250 Chateau Dr SW, Suite 115

Huntsville, AL 35803

Premier Wound Care & ID Specialist

PH: 256.533.4645

FAX: 256.808.3178

NEW PATIENT FORM

Full Legal Name:_____ Date of Birth_____/_____/_____

Preferred Name:_____Sex assigned at birth: ☐ Male ☐ Female

Patient's SSN: _____-_____-_____ Driver's License # (indicate state)_____ Age_____

Address: _____City, State, Zip:_____

Preferred Contact Phone #: _____Type (Circle One): Cell Home Work

Secondary Contact Phone #: _____ Type (Circle One): Cell Home Work

Email Address: _____Portal Access? (circle one) YES NO

Appointment Reminder Method (circle one): Phone Call (Primary #) Text (provide Cell # above) Email

Marital Status: ○ Single ○ Married ○ Widowed ○ Divorced Employment Status: ○ Employed ○ Unemployed ○ Retired

Occupation:_____Current Employer:_____Work Phone#: _____

Emergency Contact: _____Relationship_____Phone #: _____

REFERRING PHYSICIAN:_____Phone #:_____

Insurance Information

Primary Insurance Provider: _____Employer:_____

Policy/Contract ID #: _____Group #: _____Copay Amt:_____

Patient's Relationship to Insured (select one): ○ Self ○ Spouse ○ Dependent ○ Other/Worker's Compensation

Insured Date of Birth (mm/dd/yyyy)_____Insured SSN:_____ Insured Sex: ☐ Male ☐ Female

Secondary Insurance Provider: _____Employer:_____

Policy/Contract ID #: _____Group #: _____Copay Amt:_____

Patient's Relationship to Insured (select one): ○ Self ○ Spouse ○ Dependent ○ Other/Worker's Compensation

Authorization to Release Information and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Signature_____**Date**_____

I hereby authorize Scott D. Parker MD LLC and Premier Medical LLC dba Premier Wound Care and ID Specialist to file for insurance benefits on my behalf for all covered services rendered by this office. I request that payment from the insurance company be made directly to Scott D Parker MD LLC or Premier Medical LLC. I certify that the information I have reported with regard to my insurance coverage is correct, and that I will be responsible for any charges my insurance does not cover. I permit a copy of this authorization to be used in place of the original.

Signature_____**Date**_____

Premier
Wound Care
&
ID Specialist

NEW PATIENT QUESTIONNAIRE/MEDICATION LIST

NAME:	DATE:
Do you use Tobacco? (Yes/No)	Do you use Drugs? (Yes/No)
If Yes, how much?	If Yes, what kind & how much?
Do you use Alcohol? (Yes/No)	Pets? If yes, please list what species below
If YES, how much?	
City, County or Well Water?	

ALLERGIES	TYPE OF REACTION

MEDICINE	WHAT DO YOU TAKE IT FOR	DOSAGE	HOW MANY TIMES A DAY

*continue on back if needed

SURGERIES YOU HAVE HAD	SURGERIES YOU HAVE HAD (cont)

*continue on back if needed

PREFERRED PHARMACY	PHONE NUMBER	ADDRESS
PRIMARY CARE DOCTOR	**PHONE NUMBER**	**ADDRESS**

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Medical History

Have you ever been treated for any of the following medical conditions:

- ☐ No changes since last appointment
- ☐ Arthritis
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Irritable bowel
- ☐ Osteoporosis
- ☐ Cancer
- ☐ Depression/anxiety
- ☐ Heart problems
- ☐ High cholesterol
- ☐ Lung problems
- ☐ Thyroid problems

Please list any new/additional medical conditions:

_____

Have you ever been hospitalized overnight? Yes / No (circle one)

If Yes, please list reason(s):

_____
_____
_____

Family History

Please list any know medical problems for the relatives listed below:
(for example, diabetes, breast/colon/ovarian/prostate cancer, heart attacks, high blood pressure, alcohol abuse, depression, skin cancer, osteoporosis)

- ☐ No changes since last appointment
- ☐ Mother:_____
- ☐ Father:_____
- ☐ Brothers/Sisters:_____
- ☐ Children:_____
- ☐ Other close related:_____

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Name_____DOB_____Date_____

Please indicate if you have been diagnosed with, or experienced any of the following conditions <u>within the past two weeks</u>.

REVIEW OF SYSTEMS	YES	NO	REVIEW OF SYSTEMS	YES	NO
CONSTITUTIONAL			**INFECTIOUS DISEASE**		
Chills			Gonorrhea		
Fatigue			Hepatitis		
Fever			HIV/AIDS		
Weight Loss			Syphilis		
EYES			Tuberculosis		
Eye Pain			**GASTROINTESTINAL**		
Visual Changes			Heartburn/Reflux		
Cataracts			Nausea/Vomiting		
Glaucoma			Abdominal Pain		
EAR/NOSE/THROAT			Constipation		
Difficulty Hearing			Diarrhea		
Ringing in ears			Black or Bloody stool		
Vertigo			**RESPIRATORY**		
Sinusitis			Cough		
CARDIOVASCULAR			Wheezing		
Palpitations			**PSYCHIATRIC**		
Chest Pain			Anxiety/Depression		
Dizziness/Fainting spells			Mood Swings		
Shortness of Breath			Difficulty Sleeping		
Leg/Ankle Swelling			**MUSCULOSKELETAL**		
HEMATOLOGICAL			Back Pain		
Blood Transfusion			Joint Pain/Swelling		
Blood Clot/DVT			Stiffness		
CANCER			Muscle Pain		
What kind?			**NEUROLOGICAL**		
INTEGUMENTARY (SKIN)			Headaches		
Lymphedema			Loss of Strength		
Rash			Numbness		
Sores/Lesions			Seizures		
Itching/Burning			**CANCER**		
			What kind?		

Patient Consent for Confidential Communication Regarding Protected Health Information

This is my consent for Premier Medical, LLC (dba Premier Wound Care and ID Specialist), and Scott D. Parker MD, LLC to use and disclose my protected health information to carry out treatment, payment, and healthcare operations. This is my acknowledgement that I may view Premier Medical, LLC and Scott D. Parker MD, LLC Notice of Privacy Practices.

This is my consent for Premier Medical, LLC, dba Premier Wound Care and ID Specialist, and Scott D. Parker MD LLC to: (please initial approval)

_____Call my home and leave a message on voicemail or in person to remind me of appointments, or obtain insurance information.
_____Text my mobile phone with appointment reminders
_____Call and leave reports of my clinical care; lab results.
_____Mail items that assist in carrying out my treatment, payment, or health operations, such as Appointment reminder card and patient statements to:
_____my home
_____other designated location:_____

This is my consent for information regarding my general health and treatment to be discussed with the following people in the event that I am unavailable or in case of an emergency.

_____

_____

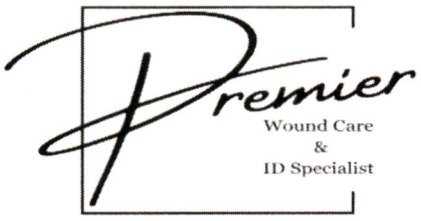
_____

By signing this form, I am consenting to Premier Medical, LLC, dba Premier Wound Care and ID Specialist, and Scott D. Parker MD LLC's use and disclosure of my protected health information to carry out treatment, payment, and healthcare operations. I understand that I will be responsible for any collection fees for unpaid account balances. I may revoke my consent in writing except on those disclosures made prior to my consent. I understand that Premier Wound Care and ID Specialist and Scott D. Parker MD LLC reserve the right to refuse to treat me if I do not sign this consent form.

_____ _____
Patient's Name Date

_____ _____
Signature of Patient or Legal Guardian If Legal Guardian signed, Print Name Here

_____ _____
Witness Date



NOTICE TO ALL PATIENTS:

PLEASE READ THE OFFICE POLICY LISTED BELOW AND THEN SIGN AND DATE THE BOTTOM OF THIS PAGE.

Thank you, Management

Print Name: _____

- Co-pays are due at the time of service.
- If your insurance requires a primary care referral, we must have this by your appointment date.
- There is a $50.00 "NO SHOW FEE" for any missed appointments without a 24 hour notice. This fee is not payable by your insurance and will be due by your next appointment.
- There is $20.00 fee for all paperwork/letters to be completed by our providers. This fee is not payable by your insurance and will be due at the time of request.
- There is a $30.00 fee for all returned checks.

_____ _____

Patient/Responsible Party Signature Date

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MEDICAL RECORDS RELEASE

By signing this form, I authorize S. Paige Slater, CRNP, Premier Medical, LLC (dba Premier Wound Care and ID Specialist), and Scott D. Parker MD, LLC to obtain/release my confidential health information or a summary/narrative of my protected health information to or from other physicians or medical/healthcare facilities as necessary for efficient continuation of my care.

PATIENT NAME:_____Date of Birth:_____

The information you may obtain/release subject to my signature below is as follows (check all that apply):

___Complete Medical Records (check this box only if you agree to release ALL records, INCLUDING those itemized below)

___History and Physical **___Hospital Consults** **___Operative Reports**

___Radiology Reports **___Pathology Reports** **___Medication Record**

___Discharge Summary **___Office Notes**

___Lab reports to include:_____

FOR HIV PATIENTS ONLY:

___HIV related, including STDs (sexually transmitted diseases), Mental Health, Substance Abuse

Signature required: _____Date:_____

I understand that:

- **My right to healthcare treatment is not conditioned on this authorization**
- **I may cancel this authorization at any time**
- **If the person of facility receiving this information is a healthcare or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.**
- **Release of HIV-related, STDs, mental health or substance abuse diagnosis and treatment information requires additional authorization**
- **There may be a charge for medical records**

Signature of Patient:_____Date:_____

Witness:_____Date:_____

Note: This authorization expires one year from date of above signature