



PATIENT DEMOGRAPHICS

First Name:		MI	Last Name:		Date of Birth:
Nickname:	Sex:	SSN:	Race / Ethnicity:	E-mail address:	
Address:			City:	State:	Zip:
Home Phone:		Cell Phone:		Work Phone:	
Preferred phone number:	<input type="checkbox"/> Home	<input type="checkbox"/> Work	<input type="checkbox"/> Cell	Marital Status:	Employer:
Ok to leave detailed msg:	<input type="checkbox"/> Home	<input type="checkbox"/> Work	<input type="checkbox"/> Cell		
Primary Care Physician:			Referring Physician:		

*Please provide first and last name. Please also provide phone & fax if they are not a local Dr., *

INSURANCE POLICYHOLDER (IF OTHER THAN SELF)

<input type="checkbox"/> Primary Ins	<input type="checkbox"/> Secondary Ins	Name:	Relationship:	DOB:	SSN:
<input type="checkbox"/> Primary Ins	<input type="checkbox"/> Secondary Ins	Name:	Relationship:	DOB:	SSN:

IN CASE OF EMERGENCY

Name:	Relationship:	Address:	Primary phone no.: ()	Secondary phone no.: ()
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PRIVACY

WHO CAN WE SHARE YOUR MEDICAL INFORMATION WITH? (Family members, etc.- Please give full names. You may want to provide a contact phone number if they are different than your emergency contact above.)

Please provide documentation if Power of Attorney applies

PHARMACY

Name:	Address (or major cross street and city)	Phone no.: ()	Fax no.: ()
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PATIENT RESPONSIBILITIES

- I hereby authorize assignment of benefits to be paid directly to Dr. Barrett, Dr. Kitei or Dr. Coerver.
- I understand that it is my sole responsibility to check with my insurance company regarding coverage & cost for any procedures and/or office visits. I am responsible for obtaining all referrals and insurance authorizations.
- I authorize Dr. Barrett, Dr. Kitei or Dr. Coerver to provide protected health information to my insurance company for billing purposes.
- I understand that regardless of any insurance coverage or other potential co-guarantor or responsible party, I am accepting full financial responsibility for payment of all charges for services provide to me, my spouse or dependents by this practice. I agree that if my employer, insurance carrier or plan sponsor denies payment to all of or any portion of my claim, I will be financially responsible for all outstanding charges. I agree to pay a late fee of \$25 if my account should become over 60 days past due. In addition, should my account become delinquent and assigned to a collection agency, I agree to pay an additional collection charge of 33% of the outstanding balance or a minimum of \$40.00 (whichever is greater) to offset in part the collection agency's fee charged to this practice. Should legal action be initiated by the collection agency, I agree to pay a collection charge of 50% of the outstanding balance as well as all costs and reasonable attorney fees incurred in such collection efforts by this office or our assignee.
- TCPA Acknowledgment - I authorize this office, its agents and assignees to contact me by telephone, text/SMS, and/or via an automated dialing system with live or recorded voice in connection with any of my accounts with this office and at any telephone number I have provided as of this date or in the future.
- A fee of \$50.00 may be assessed if I do not show up for a follow-up appointment or if I cancel without 24 hours notice. A fee of \$150 may be charged if I do not show up for a testing appointment. The implementation of this policy is at the discretion of the office and circumstances are always considered.
- I give permission for the office to access my external medication history.
- I acknowledge review of HIPAA notice, and have received a copy if I requested it.

PATIENT (or POWER OF ATTORNEY/GUARDIAN*) SIGNATURE

DATE

If signed by a Legal Guardian or Power of Attorney

Legal Guardian/POA Name: _____ Relationship to patient: _____

*By providing your signature above, you attest that you have the legal right to sign for the patient.



NAME: _____

DATE OF BIRTH: ____ / ____ / ____

What symptoms are you being seen for today? _____

Height: ____ ft ____ in	Weight: ____ lbs.
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MEDICATIONS			
Name	Strength (mg etc.)	Frequency (how often?)	Condition this medication is for

Are you allergic to any medications? YES NO If so, which ones? _____

ADDITIONAL MEDICAL CONDITIONS	DATE (IF APPLICABLE)

MAJOR SURGERIES	DATE (IF APPLICABLE)

FAMILY HISTORY	
Father <input type="checkbox"/> Alive <input type="checkbox"/> Deceased <input type="checkbox"/> Unk.	Medical conditions:
Mother <input type="checkbox"/> Alive <input type="checkbox"/> Deceased <input type="checkbox"/> Unk.	Medical conditions:
Are there any other medical conditions that run in your family?	
<i>(Examples of medical conditions we're looking for: diabetes, hypertension, heart disease, stroke, mental illness, cancer etc.)</i>	

REVIEW OF SYSTEMS
(Please circle all that applies)

General: weight loss, weight gain, fevers **ENT:** sinus infections, ear pain/fullness, dizziness, ringing in ears
Eyes: blurry vision, double vision, loss of vision **Psychiatric:** sadness/depression, anxiety, hallucinations
Respiratory: shortness of breath, wheezing, cough **Genitourinary:** frequent urination, impotence, painful urination
Cardiovascular: heart palpitations, passing out/blackouts, poor circulation **Skin:** rashes, birthmarks, skin growths
Gastrointestinal: burning in stomach, constipation, diarrhea **Musculoskeletal:** weakness, joint pain, joint swelling
Neurologic: headache, difficulty swallowing, tingling/burning, neck/back pain, slurred speech, tremors, memory problems, balance problems, muscle cramps, numbness

ADDITIONAL QUESTIONS	SOCIAL HISTORY
<i>(Please circle)</i>	Are you a:
Do you have an Advanced Directive? YES NO	<input type="checkbox"/> Never smoker
<i>If so, have you assigned a decision maker?</i> YES NO	<input type="checkbox"/> Former smoker
Have you received a flu shot? YES NO	<i>If so, date range:</i> _____ - _____
Have you received the pneumonia vaccine? YES NO	<input type="checkbox"/> Current smoker
Are you in pain today? YES NO	<i>If so, how much?</i> _____
<i>If so, please rate your pain on a level of 1-10:</i> _____	Date started: _____
Is your appointment today regarding a work or auto related injury? WORK AUTO N/A	Do you drink alcohol?
<i>If so, what was the date of injury?</i> _____	<input type="checkbox"/> Yes
	<i>If so, how often?</i> _____
	<input type="checkbox"/> No