NEW ADULT PATIENT INFORMATION

COUNTRY MEADOWS CLINIC
FAMILY PRACTICE & PEDIATRICS

Date: _____

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer:_____ Work Phone: _____

E-Mail: _____

Would you like access to our patient portal via email? ❑ Yes ❑ No, I decline
Country Meadows Clinic will not share your contact or email info with any third parties.

Preferred Language: ❑ English ❑ Spanish ❑ Other_____

Gender: ❑ Male ❑ Female

Primary Race: ❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian or Alaskan Native
❑ Asian ❑ Native Hawaiian or Other Pacific Islander ❑ Declined to Specify

Marital Status:❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other

Ethnicity: ❑ not Hispanic or Latino ❑ Hispanic or Latino ❑ Prefer not to answer ❑ Unknown

Employment Status: ❑ Employed ❑ Disabled ❑ Retired ❑ Part-time ❑ Not Employed ❑ Student
❑ Unknown

Student Status: ❑ Full time ❑ Part Time ❑ N/A School Name: _____

Emergency Contact

Name:_____ Relationship:_____ Phone:_____

Primary Care Physician

Doctor Name: _____ Office Phone: _____

Pharmacy

Name: _____ City: _____ Phone: _____

Referral Source: ❑ Facebook ❑ Radio ❑ Newspaper ❑ Google ❑ Insurance List ❑ Other:

COUNTRY MEADOWS CLINIC
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Date: _____

Patient Name: _____ DOB: _____

SOCIAL HISTORY & HABITS

Marital Status (circle): SINGLE MARRIED SEPARATED DIVORCED WIDOWED

Highest Level of Education: _____Occupation: _____

Children: _____ Religious Preference: _____

Tobacco Use: ____ YES ____ *packs (or dips) per day x ____ years*
(or Vaping) ____ NO
____ HISTORY OF ____ *packs (or dips) per day,* _____ *year began* _____ *year quit*

Alcohol Use: ____ YES* *type, quantity, frequency* _____
____ NO _____
*CAGE QUESTIONAIRRE

Illicit Drug Use: ____ YES *type, quantity, frequency* _____
____ NO
____ HISTORY OF _____ *drug of choice* _____ *year began* _____ *year quit*

Caffeine Use: ____ YES *type, quantity, frequency* _____
____ NO

ALLERGIES ☐ *NO ALLERGIES*

ALLERGY	ALLERGIC REACTION

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Date: _____

Patient Name: _____ DOB: _____

PAST MEDICAL HISTORY

PLEASE CIRCLE ANY PROBLEMS YOU HAVE NOW OR IN THE PAST

ASTHMA	CANCER*	BONE DISEASE	DIABETES (TYPE 2)	HIV/AIDS	STOMACH ULCER
ALLERGIES	COPD	DEMENTA	GOUT	KIDNEY DISEASE	SEIZURES
ANXIETY	CORONARY ARTERY DISEASE	DEPRESSION BIPOLAR?	HEPATITIS A B C	MIGRAINES	THYROID DISEASE
ARTHRITIS	CONSTIPATION	DIVERTICULOSIS	HYPERTENSION	PROSTATE DISEASE	VALVE REPLACEMENT
ATRIAL FIBRILLATION	COUMADIN THERAPY	DIABETES (TYPE 1)	HIGH CHOLESTEROL	REFLUX (GERD)	VASCULAR DISEASE

OTHER: _____

*TYPE OF CANCER(S): _____

Number of pregnancies: _____ Number of live births: _____ LMP: _____

SURGICAL HISTORY

HAVE YOU HAD ANY SURGERY IN THE PAST? ____ YES ____ NO

IF YES, PLEASE LIST WHAT TYPE AND THE DATE PERFORMED:

_____

_____

COUNTRY MEADOWS CLINIC
FAMILY PRACTICE & PEDIATRICS

Date: _____

Patient Name: _____ DOB: _____

FAMILY HISTORY

PLEASE CIRCLE THE DISEASE AND WHO IT AFFECTED IN YOUR FAMILY

ASTHMA	MOTHER FATHER SISTER BROTHER GRANDMOTHER GRANDFATHER	ALZEHIEMER'S	MOTHER FATHER SISTER BROTHER GRANDMOTHER GRANDFATHER	CANCER*	MOTHER FATHER SISTER BROTHER GRANDMOTHER GRANDFATHER
ARTHRITIS	MOTHER FATHER SISTER BROTHER GRANDMOTHER GRANDFATHER	ALCOHOLISM	MOTHER FATHER SISTER BROTHER GRANDMOTHER GRANDFATHER	DIABETES (TYPE 1)	MOTHER FATHER SISTER BROTHER GRANDMOTHER GRANDFATHER
AUTOIMMUNE DISEASE*	MOTHER FATHER SISTER BROTHER GRANDMOTHER GRANDFATHER	ANXIETY	MOTHER FATHER SISTER BROTHER GRANDMOTHER GRANDFATHER	DIABETES (TYPE 2)	MOTHER FATHER SISTER BROTHER GRANDMOTHER GRANDFATHER
HEART DISEASE	MOTHER FATHER SISTER BROTHER GRANDMOTHER GRANDFATHER	MIGRAINES	MOTHER FATHER SISTER BROTHER GRANDMOTHER GRANDFATHER	THYROID DISEASE	MOTHER FATHER SISTER BROTHER GRANDMOTHER GRANDFATHER
HIGH BLOOD PRESSURE	MOTHER FATHER SISTER BROTHER GRANDMOTHER GRANDFATHER	OSTEOPOROSIS	MOTHER FATHER SISTER BROTHER GRANDMOTHER GRANDFATHER	OTHER:	MOTHER FATHER SISTER BROTHER GRANDMOTHER GRANDFATHER
HIGH CHOLESTEROL	MOTHER FATHER SISTER BROTHER GRANDMOTHER GRANDFATHER	STROKE	MOTHER FATHER SISTER BROTHER GRANDMOTHER GRANDFATHER	OTHER:	MOTHER FATHER SISTER BROTHER GRANDMOTHER GRANDFATHER

*TYPE OF CANCER(S): _____

*TYPE OF AUTOIMMUNE DISEASE(S):_____

COUNTRY MEADOWS CLINIC
FAMILY PRACTICE & PEDIATRICS

Date: _____

Patient Name: _____ DOB: _____

NUTRITION & EXERCISE

Typical Breakfast: _____

Typical Lunch: _____

Typical Dinner: _____

Do you snack? If so, on what?: _____

Type of Exercise: _____

MEDICATIONS

PLEASE INCLUDE ALL VITAMINS, SUPPLEMENTS AND OVER THE COUNTER MEDICATIONS

MEDICATIONS	DOSE	TIMES PER DAY

☐ *Additional medications listed on the back*

COUNTRY MEADOWS CLINIC
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Patient Name: _____ DOB: _____

PROVIDER LIST

PLEASE LIST ANY OTHER PROVIDERS YOU SEE ON A REGULAR BASIS

PROVIDER NAME	SPECIALTY	LOCATION OR PHONE NUMBER

HEALTH MAINTENANCE SCREENING

TEST	DATE	FACILITY	RESULT (NORMAL?)
CHOLESTEROL			
COLONOSCOPY			
MAMMOGRAM			
PAP SMEAR			
BONE DENSITY			
VISION EXAM			
EKG/ECG			
CHEST XRAY			
AAA SCREEN			
WELLNESS LAB			

VACCINATION HISTORY

Last Tetanus Booster or Tdap (every 10 years):
Last Flu Vaccine (every year):
Last Zostavax or Shingles Vaccine (once at age 60+):
Last Shingrix or *new Shingles Vaccine (2 doses at age 50+):
Last Pneumovax 23 or Pneumonia Vaccine*:
Last Prevnar 13 or Pneumonia Vaccine*:

*CDC recommends 2 pneumonia vaccines for all adults 65 years or older. You should receive a dose of PCV13 first, followed by a dose of PPSV23 at least 1 year later.

COUNTRY MEADOWS CLINIC
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Date: _____

Patient Name: _____ DOB: _____

PERSON RESPONSIBLE FOR BILL *(complete only if different from patient)* ❑ Same as above

Name:_____ Relationship: _____

Mailing Address: _____ Apt # _____

City_____ State:_____ Zip: _____

DOB: _____ Phone (home): _____ (cell): _____

PRIMARY MEDICAL INSURANCE

Insurance Company : _____

Policy Number:_____ Group Number: _____

Policy Holder's Name (if different from patient): _____

DOB (*Required) : _____ SSN: _____

Relationship to Patient ❑ Self ❑ Spouse ❑ Child ❑ Other_____

SECONDARY MEDICAL INSURANCE

Insurance Company : _____

Policy Number:_____ Group Number: _____

Policy Holder's Name (if different from patient): _____

DOB (*Required) : _____ SSN: _____

Relationship to Patient ❑ Self ❑ Spouse ❑ Child ❑ Other_____

The above information is accurate and complete to the best of my knowledge.
**WILL NEED COPIES OF INSURANCE CARD(S) & GOVERNMENT ISSUED PICTURE ID*

_____

Signature of Patient/Responsible Party Date Signed

COUNTRY MEADOWS CLINIC
FAMILY PRACTICE & PEDIATRICS

Date: _____

Patient Name: _____ DOB: _____

CONSENT TO CONTACT

Please initial next to each paragraph as well as sign at the bottom of this page to acknowledge that you have read, understand, and agree to comply with each of our office's policies.

____ CONTACT PERMISSION

In the event that Country Meadows Clinic needs to contact you (patient) regarding an appointment, lab result, medication, or any other reason, it is permissible to:
(check all that apply)

- ❑ Leave a message on an answering machine or voice mail. Phone # _____
- ❑ Speak with spouse/significant other. Name: _____
- ❑ Speak with other family members. Name: _____

____ CONSENT TO TELEPHONE/EMAIL COMMUNICATION

I understand that any phone or email communication will be part of my medical record. I also understand that all email communication is not secure, not to be used for any emergent matters, and response will be given back within three to five business days.

_____ _____
Signature Date Signed

_____ _____
Patient Printed Name/Legal Guardian Relationship to patient

OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained due to the following:

- ❑ Individual waived signature
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other:

_____ _____
Practice Representative Date

COUNTRY MEADOWS CLINIC
FAMILY PRACTICE & PEDIATRICS

Date: _____

Patient Name: _____ DOB: _____

FINANCIAL POLICY

Please initial next to each paragraph as well as sign at the bottom of this page.

____ **Insurance claims**. If we participate with your managed care or commercial insurance plan under which you are covered, we will bill the carrier for all charges for services rendered. We will bill both your primary and secondary insurance plans. You will be responsible at the time of service for the payment of the copayments and annual deductibles.

We will call your insurance company to verify eligibility and benefits. However, verification of benefits is not a guarantee of payment. You will be billed a balance if:

- Your insurance company pays less than what we expected (i.e. deductible plan)
- We obtain a denial from your insurance company
- We have not received payment from the insurance within 60 days of our filing the claim

____ **Authorization/Financial Responsibility**. I authorize the release of any medical information necessary to process an insurance claim on my behalf. I understand that I am financially responsible for all charges and responsible for obtaining referrals required by my insurance carrier. I request that my medical insurance carrier make any payment directly to CMC HEALTHCARE, PLLC for services rendered to me.

____ **Medicare**. We are Medicare participating providers, therefore we will bill Medicare directly. You will be responsible at the time of service for payment of:

- The copayments and annual deductibles
- Charges for non-covered services. You will be asked to sign a Waiver of Liability in the event a service is provided that is not covered by Medicare.

____ **Patients without insurance coverage or out-of-network coverage**. Payment is due for all services on the day they are rendered.

____ **Returned checks**. There will be a $25.00 service fee charged to your account if your check is returned for any reason. Upon notification from our office, payment of the entire balance is due immediately.

____ **Healthcare products**. If you purchase healthcare products/supplies from our office, please understand that these items are a non-refundable. If the product/supply is defective, we will gladly replace the item(s).

____ **No show policy**. We kindly request that you give us 24 hours' notice if you are unable to keep your appointment. Failure to give 24 hours' notice will result in a $35.00 missed appointment fee. This fee is not covered by your insurance plan.

Your signature below signifies that you understand our financial policy and policies listed above, your responsibility regarding charges incurred in this office, and have read and reviewed all of the above notices.

_____ _____

Signature Date

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Patient Name: _____ DOB: _____

QUEST DIAGNOSTICS

If your provider performs a biopsy or orders a lab test during your appointment, it will be sent to an outside laboratory. The pathology or lab results will be communicated to your provider and your provider will notify you of these results.

The outside laboratory will submit a bill to your insurance company. You may receive a bill from them should you have deductibles*, co-insurance, or co-payments. If you are a self-pay patient, rates will be discussed with you during your visit. Medicare: You may be asked to sign a Waiver of Liability in the event a service is not covered by Medicare.

*Those with high deductible plans have the option to bill as self-pay, please discuss this with the front desk or your provider.

If you have any questions regarding this process, please do not hesitate to ask your provider or nurse.

By signing below, you understand that you may be billed by an outside laboratory in the event that you receive a biopsy or lab test during your examination.

_____ _____

Signature Date