New Patient Paperwork

1. Last Name

2. First Name

3. Middle Initial

4. Date of Birth

Example: January 7, 2019

5. Gender

Mark only one oval.

- ◯ Female
- ◯ Male
- ◯ Prefer not to say
- ◯ Other: _____

6. Marital Status

_____

7. Address

_____

_____

_____

_____

_____

8. City

_____

9. State

_____

10. Zip Code

_____

11. Home Phone Number

_____

12. Work Phone Number

_____

13. Mobile Phone Number

14. Email

15. SS#

16. Preferred Method of Contact (Home, Work, Cell, Email, Other)

17. Insurance - Please provide your insurance card - the accuracy of information will insure that your claims are filed correctly.

18. Ethnicity/race (Please check one)

Mark only one oval.

- ◯ American Indian or Alaskan Native
- ◯ Asian
- ◯ Black or African American
- ◯ Native Hawaiian or Other Pacific Islander
- ◯ White
- ◯ I do not wish to specify my race

19. Preferred Language

_____

20. Individual Medical Release - Please list all individuals that we are authorized to provide information to. This release will authorize us to provide medical information, billing information, etc... with all individuals listed below. Any change in this authorization must be made to MLFP staff. Please designate at least one of the below as your emergency contact. Please include name, relationship, and phone number.

_____

_____

_____

_____

_____

21. I give consent to MLFP to send text and voice reminders fro appointments. By typing your name below you are giving your consent to the statement above.

_____

22. Patient consent for use and disclosure of protected health information - I hereby give my consent for Mountain Laurel Family Practice (MLFP) to use and disclose my Protected Health Information (PHI) to carry out treatment, payment, and health care operations. the Notice of Privacy Practices (NOPP) describes such uses and disclosures more completely and is available upon request. I have the right to review the Notice of Privacy Practices prior to signing this consent. MLFP reserves the right to revise it at any time. A revised NOPP may be obtained by forwarding a written request to Mona McClure at MLFP. With this consent MLFP may call or text any provided numbers and leave a message on voicemail or in person in reference to any items that assist MLFP in carrying out treatment, payment, and health care operations, such as appointment reminders, insurance issues, laboratory/test results, etc... MLFP may also e-mail or mail through postal services any items that assist in treatment, payment, and health care operations. I have the right to request that MLFP restricts how it uses or discloses my PHI. MLFP is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to allow MLFP to use and disclose my PHI to carry out treatment, payment, and health care operations. I may revoke my consent in writing except to the extent that the practice has already Mae disclosures in reliance upon my prior consent. if I do not sign this consent, or later revoke it, MLFP may decline to provide treatment to me. Medical Benefits Authorization: By signing below I authorize payment of medical benefits to MLFP and/or its provider for all services provided. I authorize the release of any medical or other information necessary to process my claim. I also request payment of government benefits to myself or the party who accepts assignment. BY TYPING YOUR NAME AND THE DATE BELOW YOU ARE GIVING YOUR CONSENT TO THE STATEMENT ABOVE.

23. Office Policies - On the day of your visit: 1.) Please arrive 15 minutes prior to your scheduled time so that you can be ready to see the provider at your appointment time. 2.) Please bring your medication bottles to each visit. 3.) Please bring your current insurance card and co-payment to each visit. 4.) For cash pay patients - be prepared to pay on the day of your visit unless PRIOR arrangements are made. - Between office visits: 1.) Refills are issued at your visit. It is YOUR responsibility to to follow-up before you are out of medications. You will be charged a $10.00 refill fee if you require refills and are overdue for a follow-up. 2.) Controlled medications are ONLY filled at office visits and will not be issued unless you are seen. 3.) Antibiotics will not be issued over the phone. - Expectations: 1.) All patients are allowed ONE no-show appointment with a $25.00 fee, a second no-show will result in a $50.00 fee and dismissal from the practice. No-shows include cancellations without a 24 hour notice. - These updated policies were created with the intent to improve our time management and to give us more face to face time with our patients. We appreciate your help with these policies. Please let us know if you have any questions or concerns. BY TYPING YOUR NAME AND THE DATE BELOW YOU ARE GIVING YOUR CONSENT TO THE STATEMENT ABOVE.

_____

24. Previous Surgeries (List type and date/year of surgical procedures; approximate dates are acceptable)

_____

_____

_____

_____

_____

25. Past Hospitalizations (List date and reason for hospitalization)

_____

_____

_____

_____

_____

26. Specialist care in the last 5 years (List provider's name and reason for care)

27. Diagnostic testing (List x-rays, MRI, and CT scans and the reason they were preformed)

28. Ongoing health issues (Conditions for which you have been treated for for more than 3 months

29. Medication Allergies (Include medication and type of adverse reaction)

30. Current Medications (Include all prescriptions, over-the-counter-medications, vitamins, and supplements)
Include dose and directions. Example -Prilosec 20 mg one a day

31. Family History (Parents, grandparents, siblings, and children) - Specify which family member had each condition on the line titled "other"

Check all that apply.

- [ ] High Blood Pressure
- [ ] Diabetes
- [ ] Cancer (specify which type in "other")
- [ ] Stroke
- [ ] Heart Attack/Cardiovascular Disease
- [ ] Depression/Anxiety/Mental Illness
- [ ] Asthma/Allergies
- [ ] Other:

32. When was your last wellness exam/physical?

33. When was your latest lab work done?

34. When was your last eye exam?

35. When was your last dental exam?

_____

36. When was your last Mammogram?

_____

37. When was your last Pap smear?

_____

38. When was your last bone density (DEXA) scan?

_____

39. When was your last colonoscopy?

_____

40. When was your last foot exam (If diabetic)

_____

41. Social History (Indicate type, amount, and duration of use on line titled "Other")

Check all that apply.

- [ ] Tobacco
- [ ] Alcohol
- [ ] Street/Elicit drugs
- [ ] Caffeine
- [ ] Other: _____

42. How many days per week do you exercise? And what type of exercise do you preform?

43. Do you have any dietary restrictions, or adhere to a specific diet?

44. When was your last flu vaccine?

45. When was your last tetanus (TDAP) vaccine?

46. When was your last pneumonia vaccine (if applicable)?

47. When was your shingles (Zoster) vaccine?

48. Have you received any other vaccines recently?

49. What do you do for a living?

50. Who do you live with?

51. Are there any specific health concerns that you would like to address during your office visit?

52. Preferred Pharmacy