Mays Medical Wellness, LLC

PATIENT INFORMATION

Personal Information (Please Print):

Full name:_____

Age:_____ Date of Birth:_____/_____/_____ Place of Birth: (city, state, country, region):_____

Address:_____ City:_____ State:_____ ZIP:_____

Home Phone: (____)_____ Business Phone: (____)_____ Cell Phone: (____)_____

Where would you prefer to be contacted for medical information or test results? (please check all that apply)

Home: Yes____ No____ Cell: Yes____ No____ Patient Portal: Yes____ No____

E-mail Address:_____

Social Security #:_____-_____-_____ Sex: Male / Female Marital Status:_____

Race or Nationality:_____

Occupation:_____ Employer:_____

Emergency Contact Name:_____ Relationship to patient:_____

Primary Phone #: (_____)_____ Secondary Phone #: (_____)_____

Local Pharmacy:_____ Phone #:(_____)_____

Mail Order Pharmacy:_____

** Do you have to use QUEST laboratories? ☐ Yes ☐No

Authorized Individuals

Are we permitted to give lab, diagnostic, and/or any other test results or appointment information to family members? (Please Check) ☐ Yes ☐No

Please provide name(s) of individuals with contact information and relationship to you for individuals we may talk to in reference of your medical information:

Name:_____ Relationship:_____ Phone #: (____)_____

Name:_____ Relationship:_____ Phone #: (____)_____

Immunization History

☐ Flu shot	Date:	☐ MMR (Measles, Mumps, Rubella)	Date:
☐ Gardasil/HPV	Date:	☐ Pneumonia	Date:
☐ Hepatitis B	Date:	☐ Tdap (Tetanus, Diptheria, Pertussis)	Date:
☐ Meningococcal	Date:	☐ Tetanus	Date:
☐ Zostavax (Shingles)	Date:	OTHER:_____	Date:

(WOMEN ONLY) Obstetric and Gynecological History

Last PAP Smear Date: ☐ Normal ☐ Abnormal

Last Mammogram Date: ☐ Normal ☐ Abnormal

Age of First Menstrual Period:_____

Last Period/Age of Menopause: (Date/Age)_____

Number of pregnancies:_____ Number of Births:_____

Current Sexual Partner is: ☐ Male ☐ Female

Current Birth Control Method Used:_____

Interested in being screened for STD/STIs: ☐ Yes ☐ No

Past Medical History (Diagnosed)

☐ Anxiety	☐ Diverticulitis	☐ Kidney Stones
☐ Anemia	☐ Fatty liver	☐ Leg/Foot ulcers
☐ Arthritis	☐ Glaucoma	☐ Liver Disease
☐ Asthma	☐ Gout	☐ Migraines
☐ Bleeding Disorder	☐ Has Pacemaker	☐ Osteoporosis
☐ Blood Clots	☐ Heart Attack	☐ Overactive Thyroid
☐ Bronchitis	☐ Heart Murmur	☐ Pneumonia
☐ Cancer *Type*:_____	☐ Hiatal Hernia or Reflux Disease	☐ Polio
☐ COPD	☐ HIV or AIDS	☐ Pulmonary Embolism
☐ Coronary Artery Disease	☐ High Cholesterol	☐ Reflux/Ulcers
☐ Diabetes- Insulin	☐ High Blood Pressure	☐ Seizures
☐ Diabetes- Non-Insulin	☐ Hypothyroidism	☐ Stroke
☐ Dialysis	☐ Kidney Disease	☐ Tuberculosis

☐ Other:_____

Specialty Care

Cardiology-NAME:_____ *Last office visit*:_____

Endocrinology- NAME:_____ *Last office visit*:_____

Gastroenterology- NAME:_____*Last office visit*:_____

Gynecology- NAME:_____ *Last office visit*:_____

Nephrology- NAME:_____ *Last office visit*:_____

Orthopaedic- NAME:_____ *Last office visit*:_____

OTHER- NAME:_____ *Last office visit*:_____

OTHER NAME:_____ *Last office visit*:_____

Allergies ☐ **No known diagnosed allergies (NKDA)**

ALLERGY:	REACTION:
1._____	1._____
2._____	2._____
3._____	3._____

MEDICATIONS

DRUG NAME:	STRENGTH:	FREQUENCY TAKEN:
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.
6.	6.	6.
7.	7.	7.
8.	8.	8.
9.	9.	9.
10.	10.	10.

****You may include additional medications with strength/frequency taken on back of this sheet**

Social History

Tobacco Yes ☐ No ☐ Packs per day:_____ for _____ years

Alcohol Yes ☐ No ☐ Drinks per week:_____

Caffeine Yes ☐ No ☐ Cups per day:_____

Illegal Drugs Yes ☐ No ☐ Type:_____

Vaping Yes ☐ No ☐ Smokeless Tobacco Yes ☐ No ☐

The last time you had a (list year)

Flu vaccine_____ Tetanus shot_____ Dental Exam_____

Hepatitis vaccine_____ TB Skin Test_____ Cholesterol Test_____

Pneumonia shot_____ Rubella vaccine_____ PSA_____

Blood Stool Test_____ Rectal Exam_____ Annual Physical_____

Sigmoid Exam_____ Eye Exam_____ Colonoscopy_____

Familial Diseases

*Have you or your BLOOD relatives had any of the following (**include** parents, grandparents, siblings, aunts & uncles, but **exclude** cousins, relatives by marriage and half relatives)?*

Check those to which the answer is YES (leave others blank):

☐ Heart attacks under the age of 55

☐ Strokes under the age of 65

☐ High Blood Pressure

☐ Elevated Cholesterol

☐ Diabetes

☐ Asthma

☐ Congenital Heart Disease (existing at birth but not hereditary)

☐ Heart operations

☐ Glaucoma

☐ Obesity (20 or more pounds overweight)

☐ Leukemia or cancer under age 60

Please specify which family member:

_____

_____

_____

_____

_____

_____

Surgical History

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____

Durable Power of Attorney/Living Will

Living Will ☐ Yes ☐ No

Durable Power of Attorney for Health Care ☐ Yes ☐ No

DNR ☐ Yes ☐ No

I would like further information for: ☐ Living Will ☐ Durable Power of Attorney for Health Care ☐ DNR

INSURANCE AND PAYMENT INFORMATION **(insurance card required on arrival to your appointment)**

Primary Insurance:

Name of Policy Holder:_____

Insurance Name:_____

Identification #:_____

Group #:_____

Employer:_____

Policy Holder Date of Birth:_____

Social Security # of Policy Holder:_____

Secondary Insurance:

Name of Policy Holder:_____

Insurance Name:_____

Identification #:_____

Group #:_____

Employer:_____

Policy Holder Date of Birth:_____

Social Security # of Policy Holder:_____

ASSIGNMENT AND RELEASE

Responsible party if different than patient or insurance information provided:

Name:_____

Address:_____

Relationship to patient:_____ Phone #: (_____)_____

I, the undersigned, certify that I (or my dependents) have insurance coverage as described above and assign directly to Mays Medical Wellness all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Mays Medical Wellness to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party:_____ Date:_____/_____/_____

Mays Medical Wellness, LLC

730 Goodman Road East Ste 2 Ph. (662)655-0456

Southaven, MS 38671 Fax: (662)655-0457

Notice of Financial Practices

As part of an effort to provide the best possible medical care to you, we would like to explain our financial policies in advance.

- ☐ Your health insurance is a contract between you, your insurance company and your employer if applicable. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, coordination of benefits, pre-certifications. Our professional services are rendered to you, not the insurance company, therefore payment for services is your responsibility. Not all services are covered benefits in all contracts. Please understand that if your insurance does not pay for a particular service, you are responsible for payment in full. It is your responsibility to understand and know your insurance benefits. Your co-pays and deductibles are due at time of visit. It is your responsibility to inform our office of changes in your insurance benefits prior to the appointment. If insurance is filed with old information and claim is denied, you will be responsible for the charges. We accept cash, checks, VISA, MasterCard and Discover card. All returned checks will be at a $40.00 returned check fee.
- ☐ Any form or letters requested (short term disability, school, employment, etc) will be completed with a minimum charge of $25.00 each. We require 5-7 business days minimum advanced notice to complete.
- ☐ If you fail to keep your appointment without a 24-hour notice and you are a no-show for your appointment, you are liable for a $25.00 charge for the time that is kept specifically for your appointment.
- ☐ Prescription refills require a return appointment. You are generally given enough medication until your next scheduled appointment or lab is due. Some chronic medications me be allowed a 30-day courtesy refill to allow for appointment scheduling. Do not wait until you are out of medication to obtain new refills as some medications will require examination.
- ☐ The medical staff will be happy to answer short questions, a phone call with regard to emergency issues, and medication clarification. However, it is best to discuss more involved issues with the provider in an appointment. We will make every effort to accommodate you as soon as possible within the constraints of our schedule.
- ☐ Accounts that are 90-120 days past due may be turned over for collection to our attorney or a collection service. All attorney or collection service fees and court costs will be your responsibility.

I have read and understand the Notice of Health Information Practices and the Notice of Financial Practices.

Patient Name:_____ Date of Birth:____/_____/_____

Patient Signature/Responsible Party:_____

Relationship to Patient:_____ Date:_____

Mays Medical Wellness, LLC

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Authorization to Use or Disclose Health Care Information

Patient Name:_____ DOB:_____/_____/_____

Previous Name:_____ SS#:_____

I. **My Authorization**

You may use or disclose the following health care information (check all that apply):

☐ All health care information in my medical record

☐ Health care information in my medical record relating to the following treatment or condition:
_____

☐ Health care information in my medical records for the date(s):_____

☐ Other (e.g., Xrays, bills), specify date(s):_____

EXCLUDE the following information from the records released (Please initial):

☐ HIV (AIDS virus) ☐ Psychiatric disorder/mental health

☐ sexually transmitted diseases ☐ Drug and/or alcohol use

I request and authorize:	**To release my records to:**
Clinic/Provider Name:_____	**Mays Medical Wellness, LLC**
Address:_____	**730 Goodman Road Suite 2**
City:_____ State:_____ Zip:_____	**Southaven, MS 38671**
Phone:_____ Fax:_____	**Phone: (662)655-0456 Fax: (662)655-0457**

Reason for this authorization (check all that apply)

☐ at my request ☐ physician request

☐ attorney request ☐ other (specify):_____

This authorization ends: (This document does not permit disclosure of health information created more than 90 days after the date is it signed):

☐ in 90 days from the date signed ☐ on (date):_____

☐ when the following event occurs_____

II, **My Rights**

- ***I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment) HOWEVER, I do have to sign an authorization form:***
  -To take part in a research study or
  -To receive health care when the purpose is to create health care information for a third party.
  -I may revoke this authorization in writing. If I did, it would affect any actions already taken by Mays Medical Wellness, LLC upon this authorization in writing. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:
  1. Fill out a revocation form. A form is available from Mays Medical Wellness, LLC
  2. Write a letter to Mays Medical Wellness, LLC
  -Once health care information is disclosed, the person or organization that receives it may redisclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature:_____ Date:_____

Printed Name if signed on behalf of the patient:_____ Relationship to patient:_____