MEDICAL HISTORY FORM

Name____ Home Phone ______________

Address ____ Cell Phone ______________

City________________________________ State ______________ Date of Birth ____________

Zip Code__________ DL#_________________ Sex __ M __ F Age ________ SS# ____________

Provide email for appointment reminders and announcements ______________________

Race *(optional)* __________________________ Ethnicity *(optional)* ______________________

Patient's Employer____ Occupation ______________

Employer's Address____ Work Phone______________

City________________________________ State______________ Zip Code ______________

Any other family members who have been treated here? __ Yes __ No Name ______________________

How did you find out about our practice? ____

Name of referring physician ___________________________________

INSURED'S INFORMATION

Name of Insured____ Date of Birth____________

Address____ Home Phone______________

Driver's License #__________________________ Social Security # ______________________

Relationship: Husband/Wife/Father/Mother/Son/Daughter ______________ Occupation______________

Employer____ Work Phone______________

Employer's Address____

City________________________________ State______________ Zip Code ______________

IN CASE OF EMERGENCY CONTACT

Name____ Relationship______________

Address ____ Telephone ______________

Our Notice of Privacy Practices (notice) provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As outlined in our notice, the terms of our notice may change. If our notice is changed or modified, you may obtain a revised copy by requested from the receptionist.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this Form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as though original.
3. I may revoke this consent at any time, except where information has already been released. This consent is valid until revoked by me in writing.

____ ______________________

Signature Date

PRIMARY INSURANCE CARRIER

Name of Primary Insurance Company ______________________________

Mailing Address for Insurance Claim ______________________________

Name of Policy Holder ____________________ Relationship to policyholder __________

Name of Employer ____________________ Group No.__________

Policy or ID No. ____________________ Effective Date of Policy__________

Phone Number for Verification ______________________________

Phone Number for Pre-certification ______________________________

SECONDARY INSURANCE CARRIER

Name of Secondary Insurance Company ______________________________

Mailing Address for Insurance Claim ______________________________

Name of Policy Holder ____________________ Relationship to policyholder __________

Name of Employer ____________________ Group No.__________

Policy or ID No. ____________________ Effective Date of Policy__________

Phone Number for Verification ______________________________

Phone Number for Pre-certification ______________________________

NATALIE A. WRIGHT, M.D.

Payment Policy

1. We will file insurance for our PPO patients. However, all co-payment and/or deductible amounts are due at the time of the service. Any disallowed amounts are due from the patient.

2. We do not file insurance for our indemnity patients. Payment in full is expected at the time of visit and a receipt will be given for you to file with your insurance carrier.

3. There will be a twenty-five dollar ($25) fee assessed for any returned check. This fee is assessed regardless of whether the check is redeposited, because the bank has already charged us a fee for the returned item. You will subsequently receive a bill for this amount.

4. If your account has a credit balance of more than $10.00, a refund will be mailed to you within thirty (30) days.

5. **Your insurance policy is a contract between you and your insurance company**. It is important that you understand what physician services are and are not covered before seeing your doctor. **We cannot guarantee payment of your claims** by your insurance company. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred.

Medicare

We accept assignment and will file insurance for our Medicare patients. However, any calendar year deductible amounts (up to the amount of the visit) are due at the time of the service. We will also file secondary insurance after payment from Medicare if we are contracted with your secondary plan. If there is no secondary insurance, the patient will be billed for any remaining balance.

Referral Authorization

Referrals must be obtained prior to the visit. If a referral is not received at the time of the visit, the patient is responsible for payment when services are rendered.

Authorization

I authorize release of medical records to determine liability for payments or treatment, and to obtain reimbursement.

I assign all medical benefits for office visits to Natalie Wright, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this instrument will have the same validity as the original.

______________________________ Signature

____________________ Date

Please complete the following questionnaire as this will help us properly address the issues important to your health:

Please list the purpose of your visit:____

____

Review of Systems: Are you currently experiencing any of the following? (please check all that apply)

SYMPTOM (CHECK IF APPLIES)	**SYMPTOM** (CHECK IF APPLIES)	**SYMPTOM** (CHECK IF APPLIES)
Fever or chills	Blood in urine	Intolerant of heat or cold
Unexplained weight loss	Pregnant	Blood coagulation disorder
Visual disturbance	Joint pain	Seasonal allergies
Bleeding gums	Muscle pain	Immunosuppression
Sore throat	Muscle weakness	Blistering sun burns
Chest pain	Rash	Allergy to latex
Cough	Change in mole or skin lesion	Allergy to Adhesive
Wheezing	Headache	Allergy to Lidocaine
Abdominal pain	Seizure	Allergy to Topical Antibiotic
Diarrhea	Anxiety	MRSA
Vomiting	Depression	History of Fainting or Vasovagal

Cautions: (please circle all that apply)

Have you ever had difficulty stopping bleeding?	Yes	No
Do you require antibiotics prior to a surgical procedure?	Yes	No
Have you had an artificial joint replacement?	Yes	No

If yes, when and what body locations? ____________________________________

Do you have an artificial heart valve?	Yes	No
Do you have a pacemaker?	Yes	No
Do you have a defibrillator?	Yes	No

WOMEN ONLY

Are you pregnant or currently trying to get pregnant? Yes No

If you circled **No**, how are you preventing?________________________________

Date last period began? ____

Difficulties with periods? ______________________ Age at menopause: ________

PHARMACY INFORMATION

PHARMACY NAME: ______________________

ADDRESS:____________________________

PHONE # ____________________________

CROSS STREETS: ____

HISTORY	PERSONAL yes/no	FAMILY yes/no	specify member
Actinic keratosis			
Anemia			
Arthritis			
Asthma			
Autoimmune disorder			
Basal cell carcinoma			
Bladder dysfunction			
Bleeding disorder			
Cancer/malignancy			
Lung disease			
Gastric ulcers			
Dementia			
Diabetes			
Dysplastic nevus			
Eczema			
Epilepsy			

HISTORY	PERSONAL yes/no	FAMILY yes/no	specify member
Glaucoma			
HIV/AIDS			
Hepatitis			
Hives			
Hypertension			
Inflammatory bowel disease			
Liver disease			
Lupus			
Melanoma			
Migraine			
Psoriasis			
Skin Cancer			
Squamous cell carcinoma			
Thyroid disorder			
Tuberculosis			
Other			

PAST SURGERIES: *(please list all that apply)* ____________________________________

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Social History: *(please circle all that apply)*

SMOKING STATUS: Current Former Never

ALCOHOL USE: More than 1/day Less than 1/day Never Drink

Medications

Please list any medications you take regularly. Prescription, non-prescription, vitamins, home remedies, birth control pills, and herbs: ❑ None

Medication *(including strength)*	**How many times a day**

Are you allergic to any medications? *(If yes, please list below)* ❑ Yes ❑ No

Allergic to:

Health Maintenance:

Did you have a flu shot this year? ❑ Yes ❑ No

If you are 65 years or older, did you have a pneumonia vaccine? ❑ Yes ❑ No

Do you have advanced directives? ❑ Yes ❑ No