	Arthritis
☐	☐	☐	☐	☐	☐	Atrial fibrillation
☐	☐	☐	☐	☐	☐	Blindness
☐	☐	☐	☐	☐	☐	Bipolar disorder
☐	☐	☐	☐	☐	☐	Blood Clots (DVTs)
☐	☐	☐	☐	☐	☐	Gall stones
☐	☐	☐	☐	☐	☐	Hepatitis, type:
☐	☐	☐	☐	☐	☐	Headache(s)
☐	☐	☐	☐	☐	☐	Heart attack
☐	☐	☐	☐	☐	☐	Herniated disc
☐	☐	☐	☐	☐	☐	High blood pressure
☐	☐	☐	☐	☐	☐	High cholesterol
☐	☐	☐	☐	☐	☐	Hypothyroidism
☐	☐	☐	☐	☐	☐	Hyperthyroidism
☐	☐	☐	☐	☐	☐	Insomnia

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M	F	S	C	GM	GF		M	F	S	C	GM	GF	
☐	☐	☐	☐	☐	☐	Chronic pain	☐	☐	☐	☐	☐	☐	Irritable bowel
☐	☐	☐	☐	☐	☐	Celiac disease	☐	☐	☐	☐	☐	☐	Kidney disease
☐	☐	☐	☐	☐	☐	Chronic bronchitis	☐	☐	☐	☐	☐	☐	Lung disease
☐	☐	☐	☐	☐	☐	COPD	☐	☐	☐	☐	☐	☐	Migraines
☐	☐	☐	☐	☐	☐	CHF	☐	☐	☐	☐	☐	☐	Osteoarthritis
☐	☐	☐	☐	☐	☐	Diabetes (childhood)	☐	☐	☐	☐	☐	☐	Osteoporosis
☐	☐	☐	☐	☐	☐	Diabetes (adult)	☐	☐	☐	☐	☐	☐	Seizures
☐	☐	☐	☐	☐	☐	Depression	☐	☐	☐	☐	☐	☐	Stomach ulcer
☐	☐	☐	☐	☐	☐	Epilepsy	☐	☐	☐	☐	☐	☐	Skin disorder
☐	☐	☐	☐	☐	☐	Glaucoma	☐	☐	☐	☐	☐	☐	Sleep apnea
☐	☐	☐	☐	☐	☐	Gout	☐	☐	☐	☐	☐	☐	Stroke
☐	☐	☐	☐	☐	☐	HIV	☐	☐	☐	☐	☐	☐	TIAs
☐	☐	☐	☐	☐	☐	Cancer, type: ______________________							
☐	☐	☐	☐	☐	☐	Cancer, type: ______________________							
☐	☐	☐	☐	☐	☐	Other: ______________________							

☐ No known family history.

MEDICATIONS & SUPPLEMENTS

Please list all medications, supplements, and over-the-counter medications

- ☐ Not currently taking any medications, supplements, or over-the-counter medications.
- ☐ A list has been provided.

Medication	Dose (mg strength)	How many times per day

ALLERGIES

Please list all allergies, the reaction you experience, and the severity of the reaction.

Name	Reaction	Severity

Allll most done… just a few more "housekeeping" items…

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CONSENTS & PATIENT POLICIES

We cannot and *will not* see you unless you have agreed to our policies.

PRIVACY POLICY

I have read, and / or been offered a copy of Main Street Medical Center's Privacy Policy. I hereby acknowledge and accept all aspects of their privacy policy. If I am the guardian, parent, or caregiver of the patient, I accept responsibility for agreeing to the Privacy policy on behalf of the patient.

Signature ____________________ Date ____________ Print ____________________

PRACTICE ASSIGNMENT OF BENEFITS AGREEMENT

I hereby acknowledge and accept all aspects of Main Street Medical Center's Practice Assignment of Benefits Agreement. A copy of the Practice Assignment of Benefits Agreement has been provided to me for my review. If I am the guardian, parent, or caregiver of the patient, I accept responsibility for agreeing to the Practice Assignment of Benefits on behalf of the patient.

Signature ____________________ Date ____________ Print ____________________

FINANCIAL RESPONSIBILITY STATEMENT

I hereby acknowledge and accept all aspects of the Main Street Medical Center's Financial Responsibility Statement. A copy has been provided to me for my review. If I am the guardian, parent, or caregiver of the patient, I accept responsibility for agreeing to the Financial Responsibility Statement on behalf of the patient.

Signature ____________________ Date ____________ Print ____________________

ONLINE & E-SCRIBING DRUG CONSENT

I hereby acknowledge and accept all aspects of the Main Street Medical Center's online e-scribing and drug consent policies. A copy has been provided to me for my review. If I am the guardian, parent, or caregiver of the patient, I accept responsibility for agreeing to the Online & E-scribing consent on behalf of the patient.

Signature ____________________ Date ____________ Print ____________________

**You may request a copy of any / all policies for your records. You may also review these policies at any time on our website*