



**General Information:**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ SSN: \_\_\_\_\_

Home Address: \_\_\_\_\_

Mailing Address (If Different than Above): \_\_\_\_\_

Email Address: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Language: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Marital Status (Please Circle One of the Following): Single Married Relationship Widowed

Spouse/Partner: \_\_\_\_\_ Contact Number: \_\_\_\_\_

**In Case of Emergency:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Cell Phone/Other Number: \_\_\_\_\_

**Insurance Information:**

**Primary Insurance:** \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

How did you hear about us? ( ) Google ( ) Website ( ) Signage ( ) Billboard

Or who can we thank for sending you to us \_\_\_\_\_



**Medical Questionnaire:**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ SSN: \_\_\_\_\_

Are you currently a patient of any specialist or any other health provider? (E.g. Cardiologist, nephrologist, etc.)

**YES**

**NO**

If yes, please list the Providers name and specialty:

Provider:

Specialty:

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**Reason for Todays Visit:**

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**Are you Currently Experiencing Any of the Following Symptoms?**

|                       |        |       |                 |
|-----------------------|--------|-------|-----------------|
| Anxiety/Depression    | Yes___ | No___ | Comments: _____ |
| Appetite Changes      | Yes___ | No___ | Comments: _____ |
| Blurred Vision        | Yes___ | No___ | Comments: _____ |
| Chest Pain            | Yes___ | No___ | Comments: _____ |
| Cough                 | Yes___ | No___ | Comments: _____ |
| Diarrhea/Constipation | Yes___ | No___ | Comments: _____ |
| Dizziness             | Yes___ | No___ | Comments: _____ |
| Fatigue               | Yes___ | No___ | Comments: _____ |
| Headaches             | Yes___ | No___ | Comments: _____ |
| Heartburn/Indigestion | Yes___ | No___ | Comments: _____ |
| Insomnia              | Yes___ | No___ | Comments: _____ |
| Memory Loss           | Yes___ | No___ | Comments: _____ |
| Muscle/Joint Pain     | Yes___ | No___ | Comments: _____ |
| Painful Urination     | Yes___ | No___ | Comments: _____ |
| Recent Fall           | Yes___ | No___ | Comments: _____ |
| Sexual Function       | Yes___ | No___ | Comments: _____ |
| Shortness of Breath   | Yes___ | No___ | Comments: _____ |
| Swelling              | Yes___ | No___ | Comments: _____ |
| Weight Loss/Gain      | Yes___ | No___ | Comments: _____ |



**Past Major Illnesses:**

|                     |             |                  |             |
|---------------------|-------------|------------------|-------------|
| Blood Disorder      | Date: _____ | Kidney Disease   | Date: _____ |
| Cataracts           | Date: _____ | Lung Disease     | Date: _____ |
| Diabetes            | Date: _____ | Stroke/TIA       | Date: _____ |
| Epilepsy/Seizures   | Date: _____ | Swelling         | Date: _____ |
| Gallbladder Disease | Date: _____ | Thyroid Problems | Date: _____ |
| Glaucoma            | Date: _____ | Tuberculosis     | Date: _____ |
| Heart Disease       | Date: _____ |                  |             |

**Medical History:**

Surgery:

Date:

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**Broken Bones:**

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**Hospitalizations:**

| Date: | Hospital | Reason for Hospitalization: |
|-------|----------|-----------------------------|
| _____ | _____    | _____                       |
| _____ | _____    | _____                       |
| _____ | _____    | _____                       |
| _____ | _____    | _____                       |
| _____ | _____    | _____                       |

**Family History:**

Mother: Living \_\_\_\_\_ Deceased Age/Cause of Death: \_\_\_\_\_  
Medical History: \_\_\_\_\_  
Father: Living \_\_\_\_\_ Deceased Age/Cause of Death: \_\_\_\_\_  
Medical History: \_\_\_\_\_  
Number of Siblings: \_\_\_\_\_ Number of Children: \_\_\_\_\_  
Do you have any family in the local area? Yes No

**Social History:**

Do you have assistance at home: Yes No  
Do you live by yourself? Yes No  
Are you retired? Yes No  
Do you have a Medical Power of Attorney or Living Will? Yes No  
Who would assist you in an emergency? \_\_\_\_\_ Relationship: \_\_\_\_\_



## Recent Preventative Care:

Date of your last Bone Density Exam: \_\_\_\_\_

Date of your last Colonoscopy: \_\_\_\_\_

Date of your last Dental Exam/ Cleaning: \_\_\_\_\_

Date of your last Eye Exam: \_\_\_\_\_

Date of your last Hearing Exam: \_\_\_\_\_

Date of your last Mammogram: \_\_\_\_\_

Date of your last Pelvic or Pap Smear: \_\_\_\_\_

Date of your last Pneumococcal Immunization: \_\_\_\_\_

Date of your last Prostate Exam: \_\_\_\_\_

Have you received the Flu Shot this season?    Yes            No            Date: \_\_\_\_\_

Have you received a Tetanus Immunization?    Yes            No            Date: \_\_\_\_\_

Do you Exercise Regularly?    Yes            No

Do you smoke or have you ever smoked?    Yes            No

If so, how many years? \_\_\_\_\_            How many packs per day? \_\_\_\_\_

Do you still smoke? \_\_\_\_\_            When did you quit? \_\_\_\_\_

Do you drink alcohol?    Yes            No

How often do you have a drink containing alcohol? (Please Circle Below)

*Never    Monthly or Less    2-4 times per month    2-3 times per week    4+ times per week*



## Activities of Daily Living:

Can you handle your personal care on your own? (Toileting, Eating, Walking, etc.)?      Yes      No

Some, please list \_\_\_\_\_

Do you do your own Cleaning?      Yes      No

Do you do your own Cooking?      Yes      No

Do you do your own Driving?      Yes      No

Do you handle your own Finances?      Yes      No

Have you ever gotten Lost?      Yes      No

Do you handle your own Medications?      Yes      No

Do you do your own Shopping?      Yes      No

If you answered no to any of these questions who does these things for you?

\_\_\_\_\_

Have you had any car accidents or near accidents in the last two years?      Yes      No



## Patient Authorization for the Release of Medical Records

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

I hereby authorize **Elite Primary Care**, to request the medical records from

Records requested are as follows:

Lab Reports, X-Rays, EKG Reports

History and Physical, Echocardiograms

Nuclear/Regular Stress Tests

Holter Monitors

Cath/ PTCA/ Stent Reports

All Records

Other: \_\_\_\_\_

I specifically release of information relating to:

Substance abuse (including alcohol/drug abuse)

STD related information (HIV and AIDS related testing)

Mental health (including psychotherapy notes)

\_\_\_\_\_  
Signature of patient and Legal Guardian

**I understand that I have the right to revoke this authorization at anytime. I also understand that I must do so in writing and present my written revocation to Elite Primary Care at the above address. I understand that the revocation will not apply to my insurance company when insurers contest a claim under my policy.**

\_\_\_\_\_  
Signature of patient and Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness Printed Name and Signature

\_\_\_\_\_  
Date





## Release of Medical Information

I, \_\_\_\_\_ hereby give authority to \_\_\_\_\_,  
Patient's Name Name and Relationship

to have access to the indicated medical information below, effective \_\_\_\_\_.  
Date

- Procedures
- Medications
- Appointment times and cancellations
- Patient history
- All medical information may be released

**I understand that I may request to cancel this release of information in writing for whatever reason, at anytime and that information about me or anything pertaining to me will not be released to anyone but the person mention above. I also understand that Elite Primary Care cannot be held liable for any misuse of information obtained by the person mentioned above.**

\_\_\_\_\_  
Signature of patient and Legal Guardian      Date      Relationship to Patient

\_\_\_\_\_  
Witness Printed Name and Signature      Date



## HIPAA Compliance Patient Consent Form

Our notice of privacy practices (on the back) 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 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.

### Your rights:

- Get a copy of your health and claims records
- Ask us to correct health and claims records
- Request confidential communications
- Ask us to limit what we use or share
- Get a list of those with whom we've shared information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you feel your rights are violated

### Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

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.



## **Patient Financial Responsibility**

As a courtesy to our patients, we have enrolled in numerous managed care insurance programs. We are pleased to be able to provide this service to you, and we will make every effort to verify coverage and bill your insurance company correctly. However, it is not possible for us to keep track of all the individual requirements of each plan.

It is the responsibility of each patient to know the details of his or her insurance plan in addition to any lapses in insurance coverage. Any charges that occur as a result of insurance plan restrictions or lapses in coverage are ultimately the patient's responsibility. Unfortunately, if you do not inform us of special requirements required by your plan and we order medically necessary services, such as lab work, hospitalization, or supplies that are not covered by your plan; we may bill you directly for those charges. If current insurance coverage cannot be verified prior to each appointment, payment will be due at the time of service.

The office bills only for services performed by our providers. Laboratories are separate entities and will bill you or your insurance company for services that are performed. If you have any questions about your laboratory bill please contact them or your insurance company directly

Providing the highest quality of medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance plan guidelines, whenever possible. With your cooperation you should be able to receive all of the insurance benefits you are entitled to, and we will be able to focus our efforts on striving to provide you with excellent medical care. Elite Primary Care offers a 50% discount for uninsured patients and this is payment is required at the time service is rendered.

We may charge an upfront \$35.00 administrative fee for completing forms such as disability or insurance and medical records requests. Please be aware that these services may require up to seven to ten days to complete.

If an account is not paid in full within 90 days, a 25% collection-processing fee will be added to the outstanding balance and will be turned over to a collection company for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

Checks returned for any reason will be assessed a \$35.00 service fee in addition to the amount of the check. NSF checks must be redeemed with certified funds and checks will no longer be permitted as payment.

We attempt to contact every patient to remind them of their appointment; however, it is the responsibility of the patient to arrive for their appointment on time. Elite Primary Care also reserves the right to charge a no-show fee for patients who miss appointments without calling to cancel within 24 hours of the appointment. The current no-show fee is \$25.00 and is subject to change without notice.

I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by myself.



**By signing this form, I understand that:**

- Protected health information may be disclosed or used for treatment, payment, or healthcare operation
- The practice reserves the right to change the privacy policy as allowed by law
- The patient 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

BY SIGNING BELOW, I ACKNOWLEDGE I HAVE RECEIVED A COPY, READ, AND UNDERSTAND THE FOLLOWING POLICIES. I ACCEPT THE RIGHTS AND RESPONSIBILITIES OUTLINED WITHIN THEM:

- Patient Rights Regarding Medical Records
- HIPPA Policy and Responsibilities
- Patient Financial Responsibility including collections, no-show policy

This consent was signed by: \_\_\_\_\_

Please PRINT Name

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_