Doctor: _________Date: ________Time:_____

PATIENT INFORMATION FORM

Please provide the following information and answer the questions below. Please note: the information you provide here is protected as confidential information.

Name: ____ ____

(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

____

(Last) (First) (Middle Initial)

Home/Cell phone: **(_______)___________________** May we leave a message? ___Yes ___ No

E-mail: _______________________________May we email you? Yes__ No__

Please note: Email correspondence is not considered to be a confidential medium of communication.

Address: ____

____

City State Zip

Employer: ____

Occupation: ____

Social Security Number: ______-______-______

Date of Birth: ___/____/_____

Sex: ________Male __________Female

Gender Identity: ______________________________________

Sexual Orientation: ___________________________________

Race/Ethnicity: _______________________________________

Marital Status:

____Never Married ___Married ___Domestic Partnership ___Divorced ___Widowed

Referred by (if any): ____

Emergency Contact Information:

Name: ____

Relation: ____

Emergency Phone: ____

1. INSURANCE – We participate in most insurance plans, including Medicare and Medicaid. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. If you are not insured by a plan we do business with, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

2. CO-PAYMENTS and DEDUCTIBLES –
   a. Co-pays must be paid at the time of service in the form of cash, check or credit card
      i. A $5.00 minimum applies to credit card payments
   b. In the event a patient has a deductible that has not been met we will collect $50 payment towards that deductible and submit the claim to your insurance company.

3. RETURNED CHECKS –
   a. A $25 fee will be charged for checks returned to us for insufficient funds

4. MISSED APPOINTMENTS / TARDY ARRIVALS
   a. We ask for a 24 hour notice to cancel or reschedule an appointment. Failure to do so, after documented warning, could result in dismissal from our practice.
   b. When a patient arrives more than 10 minutes after the start time of their scheduled appointment, we reserve the right to re-schedule the appointment.

5. NON-PAYMENT – If your account is over 120 days past due, HealthFit Medical Professionals, LLC has the right to disclose to an outside collection agency or attorney all relevant personal and account information necessary to collect payment for services rendered. You are responsible for all costs of collection. Once an account is sent to a collections agency you and your immediate family members may be discharged from this practice.

6. INSURANCE BENEFITS AND INFORMATION RELEASE FORM
   I hereby authorize the Doctor to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the Doctor for any services rendered that are not paid for directly by me.

7. MEDICARE AUTHORIZATION
   I request that payment of authorized Medicare benefits be made either to me or on my behalf to HEALTHFIT MEDICAL PROFESSIONALS, LLC *for any services furnished me. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.*

____ ____________________

Patient Signature — Date

____ ____________________

HealthFit Staff Witness — Date

Health Insurance Information

It is your responsibility to check with your insurance carrier directly to see if we're in network, and obtain an understanding of the parameters of your coverage. Failure to do so may cause you to incur additional charges for which you will be responsible. Falsification of insurance information could result in dismissal from practice.

Insured's Name: ____

Primary Insurance Company: ____________________________________Effective Date: ___________________

Secondary Insurance Company: __________________________________Effective Date: ___________________

The above information is true and to the best of my knowledge. ****A copy of your insurance card is required****

Signature (required): ____Today's Date: __________________

Have you ever had or suffered from any of the following?

Allergies	Yes___ No___	Coughing up blood	Yes___ No___
Asthma	Yes___ No ___	Low Blood Sugar	Yes___ No___
AIDS/HIV	Yes___ No___	Epilepsy or Neurological Problems	Yes___ No ___
High Blood Pressure	Yes___ No___	Cancer	Yes___ No___
Thyroid Problems	Yes___ No___	Sinus Trouble	Yes___ No___
Respiratory Problems	Yes___ No___	Fainting Spells	Yes___ No ___
Kidney Trouble	Yes___ No___	Diabetes	Yes___ No ___
Migraines	Yes___ No___	Hepatitis/Jaundice/Liver Problems	Yes___ No ___
Chronic cough	Yes___ No___	Stomach Problems	Yes___ No ___
Tuberculosis	Yes___ No ___	Sexually Transmitted Diseases	Yes___ No ___
Mental Health Problem	Yes___ No ___	Immune System Problems	Yes___ No ___
Congestive Heart Failure	Yes___ No ___	High Cholesterol	Yes___ No ___
Heart Disease	Yes___ No ___	Thyroid Disease	Yes___ No ___
Stroke	Yes___ No ___	Arthritis	Yes___ No ___
COPD	Yes___ No ____		

Do you have any allergies to?

Anesthesia	Yes___ No___	Sulfa Drugs	Yes ___ No___
Narcotics	Yes___ No___	Penicillin or Antibiotics	Yes___ No ____
Barbiturates	Yes ___ No ___	Iodine	Yes___ No ___
Other	Yes___ No ___		

If you have other allergies, please describe: ____

____

____

Hospitalizations: ____

Surgeries (Type and Date): ____

____

____

Medications: ____

____

____

____

____

Review of Symptoms

Please check if you have had any of the following in the ***past six months****:*

Weight Loss or Gain	Yes _____No ___	Chest Pain	Yes ___ No ______
Night Sweats	Yes _____ No ___	Racing Heart	Yes ___ No______
Muscle Weakness	Yes _____ No ___	Difficulty Breathing	Yes _____ No ___
Skin Rashes	Yes _____ No ___	Coughing	Yes _____ No ___
Itching	Yes _____ No ___	Seizures	Yes _____ No ___
Dry Skin	Yes _____ No ___	Dizziness	Yes _____ No ___
Headaches	Yes _____ No _____	Numbness	Yes _____ No ___
Injuries	Yes _____ No ___	Breast Pain	Yes _____ No ___
Blurred Vision	Yes _____ No ___	Nipple Discharge	Yes _____ No ___
Ringing in Ears	Yes _____ No ___	Disorientation	Yes _____ No ___
Hearing Loss	Yes _____ No ___	Loss/Increased Appetite	Yes _____ No ___
Muscle Pain	Yes _____ No ___	Nausea	Yes _____ No __
Runny Nose	Yes _____ No ___	Vomiting	Yes _____ No ___
Nose Bleed	Yes _____ No ___	Diarrhea	Yes _____ No ___
Joint Pain	Yes _____ No ___	Constipation	Yes _____ No ___
Cold Hands or Feet	Yes _____ No ___	Indigestion	Yes _____ No ___
Feeling Cold Often	Yes _____ No ___	Excessive Sleeping	Yes _____ No ___
Feeling Warm Often	Yes _____ No ___	Difficulty Sleeping	Yes _____ No ___
Sore Throat	Yes _____ No ___	Anxiety	Yes _____ No ___

Please check if you have had any of the following in the ***past six months*** *Continues…..*

Hoarseness	Yes _____ No ___	Mood Swings	Yes _____ No ___
Fatigue	Yes _____ No ___	Depressed Mood	Yes _____ No ___
Neck Stiffness	Yes _____ No ___	Impotence	Yes _____ No ___
Hair Loss/Growth	Yes _____ No ___	Decreased Libido	Yes _____ No ___

How would you rate your current physical health?

____Poor ____ unsatisfactory ____Satisfactory _____ Good _____ Very Good

Please list any specific health problems you are currently experiencing___________________________

____

____

____

How would you rate your current sleeping habits? ___Poor ____Unsatisfactory _____Satisfactory

_____Good _____Very Good

Please list any specific sleep problems you are currently experiencing: ___________________________

____

Do you follow a particular diet? ____Yes ____No

If so, what type: ____

Do you use tobacco? _____Yes _____No

If so, how often: ____

Do you use alcohol? _____ Yes _____No

If so, how often: ____

What hobbies do you enjoy? ____

____

____

____

Purpose of today's visit: ____

____

____

____

____

Family Medical History

Please list all first- degree relatives who have experienced the following:

A first-degree relative is defined as a close blood relative which includes the individual's parents, full siblings, or children.

Heart Attack____

Stroke: ____

Diabetes: ____

High Blood Pressure: ____

Cancer: ____

Sudden Death: ____

Other: ____

Women Only

Date of your last menstrual period____________________________________(mm/dd/yyyy)

Do your periods come every month ___Yes ____No?

If no, how often? ____

How long do your periods last? ________________________________

Is your flow: ____Light ____Medium ____Heavy

Do you have pain or bleeding after sexual intercourse? ____Yes ____No

Have you been pregnant? ___Yes ___No

If yes, how many children do you have? ____

Are you currently taking birth control? ____Yes ____ No

If so, what kind? _______________________________________

Date of your last pap smear: ________________________(mm/dd/yyyy)

Have you ever had an abnormal pap? ___ Yes ___ No

When was your last mammogram/breast exam: ________________________mm/dd/yyyy

Was it normal? ____ Yes ____ No Do you do self-breast examinations? ____Yes ____No

Social History

Do you exercise regularly? ___ Yes ____ No

If so, how often and what type? ____

____

____

Release of Medical Information

____

Patient Name

____

Address

____

Phone **Date of Birth** **Social Security Number**

In accordance with HIPPA regulations, we require written authorization prior to sending any protected health information. If you wish for your medical records to be sent to any family members, please list below their names and addresses. Upon signing this form, you are granting consent for our practice to use and disclose your protected health for the purposes of payment, treatment and health care operations.

If you request more detailed information about how we may use and disclose this protected health information, please consult with our staff. You have a legal right to review our full policy regarding the release of protected health information before you sign this consent, and we encourage you to ask any questions you may have. You have a right to request that we restrict how we use and disclose your protected health information for the purposes of payment, treatment or health care operations, however, we are not required by law to grant your request. If we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Please initial if you authorize us to speak to any of the following regarding your health information:

___Spouse ____Mother ____Father ____Daughter _____Son

____

Please write the names and relationship of friends/family you authorize us to speak to:

____________________________________ ________________________________

____________________________________ ________________________________

____________________________________ ________________________________

____________________________________ ________________________________

Signature Date