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

3963 Goodman Road East Ste 128
Ph. (662)655-0456

Southaven, MS 38672
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

3964 GoodmanRoad East　　Ph. (662)655-0456

Southaven, MS 38672　　Fax: (662)655-0457

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:______________