Redmond Medical Clinic

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HEALTH HISTORY

Patient Name _____ Birth Date_____ Today's Date: _____

PAST MEDICAL HISTORY:
Have you ever had the following? (Check Yes or No – leave blank if uncertain)

	Yes	No		Yes	No		Yes	No	
Chickenpox			Diabetes			AIDS or HIV+			Any other diseases? (please list below)
Scarlet Fever			Cancer			Bronchitis			
Pneumonia			Polio			Mitral Valve Prolapse			
Rheumatic Fever			Glaucoma			Stroke			
Heart Disease			Hernia			Hepatitis			
Arthritis			Blood or Plasma Transfusions			Ulcer			
Venereal Disease						Kidney Disease			
Anemia			Back Trouble			Thyroid Disease			
Bladder Infections			High Blood Pressure			Bleeding Tendency			
Epilepsy			Low Blood Pressure						
Migraine Headaches			Hemorrhoids						
Tuberculosis			Asthma						

Previous Hospitalizations / Surgeries / Serious Illnesses	**When?**	**Hospital, City, State**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIC / IMMUNOLOGIC:
History of skin reaction or other adverse reaction to:

	Yes	No		Yes	No
Penicillin or other antibiotics			Morphine, Demerol, or other narcotics		
Novocain or other anesthetics			Aspirin or other pain remedies		
Tetanus antitoxin or other serums			Lodine, Merthiolate or other antiseptic		

Other drugs/medications: _____
Known food allergies: _____
Environmental allergies: _____

PAST SOCIAL HISTORY: (Check all that apply)

Marital Status Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____
Use of alcohol: Never: _____ Rarely: _____ Moderate: _____ Daily: _____
Use of tobacco: Never: _____ Previously but quit: _____ Current packs/day: _____ Chew: _____
Use of Drugs: Never: _____ Type/Frequency: _____

Excessive exposure at home or work to: Fumes: _____ Dust: _____ Solvents: _____ Airborne Particles: _____ Noise: _____

FAMILY MEDICAL HISTORY:

	Age	Diseases	If deceased, cause of death
Father			
Mother			
Siblings'			
Spouse			
Children			

REVIEW OF SYSTEMS: (Please indicate any personal history below)

	Yes	No		Yes	No		Yes	No
CONSTITUTIONAL SYSTEMS			**GASTROINTESTINAL**			**INTEGUMENTARY (SKIN/BREAST)**		
Good general health lately			Loss of appetite			Rash or itching		
Recent weight change			Change in bowel movements			Change in skin color		
Fever			Nausea or vomiting			Change in hair or nails		
Fatigue			Frequent diarrhea			Varicose veins		
Headaches			Painful bowel movements or constipation			Breast pain		
EYES:			Rectal bleeding or blood in stool			Breast lump		
Eye disease or injury			Abdominal pain			Breast discharge		
Wear glasses/contact lenses			**GENITOURINARY**			**NEUROLOGICAL**		
Blurred or double vision			Frequent Urination			Frequent/Recurring headaches		
EARS/NOSE/MOUTH/THROAT			Burning or painful urination			Light headed or dizzy		
Hearing loss or ringing			Blood in urine			Convulsions or seizures		
Earaches or drainage			Change in force of strain when urinating			Numbness or tingling sensations		
Chronic sinus problem or rhinitis			Incontinence or dribbling			Tremors		
Nose bleeds			Kidney stones			Paralysis		
Mouth sores			Sexual difficulty			Head injury		
Bleeding gums			Male – testicle pain			**PSYCHIATRIC**		
Bad breath or bad taste			Female – pain with periods			Memory loss or confusion		
Sore throat or voice change			Female – irregular periods			Nervousness		
Swollen glands in neck			Female – vaginal discharge			Depression		
CARDIOVASCULAR			Female – number of pregnancies			Insomnia		
Heart trouble			Female – number of miscarriages			**ENDOCRINE**		
Chest pain or angina pectoris			Female – date of last pap smear			Glandular or hormone problem		
Palpitation			**MUSCULOSKELETAL**			Excessive thirst or urination		
Shortness of breath w/walking or lying flat			Joint pain			Heat or cold intolerance		
Swelling of feet, ankles or hands			Joint stiffness or swelling			Skin becoming drier		
RESPIRATORY			Weakness of muscles or joints			Change in hat or glove size		
Chronic or frequent coughs			Muscle pain or cramps			**HEMATOLOGIC/LYMPHATIC**		
Spitting up blood			Back pain			Slow to heal after cuts		
Shortness of breath			Cold extremities			Bleeding or bruising tendency		
Wheezing			Difficulty in walking			Anemia		
						Blood clot		
						Past transfusion		
						Enlarged glands		

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of Patient, Parent or Guardian **Date**

_____ _____

Provider Signature **Date**

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Patient Registration Form

(**PLEASE PRINT**)

PATIENT INFORMATION:
Name – Last, First, Initial

Home Phone ( )

Cell Phone ( )

Mailing Address City State Zip

Birth Date / /

Sex M F

Social Security Number

Married / Single / Other
Spouse Name:

Employer Name & Phone

E-mail Address

Race Ethnicity Language

For new patients only: How did you hear about us? ☐Physician Referral ☐Friend/Family Member/Patient ☐Advertisement (what source?:_____) ☐Provider Directory ☐Other:_____

First Visit to the clinic? Yes No

Family Physician:

RESPONSIBLE PARTY: (IF DIFFERENT FROM PATIENT)
Name – Last, First, Initial

Home Phone ( )

Cell Phone ( )

Mailing Address City State Zip

Birth Date / /

Sex M F

Relationship to patient

Social Security Number

Employer Name & Phone

EMERGENCY CONTACT INFORMATION:

Name Relationship Phone

HEALTH INSURANCE INFORMATION: (COPY OF CARD NEEDED)

1st Insurance	Policy Number	Group Number
Subscriber's Name	Subscriber's DOB	Relationship to Patient
2nd Insurance	Policy Number	Group Number
Subscriber's Name	Subscriber's DOB	Relationship to Patient

FINANCIAL AGREEMENT:

I, the undersigned, ☐ have insurance coverage, ☐ do not have insurance coverage and authorize direct payment to Redmond Internal Medicine Clinic LLP DBA Redmond Medical Clinic.

I acknowledge that I have read the Financial Agreement, and agree that I am financially responsible for all charges, whether or not paid by my insurance. IF IT BECOMES NECESSARY FOR THIRD PARTY COLLECTION, THE UNDERSIGNED AGREES TO PAY FOR ALL COSTS AND EXPENSES INCLUDING REASONABLE ATTORNEY FEES.

SIGNATURE:_____ DATE _____

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Prescription History Consent

☐ **YES** ☐ **NO**

I voluntarily consent to provide Redmond Medical Clinic access to and use of my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes. I understand that my prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions dating back several years. I acknowledge that Redmond Medical Clinic may use health information exchange systems to electronically transmit, receive and/or access my prescription history. I understand that this Prescription History Consent will be valid and remain in effect as long as I receive services from Redmond Medical Clinic, unless revoked by me in writing.

Signature: _____ Date: _____

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

This release allows your medical information to be given to the individuals (family/friends) you list below.
It is a permanent document in your chart and will remain in effect until you contact medical records in writing for it to be updated.

I authorize the following people:

_____

_____

_____

_____
(put a line through if no one is to be authorized)

Sign and date form for it to take effect. I understand this release will remain in effect until I contact Redmond Medical Clinic records in writing.

Signature _____ Date_____

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Financial Policy

All patients must read and sign this document, which will become a permanent part of the patient chart.

We accept cash, checks, and most major credit cards. If you are unable to meet your payment obligations, your appointment will be rescheduled to a more convenient time. We appreciate your understanding in this matter.

Please be aware that we will add a $25.00 charge to your account for returned checks. We reserve the right to send all accounts with balances over 60 days old to an outside collection agency. You may be responsible for all reasonable collection and attorney costs.

Insurance

Please note that you, the patient, have a contract with your insurance carrier. We cannot guarantee that your insurance will cover our services. Therefore, we strongly suggest that you verify coverage options with your insurance carrier prior to your appointment. We will gladly bill your insurance carrier for the service we provide, however if your insurance has not paid within 30 days, we reserve the right to make it your responsibility to follow up with them.

It is the patient's responsibility to notify the clinic of any changes in your insurance coverage. Please bring your insurance card(s) to every visit so we may ensure our records are kept current.

Please be aware that many insurance plans do not cover lab services, procedures or immunizations under their office visit benefit, which can result in a greater out-of-pocket expense for you beyond the office visit co-pay amount. If you have scheduled an annual physical or preventative exam, and you wish the physician to address other concerns during that appointment time, the additional service we provide will be billed to your carrier.

In addition, I authorize electronic release of my demographic and insurance billing information, as necessary, in order to facilitate treatment, payment, or other healthcare operations to medical providers or insurance companies involved in my medical care.

Uninsured Patients

If you plan to pay privately for your services, please be advised that it is Redmond Medical Clinic's practice to collect payment in full at the time of service. For your convenience we can offer you a prompt pay discount toward your office visit charge. If you are unable to make payment in full at the time of service, your appointment will be rescheduled to a more convenient time. We appreciate your understanding.

Worker's Compensation

If you believe your injury is work related, you must tell us **BEFORE** being seen by the doctor. You are required to notify your employer and initiate a worker's compensation claim. You must provide us with complete employer information, claim information (i.e., work comp insurance carrier, claim number), and the details surrounding your injury.

We also require you to furnish us with your regular health insurance information in the event that your work comp carrier denies your claim. If you do not have health insurance and your work comp claim is denied, you will be held responsible for the balance in its entirety.

Motor Vehicle Accidents (MVA)/Third Party Liability

We will require all claim details (claim #, contact info, billing address) at the time of your appointment; otherwise we will require payment in full for services rendered for each patient being treated for a MVA/other accident-related injury. We will file claim(s) with the motor vehicle or third party insurance company that you designate, provided we receive all necessary information with which to bill. If the claims are denied, or a protracted lawsuit is involved, the patient is responsible to pay the account balance in full. We will bill your private health insurance for balances left after your personal injury protection (PIP) is exhausted.

Form Fees

Please be advised that we may need to charge $25.00 for additional paperwork that may be required for your work comp carrier, employer, other insurance carriers or attorneys. This fee covers our administrative expenses related to physician/staff time, photocopying, mailing, etc.

Collection Status / Bankruptcy Patients

If your account is in a collection status or a bankruptcy is filed, We will require all future visits be paid upfront. Our relationship with you may also need to be terminated if your financial obligations are not met.

I acknowledge that I have received a copy of this financial policy. I agree to read this document and comply with the terms set forth in this policy for services rendered by Redmond Medical Clinic.

_____ _____

Patient Signature **Date**

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Acknowledgment and Consent

I understand that Redmond Medical Clinic will use and disclose health information about me.

I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results diagnoses, treatments, procedures, prescriptions, and similar types of health related information.
I understand and agree that Redmond Medical Clinic may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment.
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment.
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care:
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost effective health care.

I also understand that I have the right to receive and review a written description of how this practice will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the practices followed by employees, staff and other office personnel of this practice, and my right regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

Patient: _____ Date: _____

Representative: _____ Date: _____

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Advance Directive Questionnaire

Name:_____ Date of Birth:_____

☐ Yes, I have executed an Advance Directive

☐ No, I have not executed an Advance Directive

Signature:_____ Date:_____