PATIENT INFORMATION FORM

PATIENT/DEPENDENT INFORMATION

Name: _____ DOB: _____ Social Security # _____
Address: _____ City/State: _____ Zip: _____
Home: _____ Work: _____ Mobile: _____
Gender: Male ___ Female ___ Marital Status: Single ___ Married ___ Other _____
Please check one: Employed ___ Full-time Student ___ Part-time Student ___
Employer Name/Address: _____
Emergency Contact Name/Number: _____

RESPONSIBLE PARTY INFORMATION

Name: _____ DOB: _____ Social Security # _____
Address: _____ City/State: _____ Zip: _____
Home: _____ Work: _____ Mobile: _____
Gender: Male ___ Female ___ Marital Status: Single ___ Married ___ Other _____
Please check one: Employed ___ Full-time Student ___ Part-time Student ___
Employer Name/Address: _____
Relationship to Patient: Husband ___ Wife ___ Child ___ Parent ___ Other _____

INSURANCE INFORMATION

Primary Insurance: _____ Phone: _____
Insured Name: _____ Relationship to Patient: _____ DOB: _____
ID# _____ Group # _____ Is this through your employer: **Yes No**
Secondary Insurance: _____ Phone: _____
Insured Name: _____ Relationship to Patient: _____ DOB: _____
ID# _____ Group # _____ Is this through your employer: **Yes No**

POLICIES AND PROCEDURES ACKNOWLEDMENT

I acknowledge that I have read and agree to the policies and procedures of Chenal Family Practice.

ASSIGNMENT

I request that payment of authorized benefits be made either to me or on my behalf to Chenal Family Practice for services furnished to me. I authorize any holdings of medical information about me to be released to the Health Care Financing Administration and its agents, any information needed to determine these benefits of the benefits payable for related services.

_____ _____

Signature of Patient/Authorized Representative **Date**

Chenal Family Practice
Office Policies and Procedures

APPOINTMENTS

To ensure that each patient is given the proper amount of allotted time for their visit, it is important for each scheduled patient to arrive on time for their appointment. Patients arriving late for an appointment by 15 minutes or more may need to reschedule.

Reminder text/calls are made 2 days prior to appointment. These are **COURTESY** reminders. Patients are responsible for managing their appointments and times.

We try to accommodate same day appointments for urgent or acute illnesses. Patients need to call first thing in the morning between **8:00 -8:30** to request an appointment time.

CANCELLATIONS: Please call within 24 hours if you are unable to keep your scheduled appointment. This allows us to provide that time to another patient who may need it. There are fees for missed appointments which are not properly cancelled. Repeated Missed Appointments may result in discharge from the practice.

INSURANCE

We are contracted with most insurance companies but it is **YOUR RESPONSIBILITY** to make sure that our physician is in your plan. Your insurance policy is a contract between you and your insurance company. It is also **YOUR RESPONSBILITY** to know and understand your individual insurance benefits. It is your **RESPONSIBILITY** to make sure we have your updated insurance information at all times.

We will file your insurance for you; however, your balance on your account is your responsibility if insurance does not pay. There may be some services that are not covered under your policy. Balances after deductibles, copays and non-covered serves will be billed.

PAYMENTS

Copays and account balances must be paid at the time of service and will be collected at the time of checking in for a visit. Failure on our part to collect copays and deductibles from patients can be considered fraud. Please help us in upholding the law by paying copays and balances at each visit.

PATIENT QUESTIONAIRE

CHIEF COMPLAINTS (what are any new medical concerns or goals you have not including anything in your current medical history) ***3 items at most please***

1)_____

2)_____

3)_____

PAST MEDICAL HISTORY: Hypertension High Cholesterol Diabetes Asthma Allergies
Other:
_____

PAST SURGICAL HISTORY: Tonsillectomy Appendectomy Gallbladder C-section Tubal Ligation Vasectomy
Other:
_____

HABITS: Tobacco for _____ years of life Alcohol _____ drinks per day/week

DRUG ALLERGIES: _____
_____

MEDICATIONS (list all meds and doses)

Medication	Dosage	Condition used for

SOCIAL HISTORY: Single Married Divorced Widowed Significant Other
Occupation: _____

FAMILY HISTORY: **Diabetes** -- Father/Mother/Brother/Sister **Coronary Artery Disease** -- Father/Mother/Brother/Sister

IMMUNIZATIONS (most recent year): TDap _____ Pneumo _____ Influenza _____

GYN: Pregnancies # _____ Births # _____ Miscarriages # _____ Abortions # _____
Last Pap Smear: _____ Last Menstrual Period: _____ Last Mammogram (if over 40): _____

CHENAL FAMILY PRACTICE
PATIENT AGREEMENT

In order to maintain compliance with the Arkansas State Medical Board Medical Practice Acts & Regulations; Reg. No. 2, I understand and agree to the following conditions of my medical care:

1) Keep my medication card/information updated and bring it with me to each office visit.

2) Keep each scheduled appointment or call and cancel/rescheduled as soon as possible.

3) Maintain compliance with my medical treatment and/or evaluations as recommended by my primary care physician.

4) I will not accept or fill prescriptions for any DEA scheduled medications, such as Narcotics, Benzodiazepines, and Amphetamines, unless my primary care physician is aware of it.

5) I hereby give my physician consent to treat me with all medications deemed medically necessary, including DEA controlled substances, if the physician deems medically necessary for therapeutic reasons.

_____

Patient Name (Printed)

_____

Patient Signature Date

CHENAL FAMILY PRACTICE

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

In an effort to comply with current HIPAA (Health Insurance Portability Accountability Act) regulations, we need you to complete the following information:

Please list any persons other than your doctor with whom we may discuss your private health information or financial matters:

Name_____ Phone_____ Relationship_____

Name_____ Phone_____ Relationship_____

Name_____ Phone_____ Relationship_____

In the event that we are unable to reach you personally, do you give your permission for Dr. _____ or one of his office staff to leave a message on your answering machine and/or leave a message with someone at your home phone number concerning your private health information or financial matters?

YES ____ NO ____

In accordance with HIPAA standards, CHENAL FAMILY PRACTICE has a document called the ANotice of Privacy Practices@

_____

_____ _____

Patient or legally authorized individual signature Date

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

_____