

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.

Signature of Patient or Representative

Date: _____

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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 #
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Name	Relationship	Phone #
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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, 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, Suite 2, Huntsville, AL 35801

FAX: 256-534-7268

Phone: _____

Fax : _____

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

John David Blankenship, D.O.
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 Tobacco	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	

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	

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

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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.
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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 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

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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:

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

_____ 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,
Initial 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.

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

_____ 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
Initial 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.

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

_____ Cancellation/No Show – Please provide at least a 24-hour notice if you need to cancel your appointment. Failure to do so
Initial will result in a \$35.00 fee. We have a 24/7 answering service that you can call and cancel your appointment. 3 same-day cancellations or no-shows could result in dismissal. 3 cancellations prior to your first visit could result in your dismissal.

_____ Please Be On Time – When an appointment is made for you, that slot is reserved for your health care. Being on time is
Initial 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 \$35.00 fee for a missed visit which will need to be paid prior to rescheduling your appointment.

_____ Please Silence Your Cell Phones – If you need to make or receive a call, please step outside for the courtesy of our other
Initial 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: _____ Our Office Hours are as follows: (We are CLOSED for lunch daily from 12:00-1:00)

Initial Monday – 8:00 am – 5:00 pm
Tuesday – 9:00 am – 12:00 pm (The second Tuesday of every month we are closed).
Wednesday – 8:00 am – 5:00 pm
Thursday – 8:00 am – 5:00 pm
Friday – 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.