PATIENT HISTORY

DATE _____

LAST NAME	FIRST NAME	MIDDLE	GENDER	BIRTH DATE	SSN

_____

STREET ADDRESS _____

MAILING ADDRESS (IF DIFFERENT) _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____(OKAY TO CONTACT YOU AT WORK?) Y N

CELL PHONE _____ EMAIL _____

By providing any/all of the contact information above, I authorize Our Family Doctor to contact me/my guardian or legal representative to remind me of appointments, obtain feedback, and provide health & wellness information. To opt out of the consent to receive calls, texts and emails described above, please check this box ☐

GENDER IDENTITY_____ SEXUAL ORIENTATION _____ PRONOUNS _____

ETHNICITY: HISPANIC/LATIN: YES☐ NO☐

RACE _____

LANGUAGE PREFERENCE _____

PREFERRED METHOD OF COMMUNICATION: HOME PHONE ☐ CELL PHONE ☐ POSTAL/MAIL ☐ WEB MESSAGE ☐

EMPLOYER _____ OCCUPATION _____

WORK ADDRESS _____ WORK PHONE _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____

RELATIONSHIP TO PATIENT _____

SOCIAL SECURITY # _____ PARENT/SPOUSE SS# _____

INSURED THROUGH EMPLOYER □ Yes □ No

PRIMARY INSURANCE COMPANY _____ GROUP # _____

POLICY HOLDER NAME _____ POLICY HOLDER DOB _____

NAME OF INSURED _____ RELATIONSHIP _____ BIRTH DATE _____ SS# _____

SECONDARY INSURANCE COMPANY _____ GROUP #
_____

NAME OF INSURED _____ RELATIONSHIP _____ BIRTH DATE _____ SS# _____

EMERGENCY CONTACT _____ RELATIONSHIP _____ PHONE # _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I HEREBY GIVE CONSENT FOR TREATMENT AND ACCEPT RESPONSIBILITY FOR THE FULL AMOUNT OF THE CHARGES INCURRED FOR MY TREATMENT. I AUTHORIZE OUR FAMILY DOCTOR TO FURNISH INFORMATION TO MY INSURANCE CARRIERS CONCERNING MY TREATMENT AND I HEREBY ASSIGN OUR FAMILY DOCTOR ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF/MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY THE INSURANCE CARRIER. I AUTHORIZE THE USE OF PHOTO STATIC COPY OF THIS STATEMENT IN LIEU OF THE ORIGINAL WHEN NECESSARY. THIS SERVES AS A LIFETIME AUTHORIZATION UNLESS REVOKED BY ME IN WRITING.

SIGNATURE _____ DATE _____

MINOR/CHILD CONSENT

I, BEING THE PARENT OR GUARDIAN OF _____ DO HEREBY REQUEST AND AUTHORIZE OUR FAMILY DOCTOR AND ITS STAFF TO PERFORM NECESSARY SERVICES FOR MY CHILD WHICH ARE ADVISABLE BY HIS/HER PHYSICIAN, WHETHER OR NOT I AM PRESENT AT THE ACTUAL APPOINTMENT WHEN THE TREATMENT IS RENDERED.

SIGNATURE _____ DATE _____

PATIENT HEALTH HISTORY AGES 18 AND UP

PATIENT NAME _____ DATE _____

REASON FOR VISIT:

_____

ALLERGY HISTORY:

□ No Known Allergies □ No Known Drug Allergies □ Allergy History Unknown
□ Have had an "Allergic Reaction", but do not know cause? Reaction Experienced: _____

Medication Allergies/Reactions:

□ Med:_____ Reaction:_____	□ Med:_____ Reaction:_____
□ Med:_____ Reaction:_____	□ Med:_____ Reaction:_____
□ Med:_____ Reaction:_____	□ Med:_____ Reaction:_____

Food Allergies/Reactions:

□ Food:_____ Reaction:_____	□ Food:_____ Reaction:_____
□ Food:_____ Reaction:_____	□ Food:_____ Reaction:_____
□ Food:_____ Reaction:_____	□ Food:_____ Reaction:_____

Environmental Allergies/Reactions:

□Mold_____ Reaction:_____	□ Pollen _____ Reaction:_____
□Dust _____ Reaction:_____	□ Insect Bite_____ Reaction:_____
□ Other: _____ Reaction:_____	□ Other: _____ Reaction:_____
□ Other: _____ Reaction:_____	□ Other: _____ Reaction:_____

PAST MEDICAL HISTORY **(**PLEASE CHECK OFF ANY CONDITIONS THAT YOU HAVE BEEN DIAGNOSED WITH)

□ Asthma	□ Diabetes
□ Bleeding Disorder	□ High Cholesterol
□ Cancer _____	□ Hypertension
□ Cancer _____	□ Kidney Disease
□ Cancer _____	□ Osteoporosis
□ CHF	□ Sleep Apnea
□ COPD (Emphysema)	□ Suicide
□ Coronary Heart Disease	□ Thyroid Problems
□ CVA (stoke) / TIA	□ Tuberculosis
□ Depression	□ Other_____

FAMILY HISTORY:

□ Asthma	Family Member:_____	□ Diabetes	Family Member:_____
□ Bleeding Disorder	Family Member:_____	□ High Cholesterol	Family Member:_____
□ Cancer _____	Family Member:_____	□ Hypertension	Family Member:_____
□ Cancer _____	Family Member:_____	□ Kidney Disease	Family Member:_____
□ Cancer _____	Family Member:_____	□ Osteoporosis	Family Member:_____
□ CHF	Family Member:_____	□ Sleep Apnea	Family Member:_____
□ COPD (Emphysema)	Family Member:_____	□ Suicide	Family Member:_____
□ Coronary Heart Disease	Family Member:_____	□ Thyroid Problems	Family Member:_____
□ CVA (stoke) / TIA	Family Member:_____	□ Tuberculosis	Family Member:_____
□ Depression	Family Member:_____	□ Other_____	Family Member:_____

SOCIAL HISTORY:

PRESENT/MOST RECENT PROFESSION/OCCUPATION: _____

HIGHEST LEVEL OF EDUCATION: □ Grade School □ High School □ College/University □ Graduate degree

MARITAL STATUS: □ Single □ Committed Relationship □ Married □ Divorced □ Widowed

SEXUAL PREFERENCE/IDENTITY: □ Heterosexual □ Homosexual □ Bisexual □ Transgender

LIVING SITUATION: Who lives at home with you? _____

EXERCISE: _____ Hours/Day _____ Day(s) Weekly **SLEEPING HABITS**: _____ Hours Nightly

TOBACCO USE:

□ **Never Smoked**	□ **Current Smoker** (_____ packs /day)	□ **Smoker of non-cigarettes such as Cigars and E-Cigarettes** Type: _____	□ **Chew/Snuff/Dip** How Much? _____
□ **Former Smoker**	When did you quit? Date: _____		

ALCOHOL USE:

□ Do Not Drink	□ Occasional Use (1-8 beverages x monthly)	□ Moderate Use (2-10 beverages weekly)	□ Heavy Use (6+ beverages daily)
□ Quit Drinking (When?)	Date: _____		

DRUG USE: □ Never □ Past Drug Use □ Quit Drug Use (When?) Date: _____

Drug Used? _____	□ Intermittent Use (Social 1x 1-3 months)	□ Occasional Use (2-3 x monthly)	□ Daily Use (1-2 x Daily)
Drug Used? _____	□ Intermittent Use (Social 1x 1-3 months)	□ Occasional Use (2-3 x monthly)	□ Daily Use (1-2 x Daily)

NUTRITION: □ Well Balanced Diet □ Vegetarian/Vegan □ Could be better □ Poorly Balanced

CAFFEINE USE: □ Coffee □ Tea (hot or iced) □ Soda □ Energy Drink □ Other _____
How many servings per typical day? _____

HIV RISKS? □ Yes □ No **If yes, what are your risk factors?** □ Unprotected Sex □ Injection Drug User □ Occupation □ Caregiver of HIV Pos. Individual(s) □ Transfusion Recipient □ Other: _____

ENVIRONMENTAL EXPOSURE:

□ Pets / Animals	□ Smoke (Non-Tobacco)	□ Smoke (2nd Hand)	□ Chemicals (_____)
How often exposed?	How often exposed?	How often exposed?	How often exposed?

TRAVEL HISTORY: Have you traveled outside of the US recently? Where and When?

Country / Date:	Country / Date:	Country / Date:	Country / Date:
/	/	/	/

MEDICATION HISTORY:

List only medications currently being taken; include over the counter drugs and vitamins/supplements.

Name:	Dose: (2 x daily, etc)	**Name:**	Dose: (2 x daily, etc)

PAST SURGICAL:

Name of Procedure:	Date Performed:	Where/Who performed by:

PAST DIAGNOSTIC STUDIES: (PLEASE LIST ALL PAST/RECENT DIAGNOSTIC STUDIES YOU HAVE HAD)

Name of Procedure/Lab:	Date Performed:	Where/Who performed by:
MAMMOGRAM		
COLONOSCOPY		
BONE DENSITY (DEXA) SCAN		
PAP SMEAR		

PAST IMMUNIZATIONS:

Name of Immunization:	**Approximate Date (if known)**
Tetanus / TdaP	
Pneumonia (Pneumovax/Prevnar)	
Influenza	
Zostavax (Shingles)	
Gardasil (HPV Vaccine)	
PPD (TB Test)	

ADDITIONAL COMMENTS:

HAVE YOU EVER RESPONDED ADVERSELY TO MEDICAL OR DENTAL TREATMENT? _____

DO YOU SEE A DENTIST REGULARLY? (CIRCLE ONE) YES NO (If yes, when was last visit?) _____

ARE YOU UNDER THE CARE OF ANOTHER PHYSICIAN? (CIRCLE ONE) YES NO (If yes) WHO?_____

DO YOU THINK YOU MAY BE PREGNANT? (CIRCLE ONE) YES NO ARE YOU NURSING? (CIRCLE ONE) YES NO

IS THERE ANY *MEDICAL HISTORY* OR COMMENTS RELATED TO YOUR CONDITION(S) THAT YOU WOULD LIKE TO NOTE?

_____

_____

_____

REVIEW OF SYSTEMS

Patient Name: _____

Please circle all that apply to you today		
General:	**HEENT:**	**Respiratory:**
Appetite change	Ear Drainage	Cough
Fatigue	Ear Pain	Coughing up blood
Feeling Well	Headache	Difficulty Breathing
Fever	Hearing Loss	Sleep Apnea
Weight Change	Hoarseness	Snoring
	Nasal Congestion	Wheezing
Skin:	Runny Nose	
Itching	Seasonal Allergies	**Breast:**
Hair Changes	Sinus Pain	Breast Mass
Nail changes	Sneezing	Breast Pain
New Skin Lesions	Sore Throat	Breast Swelling
Rash	Visual Change/Disturbance	Nipple Discharge
Neck:	**Cardiovascular:**	**Psychiatric:**
Neck Pain	Chest Pain	Anxiety
Swollen Glands	Difficulty Breathing lying down	Change in sleep pattern
	Difficulty Breathing on Exertion	Depression
Gastrointestinal:	Elevated Blood Pressure	Easily Irritated
Abdominal Pain	Fainting	Frequent Crying
Belching	Heart Palpitations	Insomnia
Black, tarry stool (melena)	Irregular Heartbeat	Memory Loss
Bloating	Leg Cramps	Mood Changes
Change in Bowel Habits	Shortness of Breath	Panic Attacks
Constipation	Swelling of Extremities	Personality Changes
Diarrhea		Suicidal Ideation
Difficulty Swallowing	**Hematology:**	
Excessive Gas	Abnormal Bleeding	**Female Genitourinary:**
Heartburn	Easy Bruising	Change in bladder habits
Nausea	Enlarged Lymph Nodes	Frequent Urination
Rectal Bleeding	Prolonged Bleeding	Irregular Periods
Vomiting		Painful Urination
		Pelvic Pain
Musculoskeletal:		Urgent Urination
Back Pain	**Neurological:**	Vaginal Discharge
Joint pain	Decreased Memory	
Leg pain	Dizziness	**Male Genitourinary:**
Muscle pain	Numbness	Change in bladder habits
	Spinning Sensation/Vertigo	Change in urinary stream
Endocrine:	Tremor	Erectile Dysfunction
Cold Intolerance	Weakness	Penile Discharge
Excessive Thirst or Urination		Penile Lesions
Hot Flashes		Testicular Mass
Libido (sex drive) Changes		Testicular Pain

FINANCIAL POLICY

Your insurance contract is an agreement between you, your insurance company and in any instances, your employer. The financial side of medical practices has become increasingly complex over the past few years with the advent of managed care and the many different types of insurance plans now available. We try our best to be familiar with the regulations and restrictions of each company, though you, the patient, are ultimately responsible for understanding the details of your own health care coverage. The following are the guidelines we use to regulate the financial side of our practice. Please make yourself familiar with these and let us know if you have any questions.

1. All charges are due at the time of service unless other arrangements have been made in advance.
2. Medicaid co-pays will be collected at the time of service in accordance with Carolina Access policy which states “failure to make co-pays will result in dismissal.”
3. Patients with third party insurance plans which require co-pays will pay their own co-pay at sign in. Failure to do may result in the patient not being seen by the provider unless it is a genuine medical emergency. We will gladly bill your insurance company for the remainder of the charges associated with your visit. Please be aware that there may be an additional balance even after your insurance payment due to your deductible and/or any non-covered services. If so, our Billing Supervisor will notify you, and the additional charges will need to be paid within 30 days of receipt of your bill.
4. We file claims for a limited number of insurance plans only. These include: Blue Cross Blue Shield, Cigna, Crescent Health Plans, Medcost, Medicaid, Medicare, Medicare Advantage, Aetna, United Health Care, Wellpath / Coventry. If you are covered by other plans you will need to file your own insurance and payment in full will be expected at the time of service.
5. Charges for all hospital and emergency visits will be filed with most insurance companies. If your company has not responded within 60 days of our filing then the charges will be sent to you directly and you will be responsible for them as with any other charges.
6. We are not contractually required to file claims for Medicare secondary plans; however, we will file them once only as a courtesy. Should the company not respond within 45 days of our filing, then the charges will be sent to you directly and you will be responsible for them as with any other charges.
7. Claims for non-Medicare secondary plans are not filed by this office.
8. Charges for services rendered to children whose parents are divorced will be the responsibility of the parent who seeks treatment for the child and are due at the time of service, irrespective of any court-ordered responsibility for medical costs.
9. We will make a charge of $25.00 for any returned checks, and such checks will not be re-deposited. Personal checks will no longer be accepted from any patient who has previously presented a check which was returned.
10. While we always see patients for emergency care, routine care will only be given to patients whose accounts are current or have made financial arrangements with us, and maintaining the conditions thereof.

11. We try to leave work-in time each day to see those patients who call in with problems that need to be managed that day. If you request that an appraisal of your condition be made over the phone and some treatment is given without an office visit, you will be charged $25.00 to cover the cost of Our Family Doctor staff time involved. Such charges are not covered by insurance plans and therefore are the responsibility of the patients. This includes any new prescription that is given over the phone without an office visit.
12. If you fail to keep a schedule appointment with a provider or the lab, and do not give the office 24 hours notice of cancellation, you will be charged a missed appointment fee. For a missed visit with a provider or nutrition counseling, there will be a charge of $35.00. For a missed lab appointment, there will be a charge of $15.00. These charges are made to cover the staffing costs, whether or not you keep your appointment. Also, not notifying us timely prevents other patients from using that time slot.
13. There will be a minimum of $10.00 fee, payable in advance, when medical records are requested to be sent to a new doctor and/or patient forms to be completed (not received at the time of the office visit). The fee may be higher depending on the size of the medical record.

I have read and understand the financial policy of Our Family Doctor. My signature below acknowledges that any questions I may have regarding the policy have been fully explained and answered.

Patient Name _____ Signature _____

Date _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION (PLEASE REVIEW IT CAREFULLY)

USES AND DISCLOSURES

Treatment Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical records to all health professionals who may provide treatment or who may be consulted by staff members.

Payment Your health information may be used to seek payment from your health plan, from other sources of coverage such as automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations Your health information may be used as necessary to support the day-to-day activities and management of Our Family Doctor. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public Health Reporting Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's health department.

Other Uses AND Disclosures Require Your Authorization

Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment Reminders Your health information will be used by our office to send or telephone you appointment reminders.

Information About Treatments Your health information may be used to send you information that you may find interesting on the treatment or management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights
You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Our Family Doctor Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revised Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Receptionist or Practice Manager. Your request will be reviewed and generally be approved unless there are legal or medical reasons to deny the request.

Complaints and Contact Information
The name and address of the person you may contact for further information concerning our privacy practice is noted below. If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Karen Fisher, Practice Manager
Our Family Doctor
43 Oakland Road
Asheville, NC 28801
(828) 252-2511
If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Effective Date: as of August 29, 2011

PATIENT INFORMATION CONSENT FORM

I HAVE READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICES FOR OUR FAMILY DOCTOR. I UNDERSTAND THAT OUR FAMILY DOCTOR MAY USE OR DISCLOSE MY PERSONAL HEALTH INFORMATION FOR THE PURPOSE OF CARRYING OUT TREATMENT, OBTAINING PAYMENT, EVALUATING THE QUALITY OF SERVICES PROVIDED. THIS INCLUDES ELECTRONIC ACCESS TO MEDICATION HISTORY AND ANY ADMINISTRATIVE OPERATIONS RELATED TO THE TREATMENT OR PAYMENT. I UNDERSTAND THAT I HAVE THE RIGHT TO RESTRICT HOW MY PERSONAL HEALTH INFORMATION IS USED AND DISCLOSED FOR TREATMENT, PAYMENT AND ADMINISTRATIVE OPERATIONS IF I NOTIFY THE PRACTICE IN WRITING. OUR FAMILY DOCTOR RESERVES THE RIGHT TO MODIFY THE PRIVACY PRACTICES OUTLINED IN THE NOTICE. THIS NOTICE OF PRIVACY IS AVAILABLE IN OUR RECEPTION AREA OF THE OFFICE AND ON OUR WEBSITE.

NAME OF PATIENT _____ DATE _____

SIGNATURE OF PATIENT _____

SIGNATURE OF PATIENT REPRESENTATIVE/ RELATIONSHIP OF PATIENT REPRESENTATIVE TO PATIENT
(required if patient is a minor or adult unable to sign this form)

_____

DESIGNATED INDIVIDUALS AUTHORIZATION

IN ORDER TO PROTECT YOUR PATIENT CONFIDENTIALITY, WE NEED TO KNOW IF THERE IS A PHONE NUMBER (WITH VOICEMAIL) FOR YOU WHERE WE LEAVE RESULTS OF YOUR LABORATORY TESTS OR OTHER SENSITIVE INFORMATION. PLEASE INDICATE THE INFORMATION BELOW, AND WE WILL KEEP THIS IN YOUR FILE UNTIL YOU INSTRUCT US IN WRITING TO REMOVE IT.

I GIVE OUR FAMILY DOCTOR EMPLOYEES PERMISSION TO LEAVE CONFIDENTIAL HEALTH CARE INFORMATION FOR ME AT THE FOLLOWING PHONE NUMBER(S):

_____ (IF NONE, PLEASE NOTE)

_____ (IF NONE, PLEASE NOTE)

_____ (IF NONE, PLEASE NOTE)

I UNDERSTAND THIS NUMBER(S) WILL BE USED UNTIL I NOTIFY OUR FAMILY DOCTOR IN WRITING IF THEY SHOULD NO LONGER USE.

I AUTHORIZE THE FOLLOWING PERSONS TO RECEIVE INFORMATION REGARDING MY MEDICAL STATUS (INCLUDING ACCESS TO MY MEDICAL RECORDS) AND FINANCIAL RECORDS ONGOING:

NAME _____ RELATIONSHIP _____ PHONE _____

NAME _____ RELATIONSHIP _____ PHONE _____

NAME _____ RELATIONSHIP _____ PHONE _____

NAME _____ RELATIONSHIP _____ PHONE _____

NAME _____ RELATIONSHIP _____ PHONE _____

NAME _____ RELATIONSHIP _____ PHONE _____

SIGNATURE _____ DATE _____

ADVANCED BENEFICIARY NOTICE

I have been informed of the Medication Pre-Authorization Policy at Our Family Doctor. I have been notified that there will be an administration fee of $5.00 for each pre-authorization required by my insurance.

I understand this service is not covered by my insurance and I agree to be financially responsible for these charges.

Patient Name (print): _____

Date: _____ Signature: _____