Name:_____ DOB_____

Provider you are seeing today:_____ Appointment Date:_____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.

Rivers Edge Family Medicine

Please Complete the following as legible as possible and to the best of your ability.

Who is your appointment with today? *Please circle one*

Sean D. Bloor, M.D. Shelley L. Blackburn, M.D. Michael L. Weiss, M.D. Ashley N. Pennington, N.P. Erin C. Welch, N.P.

Legal Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Preferred Name: _____ **Marital Status:** Married Single Partner Divorced Widowed

Gender: Please circle **Male** **Female** **Social Security #:** _____ *(We use your SSN# for insurance purposes.)*

Insurance Name & Payer ID(on back of card)_____ **Member ID:**_____

Secondary Insurance Name & Payer ID_____ **Member ID:**_____

Custodial Parent(s) (if pt is under 18): _____ **Presenting Parent(s)** (Who is here today): _____

Mailing Address: _____ Apt #_____

City: _____ State: _____ Zip: _____

Cell Phone: _____ **Work Phone:** _____ **Home:** _____

Primary Phone: Cell / Home / Work **May we leave a message on your Cell or Home Number?** Y / N

Email: _____ **Patient Portal Invite?** Y / N

Preferred Appointment Reminders (Reminders are all automated): Please circle one Text / Phone / Email

Employer: _____ **Occupation:** _____

Would you like a copy of your HIPAA Notice of Privacy Rights? If so, please see the front staff. Thank you.

Responsible Party Name (If different from above): _____

Relationship to Patient: _____ Date of Birth: _____

Social Security #: _____ Gender: M / F Phone: _____ cell or mobile

Mailing Address: _____ City, State, Zip: _____

Emergency Contacts: **May we share health care information with your Emergency Contacts? Please circle Yes or No.**

Name: _____ Phone: _____ Relationship: _____ Yes or No

Name: _____ Phone: _____ Relationship: _____ Yes or No

Name: _____ Phone: _____ Relationship: _____ Yes or No

Federal Health Regulations now require that we record the following data as part of every health record:

Race: _____ Preferred Language: _____ Ethnicity: _____

Or Check this box if you refuse to provide this information: [ ]

Preferred Pharmacy: _____ **Phone #:** _____

Address (Please include zip code): _____

***Copies of Insurance Card (s) are required to bill your insurance. Please bring all copies of your insurance cards to your appointment; otherwise, you may be responsible for payment of your appointment. Thank you. *Any Legal Name change, Gender change, or Custodial Documents should be brought in to keep a copy on file. Thank you.**

I verify all my information above is accurate and filled out completely.

Patient Signature or Guarantor Signature: _____ **Date:** _____

Patient Acknowledgment and Payment Responsibility

Rivers Edge Family 4626 Sawmill Rd, Columbus, Ohio 43220 614.538.9339

Our goal is to work together, with you, to provide you the best medical care we can and have you use your insurance benefit to the fullest.

- *You acknowledge all Auto Accident appointments are self-pay. No exceptions.*
- *You acknowledge that we do not see any BWC (Workman's Comp) Claims. We are not licensed. You need to contact your HR dept to find out where to go. No exceptions.*
- *If you do not have proof of your insurance at the time of your visit, or we cannot verify properly, you may be asked to pay for your appointment.*
- *We may not be in network with your insurance. It is not REFM's responsibility to find out if your insurance is in network with our office. We will not call your insurance to verify coverage. IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE INFORMATION.*
- *Should you fail to provide REFM with your current insurance before your insurance's timely filing deadline, you will be fully responsible for the costs of the services rendered by REFM.*
- *If you are asked to schedule an appt to go over lab or test results, you may incur a fee.*
- *If you have a Medicaid Plan that we are not in network with and still choose to go here, willingly, and knowingly, that you can have services fully covered by a different provider, other than one at REFM, you will be responsible for payment.*
- *All injection fees for medication, that is prescribed to you by REFM, may result in an injection fee that is due at the time of service.*
- *If your COB (coordination of benefits) has not been been updated and insurance denies the date of service, you may be responsible for payment.*
- *If you are a non-Medicare patient and want an early Annual Well Physical, prior to our guidelines at REFM and most insurances have, of the 365 days + 1, your insurance may not cover your appointment and you may be responsible.*
- *If you are having your Annual Well Physical, only specific topics are covered by a routine Annual Well Physical. If you choose to speak about other topics that are not included in what your insurance deems as your Annual Well Physical, such as medications, sickness, or chronic conditions, etc, you may either be asked to schedule another appointment to cover those items or you may be responsible for payment for those items per your insurance.*
- *Services rendered at REFM only covers services performed by your provider at REFM- NOT any labs done here, by Path Group. They are a separate company. Services will be billed separately.*
- *If you are self-pay for today's visit, then you are responsible for paying, in full, for today's visit. Leaving without payment, may result in not having medication sent in or being able to schedule another appointment.*
- *If you do not show up for your appointment or cancel late for your appointment you may be asked to pay a fee before you can reschedule.*
- *If you show up late for your appointment, you may be asked to reschedule your appointment. Please show up 10-15min prior to your appointment so we can make sure you are checked in correctly.*

*Signature of Patient*_____ *Date*_____

*Printed Name of Patient*_____

*If patient is a minor, Signature of parent or legal Guardian*_____

*Relationship to Patient, if not the patient*_____

Missed Appointment Policy & Notice of HIPAA

4626 Sawmill Rd, Columbus, Ohio, 43220 614.538.9339

In effort to improve access for all patients, Rivers Edge Family Medicine will actively work to reduce missed appointment activity, or no-show appointments. We aim to provide the best quality care for our patients.

**** To ensure our patients do not miss their appointments, REFM makes their patients eligible for phone, text, or email reminders prior to your appointment, if scheduled 2 days prior to your appointment.***

**** Please listen to your voicemails, read your texts, or read your emails concerning your scheduled appointment. This is your responsibility.***

* **Please notify REFM of any cancellations 24 hours prior to your scheduled appointment**. This will allow our office enough time to fill the appointment slot with another patient in need.

* If you cancel less than 24 hours of your scheduled appointment time, it may count as a missed appointment.

* New patient's missing their first scheduled appointment may not be allowed to reschedule.

****All missed appointments may be charged a fee that will need to be paid prior to scheduling another appointment.*** *Fees are subject to change at any given time.*

We ask that you **arrive 10-15 minutes prior to your scheduled appointment time so you can be checked in to your appointment correctly and taken back for your appointment so your provider can have the allotted scheduled time for your appointment.*

***Out of respect for other patients & your providers time, there is Only a 5 Minute Grace Period for being late. You may be asked to reschedule & may be asked to pay the fee mentioned above. This is an office policy and no exceptions will be made.**

Witness Signature Date Insurance Authorization & Assignment (Please Read)

I authorize Rivers Edge Family Medicine to provide any applicable personal & medical healthcare information contained in my records for my treatment, account balance resolution, & other healthcare operations to appropriate agencies, including collection agencies, insurance companies, & third-party payers. I CERTIFY THAT I AM THE PERSON NAMED ABOVE OR THE LEGAL GUARDIAN OF THE PATIENT and agree to pay for all fees & charges for my treatment & services provided by Rivers Edge Family Medicine. I understand that should I default on payment of my account and collection agencies are required, all cost of collections up to 40% of the balance, including attorney/court costs will be added to the balance of my account.

Receipt of Notice of Privacy Practices (printable on-line and available in the office)

I have been offered the HIPAA Notice of Privacy Practices at Rivers Edge Family Medicine which outlines my privacy rights and how REFM may use and disclose Protected Health Information about me.

Please circle one: Yes No Offered but declined **Your Initials:** _____

I have read, acknowledge, & understand all the above information.

Patient/Responsible Party Signature: _____ **Date:** _____

Rivers Edge Family Medicine Screening Questions

Name: _____ DOB: _____ Today's Date: _____

Your insurance *may* require screening tests to be completed.

Please fill out your medical history for the following tests, to the best of your knowledge.

Smoking Status:

Do you Smoke? Yes or No

Former Smoker: How long did you smoke? _____ Quit date _____

If yes, please circle your best answer below:

1: Current Every day or Current Some days

2: On average how much do you smoke daily?

Less than 1 pack daily one pack per day 1.5 packs per day 2 packs per day 2+packs per day

Colorectal Screening:

Have you had a Screening Colonoscopy? Yes or No Have you done a Cologuard? Yes or No

If yes: Date of Completion_____

Name of Medical Facility, City, and State: _____

Screening Mammogram:

Have you had a Screening Mammogram? Yes or No Not Applicable

If yes: Date of Completion_____

Name of Medical Facility, City, and State: _____

Pap Smear:

Have you had a Screening Pap Smear? Yes or No Not Applicable

If yes: Date of Completion_____

Name of Medical Facility, City, and State: _____

Eye Exam:

Have you had an Eye Exam? Yes or No

If yes: Date of Completion_____

Name of Medical Facility, City, and State: _____

Dental Exam:

Have you had a Dental Exam? Yes or No

If yes: Date of Completion_____

Name of Medical Facility, City, and State: _____

Bone Density Scan:

Have you had a Bone Density Scan? Yes or No

If yes: Date of Completion_____

Name of Medical Facility, City, and State: _____

Tdap/Tetanus Vaccine:

When was your last Tetanus Vaccine: _____

Thank you for taking your time to complete your forms. We appreciate YOU!

Name:_____

Review of Systems:

Please indicate any problems in the following areas that are bothering you. If your planned visit is for a Preventative Physical, please be aware that another office visit may need to be scheduled to address new specific issues in appropriate detail.

Check all that apply:					
Constitutional:	☐ Fever	☐ Chills/Sweats	☐ Weight gain / Loss	☐ Fatigue	☐ Weakness
	☐ Poor appetite	☐ Appetite change			
Eyes:	☐ Blurred vision	☐ Double vision	☐ Eye pain		
Ears:	☐ Ear pain	☐ Decreased hearing	☐ Dizziness (light headed, room spinning)	☐ Ringing	
Nose:	☐ Congestion	☐ Sinusitis	☐ Difficulty breathing through nose	☐ Frequent nose bleeds	
Throat:	☐ Sore throat	☐ Sensation of fullness	☐ Difficulty swallowing		
Neck:	☐ Neck pain	☐ Fullness or lumps			
Cardiovascular:	☐ Chest discomfort (pain, pressure, fullness squeezing) with exertion or exercise			☐ Heart palpitations	
	☐ Heart racing	☐ Shortness of breath while lying down or with exertion (out of proportion to activity)			
	☐ Swelling of legs	☐ Fainting			
Pulmonary:	☐ Cough	☐ Emphysema (COPD)	☐ Shortness of Breath	☐ Asthma	
GI:	☐ Nausea	☐ Vomiting	☐ Abdominal pain		
	☐ Heartburn	☐ Sudden fullness	☐ Hemorrhoids		
	☐ Diarrhea	☐ Constipation	☐ Blood in stool	☐ Change in frequency of stools	
Genitourinary:	☐ Pain with urination	☐ Increased frequency of urination		☐ Frequent nighttime urination	
	☐ Blood in urine	☐ Sexual problems	☐ Difficulty with erections	☐ Vaginal pain	
	☐ Vaginal discharge	☐ Slow stream/dribbling	☐ Incontinence		
Musculoskeletal:	☐ Joint pains	☐ Muscle weakness	☐ Muscle pain	☐ Back pain	
Skin:	☐ Rash	☐ Sores	☐ Moles that are changing	☐ Itching	☐ Dry skin
	☐ Eczema	☐ Have seen dermatologist in past year	Dermatologist's name: _____		
Neurological:	☐ Headaches	☐ Numbness/Tingling	☐ Weakness	☐ Speech abnormalities	
	☐ Fainting	☐ Memory Problems	☐ Imbalance/vertigo	☐ Headaches	☐ Tremors
Psychological:	☐ Anxiety	☐ Eating disorder	☐ Obsessive behavior	☐ Depression	☐ Unusual fears
	☐ Mood swings	☐ Crying spells	☐ Lack of motivation	☐ Drug dependence	
	☐ Alcohol problems	☐ Insomnia	☐ Panic attacks	☐ Anger/Rage	

In the last 2 weeks, have you felt down, depressed or hopeless? ☐ Yes ☐ NO

In the last 2 weeks, have you felt little interest or pleasure in doing things? ☐ Yes ☐ NO

Do you have Advanced Directives (Living Will, Durable Medical Power of Attorney)? ☐ Yes ☐ NO

Reviewed with patient on _____ Signature _____

RIVERS EDGE FAMILY MEDICINE

Adult Comprehensive Patient History

☐ New Patient ☐ Established Patient

Name:_____ D.O.B_____ Age:_____ Date:_____

Past History: *Check all that apply*

- ☐ Acid reflux
- ☐ Alcohol or Drug problems
- ☐ Allergy problems
- ☐ Anemia
- ☐ Artery problems
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Bleeding problems
- ☐ Blood clots
- ☐ Cancer
- ☐ Colitis
- ☐ Crohn's disease
- ☐ Depression, Anxiety
- ☐ Diabetes
- ☐ Emphysema
  - ☐ Other lung disease
- ☐ Esophagitis, ulcers
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart disease
- ☐ Heart valve problems
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irritable bowel
- ☐ Kidney stones
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Recurrent skin infections
- ☐ Recurrent UTI
- ☐ Seizures
- ☐ Sexually transmitted infections
- ☐ Stroke
- ☐ Thyroid diseases
- ☐ Vein problems

☐ Other diseases not listed _____

☐ Explain any of the above if necessary _____

_____

_____

☐ Hospitalizations _____

_____

Surgery/Procedures: (*check all that apply*) ***PLEASE ADD APPROX DATE(S): MONTH AND YEAR***

- ☐ Appendix
- ☐ Bladder suspension
- ☐ Blood vessel surgery
  - ☐ Arteries
  - ☐ Veins
- ☐ Dental surgery
- ☐ Eye surgery
- ☐ Gallbladder
- ☐ Heart surgery
  - ☐ Bypass
  - ☐ Heart valve surgery
  - ☐ Angioplasty (balloon)
  - ☐ Stents
- ☐ Hysterectomy
  - ☐ Complete
  - ☐ Partial (ovaries preserved)
- ☐ Joint Replacement
- ☐ Orthopedic surgery
- ☐ Prostate surgery
- ☐ Tonsils and/or adenoids
- ☐ Tubal Ligation
- ☐ Vasectomy

☐ Other surgery not listed above _____

☐ Significant injuries _____

Medication List:

Name of medication, vitamin, OTC supplements or herbal medicine | Dosage | Supplies | Times/day | Disease or Reason

Medication allergies or reactions:

Medication	Reaction	Medication	Reaction
1		2	
3		4	

Name:_____

Family History:

Family Member	Date(s) of Birth	Living	Deceased	Diseases
Father				
Mother				
Brother(s) #				
Sisters(s) #				

Diseases in the family: Check all that apply

☐ Arthritis ☐ Addiction problems ☐ Bleeding Problems

Cancer(s) ☐ Colon ☐ Breast ☐ Prostate ☐ Other type of cancer(s) _____

☐ Depression/Anxiety ☐ Diabetes ☐ Heart disease ☐ High blood pressure

☐ High cholesterol ☐ Kidney disease ☐ Liver disease ☐ Mental illness

☐ Other

☐ Details / Other _____

_____

Social History:

Married? ☐ NO ☐ YES Divorced? ☐ NO ☐ YES Children? ☐ NO ☐ YES If yes, number of children _____

Family members living in the home: ☐ Mother ☐ Father ☐ Siblings ☐ Others: _____

Do you smoke? ☐ Currently ☐ Past ☐ Never _____ packs/day for _____ years. Other tobacco use? ☐ NO ☐ YES

If you do smoke, would you like information about our smoking cessation program? ☐ NO ☐ YES

Do you drink alcohol? ☐ NO ☐ YES ☐ Beer ☐ Wine ☐ Liquor. How many drinks per week? _____

How many servings of caffeine per day? _____ ☐ Coffee ☐ Tea ☐ Sodas

Do you limit salt in your diet? ☐ NO ☐ YES Do you limit fat? ☐ NO ☐ YES

Any illegal drug use? ☐ NO ☐ YES Type _____

Occupation _____ Any known occupational exposures? _____

Do you exercise regularly? ☐ Yes ☐ No If so, how many times per week? _____ Type of exercise _____

Do you feel safe in your home? ☐ NO ☐ YES

Sexual Orientation? ☐ Not Applicable ☐ Heterosexual ☐ Homosexual

Preventative Care:

Date of last Colon and Rectal Cancer screening: _____ ☐ Rectal exam ☐ Sigmoidoscopy ☐ Colonoscopy

Date of last eye exam: _____ Have you had bone density (DEXA) exam? ☐ NO ☐ YES Date: _____

Do you use your seat belt? ☐ Yes ☐ No

Immunizations:	Date	**Immunizations:**	Date
Tetanus		Hepatitis A	
Influenza		Hepatitis B	
Pneumonia		Shingles	
Whooping cough		HPV	

For our FEMALE patients only:

Do you have a Gynecologist? ☐ Yes ☐ No If yes, Gynecologist name: _____

Date of last PAP test _____ Date of last mammogram _____ Do you do self-breast exams? ☐ Yes ☐ No

Have you gone through menopause? ☐ Yes ☐ No

Menstrual or period problems: ☐ Irregular ☐ Heavy ☐ Change in frequency _____

Number of pregnancies _____ Number of live births ____ Vaginal ____ C-section ____ Miscarriages ____ # of abortions _____

Can you think of anything else that you think we should know about your health and lifestyle that is not listed here?

_____

For our MALE patients only: Date of last PSA test _____ Date of last rectal exam _____

RIVERS Edge FAMILY MEDICINE

Dr. Michael L. Weiss
Dr. Shelley L. Blackburn
Dr. Sean D. Bloor
Ashley N. Pennington, CNP
Erin C. Welch, CNP

4626 Sawmill Road
Columbus, Ohio 43220
p. 614-538-9339
f. 614-538-9162

Release of Medical Records To Office

AUTHORIZATION: I hereby authorize the release of any and all medical records, to Rivers Edge Family Medicine, including but not limited to: hospitalization for diagnosis and/or treatment of psychiatric and/or mental condition, alcoholism, drug abuse, and/or HIV test results, AIDS, or AIDS related conditions.

Release Records from:

Name: _____ **Office Phone:** _____
(Provider Name &/or Practice Name) or *(*required)*
(Write your name if you are requesting records for yourself.)

Address: _____ **Fax Number:** _____
(street) *(*preferred)*

_____
(city, state, zip code)

INFORMATION TO BE RELASED:

___ Progress Notes ___ Consultations
___ Radiology ___ Cardiovascular
___ Procedure and/or Lab ___ Other Diagnostic Tests
___ All the Above

RESTRICTIONS: The recipient should not further disclose medical information unless a valid authorization is obtained or unless such use of disclosure is specifically required or permitted by law.

DURATION: This authorization will expire sixty (60) days from the date this release is signed, or at an earlier date, at my election. To cancel this authorization prior to the above limit, signed written notification must be sent to the office releasing said records.

PRINTED NAME: _____ **PATIENT SIGNATURE:** _____

COMPLETE ADDRESS: _____

PHONE NUMBER: _____ **DATE OF BIRTH:** _____

LEGAL REPRESENTATIVE SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____ **DATE SIGNED:** _____

***Must filled out in completion for records to be released.