HOPE MEDICAL SERVICES

New Patient Information Form

Last Name	First Name	
DOB	Gender	
Race	Ethnicity	
Address		
City	State	Zip
Cell #	Work #	Home #
Email Address		
Primary Physician	Phone #	Fax #

Pharmacy Information

Name	
Address	
Phone #	Fax #

Emergency Contact

Last Name	First Name
Relation (circle one) Self ouse Child	Other
Phone #	

Responsible Party (circle one)	Self	Other
If Other Last Name		First Name
Relationship	DOB	
	Address	

Insurance Information

Primary Insurance	Secondary Insurance
Company	Company
ID #	

Authorization to release I hereby authorize Hope Medical Services to release any medical information records necessary to process insurance claims. Initial:_____

Form revision: 5/14/22

I authorize payments to Hope Medical Services for any medical care rendered to myself or to my dependents. I understand that I am responsible for any amount Assignment of Benefits not covered by my insurance.

Signature:_____

Form revision: 5/14/22

Patient History

Name	**DOB**
Occupation	**Marital Status (circle one)** S M W D
Allergies	
Latex Allergy (circle one) Yes No	

Social History

Exercise (circle one) Yes No			
Smoke or Tobacco use (circle one) Yes No			
How much	**In the Past (circle one)** Yes No	**Currently (circle one)** Yes No	
How long	**In the Past (circle one)** Yes No	**Currently (circle one)** Yes No	
Drink Alcohol (circle one) Yes No		**How much**	
Recreational Drugs (circle one) Yes No			
Specify	**In the Past (circle one)** Yes No	**Currently (circle one)** Yes No	
How long	**In the Past (circle one)** Yes No	**Currently (circle one)** Yes No	

Medication

Name of Medication (Please include all vitamins and supplements)	Dosage	Frequency Taken

Patient Signature:	**Date:**

HOPE MEDICAL SERVICES

HIPAA Consent Form

You agree to permit your protected health information to be used and disclosed for purposes of treatment, payment, or health care operations.

I understand that I may request restrictions on how my information is used or disclosed and that I can also revoke this consent in, but only to the extent that the office has not acted in reliance thereon and provided that I do so in writing. I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Patient Name	Date of Birth
Patient Signature:	Date:

Request for Release of Medical Records

Patient Name	Date of Birth
Address	
City	State / Zip
Social Security Number	

I hereby request that my medical records be released to Hope Medical Services

Patient Signature:	Date:

Release of Medical Record Request (to family and friends)

Patient medical records are CONFIDENTIAL. Protecting your privacy is important to us, therefore according to Federal Law, we may not discuss or release information to anyone but the patient unless you authorize us to do so.

I give permission to share my medical records with the following

Last Name	First Name	Date of Birth	Relationship

Patient Name	Date of Birth
Patient Signature:	Date:

HOPE MEDICAL SERVICES

CONSENT FOR TREATMENT

Patient Name:

DOB:

I , hereby give my consent to the physicians/ APP, nurses and other healthcare staff at **HOPE MEDICAL SERVICES** to perform physical exam, medical treatment, procedures that are deemed necessary for my diagnosis, treatment and care.

Print Patient Name or Representative:	Patient Signature:
Relationship to Patient:	Date:

NO SHOW POLICY

HOPE MEDICAL SERVICES

ST LUKE MEDICAL SERVICES

Definition of a NO-SHOW

A "NO-SHOW" appointment is A failure to arrive for a scheduled appointment, or a cancellation or rescheduling made less than 24 hours prior to the scheduled appointment time.

Patient Responsibility

A **$50.00** fee will be charged. This fee is the patient's responsibility and cannot be billed to insurance. The fee must be paid prior to scheduling any future appointments.
Patients are expected to notify the office at least 24 hours in advance if they are unable to keep their scheduled appointment. Notifications can be made by calling our office phone number **732-569-6166**

Exceptions

Medical Emergencies
Severe weather conditions
Other situations deemed acceptable by the practice

Patient Name:_____

Patient Signature:_____

Date:_____