ADVANCED MEDICAL CENTER
HELPING YOU FEEL LIKE YOU

New Patient Forms

Patient Last Name: _____ First Name: _____ Middle In: _____

Preferred Name: _____ DOB: _____ Social Security#: _____

Home Address: _____ City: _____Zip: _____

Sex: M F Home Phone: _____ Cell Phone: _____Work phone: _____
Would you like to receive text reminders from our office? Yes NO Email: _____
Marital Status: Single Married Divorced Widowed Preferred Language: _____
Race: White American Indian Native Hawaiian /Pacific Islander African American Ethnicity: Hispanic Non-Hispanic
Preferred Pharmacy: _____ Cross Streets: _____
How did you hear about us? _____
_____

Primary Insurance: _____ ID#: _____

Policy Holder: _____ DOB: _____SS#: _____

Relation to patient: _____

Secondary Insurance: _____ ID#: _____

Policy Holder: _____ DOB: _____SS#: _____

Relation to patient: _____
Are you being seen in relation to a work or auto injury? Yes No

If yes, Claim #:_____ Date of Injury/accident: _____

Employer Name: _____ Phone: _____

Claim address: _____City: _____State: _____ Zip:_____
_____

Emergency Contact Name: _____ Phone: _____
_____

I understand that I am responsible for all charges regardless of insurance coverage. I agree to pay my account with Advanced Medical Center in accordance with the regular rates and payment terms of this office. If my account is referred for collections, I agree to pay reasonable collection expenses including any administration and/or attorney's fees. In the event that I am entitled to health insurance or other benefits relating to my medical condition and it is available to cover the costs of treatment provided by this office, I hereby assign those benefits to Advanced Medical Center to be applied to my bill. Advanced Medical Center may release records pertaining to my treatinent to my insurance company or other third parties responsible for payment of my medical charges.

Patient/Guardian Signature: _____ Date: _____

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Patient's Name: _____ DOB: _____

Allergies & Reaction

(Please list All allergies and reactions, include seasonal allergies)

Allergy Type/Medication	Reaction

Current Medications

(please list ALL medications you are currently taking with dosage)

Medication/Dosage	Frequency	Start Date

Please provide the office with an additional list of more room is needed.

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Patient's Name: _____ DOB: _____

Vaccines

(Please check if you had any of the following vaccines within the last 6 months and list dates of vaccination)

VACCINE: TETANUS_____ Date: _____ FLU_____ Date: _____

PNEUMONIA_____ Date: _____ OTHER_____ Date: _____

FAMILY HISTORY: Please check off the appropriate box if anyone in your has ever had any of the following medical history. If you check yes, please list the relation of your family member (mother, father, siblings, paternal or maternal grandparent).

High Blood Pressure: ☐ No ☐ Yes Family Member: _____ Kidney Disease: ☐ No ☐ Yes Family Member: _____

Bleeding Disorder: ☐ No ☐ Yes Family Member: _____ Mental Illness: ☐ No ☐ Yes Family Member: _____

Epilepsy: ☐ No ☐ Yes Family Member: _____ Osteoporosis: ☐ No ☐ Yes Family Member: _____

Heart Disease: ☐ No ☐ Yes Family Member: _____ Thyroid Disease: ☐ No ☐ Yes Family Member: _____

Diabetes: ☐ No ☐ Yes Family Member: _____ Cancer: _____ Family Member: _____

Other: _____

Social History

Do you: (please respond to all that apply)

Smoke Tobacco? ☐ No ☐ Yes Tobacco Type: _____ how many years: _____

Have you traveled out of the country: Yes No

Occupation : _____ Highest grade completed in school: _____

Marital Status: _____ Sexual orientation: _____

Do you exercise/walk daily? _____ What does your diet consist of? _____

Drink alcohol? ☐ No ☐ Yes Alcohol Type: _____ Amount: _____ Daily_____ Weekly_____

Drink Coffee/Caffeine? ☐ No ☐ Yes Caffeine Type: _____ How many cups daily: _____

Surgical History

(Please list ALL surgeries you have had in the past)

Type of Surgery	**Date**
_____	_____
_____	_____
_____	_____

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PAST MEDICAL HISTORY

(please circle if you have ever had any of the following):

____ High Blood Pressure **____High Cholesterol** **____Diabetes** **____Asthma**
____Bronchitis **____Thyroid Disease** **____Prostate Disease** **____Stroke**
____Chest Pain **____Heart Disease** **____Arthritis** **____Turbucolisis**
____Cancer: Type of Cancer_____ **Other: _____**

FEMALES: are you pregnant Yes No Planning a pregnancy Yes No Number of pregnancies _____
Have you had any : abortions: _____ Miscarriages: _____
Menstrual flow: Regular Irregular Painful/cramps Days of flow: _____ 1st day of last period: _____
Do you experience any pain/bleeding during or after sex? Yes No Date of last pap smear? _____
Are you currently on birth control? Yes No Date of last mammogram? _____

What is the reason you are being seen today? (please list symptoms you are having)

_____
_____
_____

Review of Systems (Please check all that apply)

General
____ Fever ____Chills
____Weight Loss ____Weight Gain
____Night Sweats ____Fatigue ____Weakness

Ears
____ Difficulty hearing ____ear pain
____ ringing in the ears

Mouth
____Sore throat ____Bleeding gums ____Snoring
____Dry mouth ____Mouth ulcers ___Oral abnormalities
____Dental problems ____Sinus problems

Respiratory
____Cough ____Wheezing ____shortness of breath
____Coughing up blood ____Sleep apnea

Eyes
____ Dry eyes ____Vision Changes
____Eye irritation ____Eye disease/injury
Do you wear contacts or glasses? __Yes __No

Nose
____Runny nose ____Nasal congestion
____Nosebleeds ____Loss of sense of smell
____Sinusitis

Cardiovascular
____Chest pain ____arm pain on exertion
____shortness of breath when walking/ lying down
____palpitations ____heart murmur
___ankle swelling

Gastrointestinal
____Abdominal pain ____Nausea ____Vomiting
____Constipation ____Normal appetite
____Diarrhea____Vomiting blood

Patient's Name: _____ DOB: _____

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Review of systems cont…..

Genitourinary

____Urinary incontinence ____Difficulty urinating

____Blood in urine ____increased frequency

Skin

____abnormal mole ____jaundice ____Rash

____laceration ____non-healing areas

____changes hair/nail ____psoriasis

____change in skin color ____breast lump

Neurologic

____loss of consciousness ____weakness numbness

____seizures ____dizziness ____migraines ____headaches

____tremor ____gait dysfunction ____paralysis

Endocrine

____fatigue ____increased thirst ____hair loss

____increased hair growth ____Cold intolerance

Allergy

____Runny nose ____sinus pressure

____itching ____hives ____frequent sneezing

____Dyspepsia ____GERD

Musculoskeletal

____muscle aches ____muscle weakness

____joint pain ____back pain

____swelling in the extremities ____neck pain

____difficulty walking ____cramps

____osteoporosis ____fractures

Psychiatric:

____Depression ____sleep disturbances

____feeling safe in relationship ____alcohol abuse

____anxiety ____hallucination

____suicidal thoughts ____mood swings

____memory loss ____agitation ____dementia

Hematologic/lymphatic

____Swollen glands ____Bruising ____runny

____Excessive bleeding ____Anemia ____ Phlebitis

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HIPAA Compliance
Privacy Practices Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.
The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.
You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:
Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
The practice reserves the right to change the privacy policy as allowed by law.
The practice has the right to restrict the use of the information but the practice does not have to agree to those Restrictions.

The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
The practice may condition receipt of treatment upon execution of this consent.
May we phone, email, or send a text to you to confirm appointments? YES NO
May we leave a message on your answering machine at home or on your cell phone? YES NO
May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____DOB: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

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Administrative/Billing Office Policies

Co-pays and patient balances: Co-pays are due at the time of service and will not be billed. If you are unable to pay your co-pay at the time of service, please call our office prior to your appointment to reschedule. Patient balances must be paid prior to your next appointment. If a payment plan is needed to please speak with the billing department to set this up.

No Show\Cancellation appointment policy: to accommodate all patients, Advanced Medical Center asks all patients to call and reschedule their appointment within 24 business hours of their scheduled appointment time. Any missed appointments with less than a 24-hour notice will incur a $35.00 No show fee. Please note after three violations of the no show/cancellation policy, you will not be able to schedule an appointment without management approval.

Disability/FMLA Forms: FMLA/Disability forms will be completed by our office at the patient requests. Please call and schedule an appointment specifically for these,if required, with your provider. Please note there is a 45.00 administration fee for completing the forms which is not covered by insurance. Payment will be collected at the time of request. Please allow 7 days for these forms to be completed.

Medication Refill appointments/ Request: All refill request must be made through your pharmacy. Please allow 3-4 business days for the refill request to be completed. Please note some refills may require a prior authorization through your insurance. Please allow 2 weeks for these to be completed. Refill appointments must be made 7 days prior to taking your last dosage to prevent going without medication.

Insurance: It is the responsibility of the patient to contact their insurance and ensure AMC is in network with your insurance plan.

Credit Authorization: Advanced Medical Center requires a valid credit card be kept on file in the case of an accumulation of any unpaid fees related to any of Advanced Medical Centers policies. Please note all financial and healthcare information is kept and will not be shared in accordance with HIPAA.

Card Type: □ Visa □ Master Card □ Discover □Amex □ Other: _____

Name on Credit Card: _____

Card#: _____ CVV: _____ Exp: _____

□ I understand by signing below I am authorizing Advanced Medical Center to charge my credit card above for agreed purchases/fees. I understand my information will be saved for future transactions on my account.

□ I have read and agreed to abide by the polices Advanced Medical Center as set in place.

Print Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____