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 INTEREST 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

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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
- ☐ Hips
- ☐ Back
- ☐ Legs
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ 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 __________

MEDICAL HISTORY Check (✓) the medical conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Gall Bladder Disease
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

CONFIDENTIAL HEALTH HISTORY

HOSPITALIZATIONS Year	Hospital	Reason for Hospitalization and Outcome
Do you exercise? Y N		If yes, how often and what type of exercise done?
Date of last eye care		Who performed last eye care?
Date of last tetanus shot		

Have you ever had a blood transfusion? ☐ Yes ☐ No
If yes, please give approximate dates: ______________________

OCCUPATIONAL CONCERNS Check (✓) if your work exposes you to the following:	HEALTH HABITS Check (✓) which substances you use and indicate how much you use per day/week.	PREGNANCY HISTORY Year of Birth	Sex of Birth	Complications if any
☐ Stress	☐ Caffeine			
☐ Hazardous Substances	☐ Tobacco			
☐ Heavy Lifting	☐ Drugs			
☐ Other	☐ Alcohol			

Do you wear seat belts? Y N Do you have smoke detectors in your home? Y N

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME
Any special diet that you are following?		

Date of last sigmoidoscopy?

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if your blood relatives had any of the following Disease	Relationship to you
Father					☐ Arthritis, Gout	
Mother					☐ Asthma, Hay Fever	
Brothers					☐ Cancer	
					☐ Chemical Dependency	
					☐ Diabetes	
					☐ Heart Disease, Strokes	
Sisters					☐ High Blood Pressure	
					☐ Kidney Disease	
					☐ Tuberculosis	
					☐ Other	

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or ommisions that I may have made in the completion of this form.

______________________ Signature ______________________ Date

______________________ Reviewed By ______________________ Date