



PATIENT INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: ____/____/____ SEX: ☐ MALE ☐ FEMALE ☐ OTHER SSN: _____

PATIENT ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

(Please check the box to indicate your preferred means of communication)

☐ PRIMARY PHONE: _____ ☐ EMAIL: _____

☐ OTHER PHONE: _____

EMPLOYER: _____ MARITAL STATUS: _____

RACE: ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ BLACK/AFRICAN AMERICAN ☐ WHITE/CAUCASIAN ☐ ASIAN
☐ HAWAIIAN/PACIFIC ISLANDER ☐ OTHER ☐ UNKNOWN ☐ DECLINED

ETHNICITY: ☐ NOT HISPANIC OR LATINO ☐ HISPANIC OR LATINO

LANGUAGE: _____ ☐ INTERPRETER NEEDED: _____

SPOUSE'S NAME: _____ SPOUSE'S DATE OF BIRTH: _____

EMERGENCY CONTACT: _____ RELATIONSHIP TO PATIENT: _____

HOME PHONE: _____ OTHER PHONE: _____

PRIMARY CARE PHYSICIAN: _____ REFERRING PHYSICIAN: _____

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION PLAN NAME: _____

POLICY HOLDER: _____ EFFECTIVE DATE: _____

INSURANCE ID #: _____ GROUP #: _____ PLAN #: _____

SECONDARY INSURANCE INFORMATION PLAN NAME: _____

POLICY HOLDER: _____ EFFECTIVE DATE: _____

INSURANCE ID #: _____ GROUP #: _____ PLAN #: _____

ASSIGNMENT AND RELEASE OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include Major Medical Benefits to which I am entitled, including Medicare, private insurance, and any other health plan to: **M&M MEDICAL CLINICS LLC dba CARE CLINIC.**

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. **I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release medical information to secure payment.**

SIGNED: _____ DATE: _____



HEALTH QUESTIONNAIRE

Name _____ Birthdate _____ Date _____

Last Date of Physical Exam Month _____ Year _____ Last Pap Smear Month _____ Year _____
Last Date of Colonoscopy Month _____ Year _____ Last Tetanus Shot Month _____ Year _____
Last Date of Mammogram Month _____ Year _____

DRUG ALLERGIES

CURRENT MEDICATIONS

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease						
High Blood Pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy/Convulsions						
Bleeding Disorder						
Kidney Disease						
Thyroid Disease						
Mental Illness						
Osteoporosis						

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

WOMEN ONLY Pregnant? ☐ YES ☐ NO Planning Pregnancy? ☐ YES ☐ NO

PAST MEDICAL HISTORY

- | | | |
|--|---|--|
| ☐ Migraines | ☐ Lactose Intolerance | ☐ Thyroid Disease |
| ☐ High Blood Pressure | ☐ Gall Bladder Disease | ☐ Diabetes Type I ☐ Type II ☐ |
| ☐ Heart Arrhythmia | ☐ Prostate Disease | ☐ Last A1C blood test _____ |
| ☐ Heart Murmur | ☐ Incontinence | ☐ Chronic Rashes |
| ☐ Heart Attack | ☐ Sexual/Menstrual Dysfunction | ☐ Cancer _____ type |
| ☐ High Cholesterol | ☐ Sexually Transmitted Disease | ☐ Sleep Apnea |
| ☐ Peripheral Vascular Disease | ☐ Hepatitis | ☐ A.D.D. |
| ☐ Allergies/Hay Fever | ☐ Anemia | ☐ Other _____ |
| ☐ Asthma | ☐ Arthritis | |
| ☐ Bronchitis | ☐ Osteoporosis | |
| ☐ Pneumonia | ☐ Gout | |
| ☐ Ulcer | ☐ Anxiety | |
| ☐ GI Disorder | ☐ Depression | |

HABITS

- | | | |
|---|------------------------|-------------------------|
| ☐ Smoke: Packs daily _____ | How long? _____ | When stopped? _____ |
| ☐ Coffee: Cups daily? _____ | Other caffeines? _____ | Diet: Salt intake _____ |
| ☐ Exercise routine: _____ | | Fat intake _____ |
| ☐ Alcohol: Type/Amount _____ | | |
| ☐ SLEEP: Difficulty falling asleep ☐ Snoring ☐ Daytime drowsiness ☐ Continuity disturbances ☐ Early morning awakening ☐ | | |



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CONSENT FOR RELEASE

CARE CLINIC

Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices Form

I, _____, hereby give my consent to:

CARE CLINIC

To use or disclose, for the purpose of carrying out treatment, payment, or healthcare operations, all information contained in the patient record of:

(patient's name)

I grant permission to view my prescription history from external sources (other physicians.) I consent to report Immunizations to the USA. I have been notified of the physician's Notice of Privacy Practices, which is available at the front desk. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved the right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available at the time of the appointment.

I understand that consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient:

- Patient's file

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initial: _____

Reason: _____



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FINANCIAL POLICY OF CARE CLINIC

Thank you for choosing Care Clinic as your primary care physicians office.

We are committed to providing you with the best possible medical care, and we are available to discuss our professional fees with you at anytime. Your clear understanding of our financial policy is important to our relationship. Your assistance in complying with our payment policies will help control our overhead expenses. Thereby keeping medical fees at a reasonable cost.

If you can't keep an appointment, please give us at least one day's notice. That way we can schedule another patient to see the doctor and you will avoid a \$35.00 charge for a missed appointment.

Full payment or copayment is due at the time of service. We accept cash, check, and all major Credit Cards.

There will be a \$25.00 service charge for any returned check.

Our office will file for commercial insurance and managed care plans (HMO/PPO) with which we are contracted. If we accept your insurance, you must pay any co-payments at the time of service. Your reimbursement is determined by your insurance company to the extent of your coverage. You need to be aware of covered benefits. Any amount indicated as patient responsibility by your insurance company is due within 30 days.

As all insurance plans have specific rules and regulations regarding the use of certain labs and treatment centers, as well as referrals to specialists, we ask that you be aware of your plans directives and inform the doctors of them so that they can try as much as possible to keep within the scope of your plan, especially if the need arises at night or over the weekend.

Please notify our office immediately when you change medical insurance, home address or telephone numbers.

Bring your current insurance card every time you visit our office. It contains valuable information regarding coverage and benefits. If your insurance card has not been issued to you by the time of your visit you will be treated as a self-pay patient. Payment will be expected at the time of the visit and the claim will be submitted for you when you receive your card.

I have read and I agree to the terms of this financial policy.

(Signature of patient or legal guardian)

Date _____

Thank you for understanding our financial policy.
Please let us know if you have any questions or concerns.