## PATIENT INFORMATION

LAST NAME_____FIRST NAME_____M.I._____NICKNAME_____

STREET ADDRES_____APT_____P.O. BOX_____

CITY_____STATE_____ZIP_____D.O.B._____AGE____

SS#____-_____-_____GENDER M F MARITAL STATUS _____REFERRED TO US BY_____

HOME PHONE_____WORK_____EXT_____CELL_____

MAY WE LEAVE A DETAILED MESSAGE RE:TEST RESULTS/CLINICAL INFORMATION **YES** **NO**

## WORK INFORMATION

EMPLOYER NAME_____OCCUPATION_____

ADDRESS_____

## INSURANCE INFORMATION

PRIMARY
INSURANCE_____SUBSCRIBER_____SS#_____-_____-_____RELATIONSHIP_____
DOB_____

SECONDARY
INSURANCE_____SUBSCRIBER_____SS#_____-_____-_____RELATIONSHIP_____
DOB_____

## SPOUSE OR PARENT'S INFORMATION

NAME_____DOB_____SS#_____-_____-_____

EMPLOYER NAME_____PHONE_____

EMPLOYER ADDRESS_____

## EMERGENCY CONTACT INFORMATION

NAME_____ADDRESS_____RELATIONSHIP_____

HOME PHONE#_____CELL#_____WORK#_____

I AUTHORIZE THE RELASE OF MY MEDICAL INFORMATION FOR PURPOSE OF TREATMENT, PAYMENT AND HEALTHCARE OPERATION. ADDITIONALLY, I AUTHORIZE AND ASSIGN ANY PAYMENT OF MEDICAL BENEFITS TO HEBRON MEDICAL ASSOCIATES,LLC, ITS SUCCESSORS AND ASSIGNS, OR ANY INDIVIDUAL IT MAY DESIGNATE FOR SERVICES PROVIDED.

AS PART OF THIS AUTHORIZATION, HEBRON MEDICAL ASSOCIATES, LLC WILL RELEASE HIV, DRUG AND ALCOHOL, AND MENTAL HEALTH/PSYCHIATRIC INFORMATION AS REQUIRED BY LAW.

I AGREE TO PAY INTERST AT THE PREVAILLING RATE FOR AMOUNTS 30 DAYS PAST DUE, AS WELL AS ALL COSTS, INCLUDING ATTORNEY'S FEES, ASSOCIATED WITH THE COLLECTION OF ANY AMOUNTS DUE, FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO HEBRON MEDICAL ASSOCIATIES, LLC, ITS SUCCESSORS AND ASSIGNS OR ANY INDIVIDUAL IT MAY DESIGNATE FOR AMOUNTS OWED BY ME IN ACCORDANCE WITH MY HEALTH BENEFIT COVERAGE. I ACKNOWLEDGE THAT I WILL BE RESPONSIBLE FOR ALL UNPAID CLAIMS IF I FAIL TO PROVIDE INSURANCE INFORMATION WITHIN MY HEALTH PLANS FILING LIMIT FOR SERVICES RENDERED.

SIGNATURE OF PATIENT OR PARENT OF MINOR_____DATE_____

**MEDICARE AUTHORIZATIN FOR TREATMENT PAYMENT& HEALTHCARE OPERATIONS MEDICARE RECIPIENTS SIGN BOTH**

I AUTHORIZE THE RELEASE OF MY MEDICALINFORMATION FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS. I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO HEBRON MEDICAL ASSOCIATES,LLC FOR SERVICES FURNISHED TO ME BY THE PROVIDERS. I AUTHORIZE ANY HOLDER OF MY MEDICAL INFORMATION TO RELEASE TO THE CENTERS FOR MEDICARE AND MEDICAID SERVICES AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE BENEFITS FOR RELATED SEVICES RENDERED.

PATIENT'S SIGNATURE_____DATE_____

# TO ALL OUR PATIENTS

This notice is to inform all patients that for over 10 years now physicians have been allowed by most insurance companies to bill a separate office procedure (called a "carve out") when a patient is scheduled for their routine exam. This will occur when your concerns or issues other than routine care are presented at the time of the exam. Also if you have chronic issues that need periodic follow up, for state of the art medical care, the carve out would apply. This coding procedure saves time for all concerned, but especially for you the patient who can get more accomplished in one visit rather than two separate visits to the doctor. If you do not wish to have this carve out procedure included with your physical exam and prefer to come back for a separate visit to address your concerns/symptoms, please notify the provider you are seeing at the time of your exam

This notice is being brought to your attention because we as your provider want you to be aware of changes in the insurance industry. With more and more of our patients having medical insurance plans with high deductibles or HSA accounts, this issue has become more apparent to the patient.

Revised 9/12

Signature Date

# CONFIDENTIAL HEALTH HISTORY

Name: _____ Date: _____

Birthdate: _____ Age: _____ Date of last physical examination: _____

Occupation: _____

Reason for visit today: _____

| **MEDICATIONS** List all medications you are currently taking | **ALLERGIES** List all allergies |
|---|---|
| | |
| | |
| | |
| | |

**SYMPTOMS** Check ( ✓ ) symptoms you currently have or have had in the past year.

### GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

### MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

### GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

### GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

### CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

### EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision - Flashes
- ☐ Vision - Halos

### SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sores that won't heal

### MEN only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

### WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____
When last done? _____
Are you pregnant? _____

Number of children _____