ASC Alabama Specialty Clinic and Urgent Care

PATIENT INFORMATION

Todays Date_____/_____/_____

Patient's Name_____Sex: M / F Marital Status:_____

Date of Birth:_____/_____/_____ Age:_____ Race:_____

Ethnicity: Not Hispanic, Hispanic, White, Other, Refuse Primary Language:_____

Dominant Hand: Right / Left SS#:_____-_____-_____ Home Phone:_____

Cell Phone:_____, Work Phone:_____, Email:_____

Home Address:_____City:_____State:_____

If patient is a minor please list responsible party name:_____

Date of birth of the responsible party:_____/_____/_____.

Employer:_____Occupation:_____
Work Phone:_____

Is this visit today related to an injury? YES or NO
If yes , Please state the date of injury:_____/_____/_____

Insurance Information:

Primary Insurance Carrier:_____Group #_____
Contract or Policy #:_____
Name on the Insurance Card:_____ Date of Birth of Policy holder:_____/_____/_____
Relationship to Policy Holder: Self_____ Spouse_____ Child _____ Other _____

Secondary Insurance Carrier:_____Group #_____
Contract or Policy #:_____
Name on the Insurance Card:_____ Date of Birth of Policy holder:____/_____/_____
Relationship to Policy Holder: Self_____ Spouse_____ Child _____ Other _____

Primary Physician Name:_____City:_____State:_____

Primary Pharmacy:_____ City:_____

Signature:_____

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PATIENT HEALTH HISTORY FORM

PLEASE FILL OUT COMPLETELY

NAME:_____**DATE OF BIRTH:**_____/_____/_____**TODAYS DATE:**_____/_____/_____

List the names of all the medicines you take including any supplements or over the counter drugs:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Please list all allergies:

_____ _____
_____ _____

Your Medical History – Please check if you have or ever have any of the following diseases:

□ Acid Reflux (Gerd) □ Heart Failure □ Cancer
□ High Blood Pressure □ High Cholesterol □ Stroke
□ Chest Pain □ Irregular Heartbeats □ Thyroid Disorder
□ Dementia □ Diabetes □ Lung Disease/Emphysema
□ Ulcer □ Heart Attack □ Mitral Valve Prolapse
□ Depression □ Asthma □ Hepatitis
□ Seizures □ Migraines □ Anemia
□ Back pain □ Neck pain □ Shoulder pain
□ Knee pain □ Other:_____

Your Surgical History – Please check if you have had any of the following Surgeries:

□ Hernia Repair □ Appendectomy □ Back Surgery
□ Breast Surgery □ C-section □ Cataracts
□ Cervical Disc □ Defibrillator □ Gallbladder
□ Heart bypass □ Heart Stent □ Heart Valve
□ Pacemaker □ Prostate □ Tonsils
□ Tubal Ligation □ Hysterectomy □ Shoulder Surgery
□ Knee Surgery □ Carpal tunnel □ None
□ Other:_____

Your Family History – Please check if your Mother, Father, Brother or Sister ever had any of the following diseases:

□ Family History: High Blood Pressure □ Family History: Heart Disease □ Family History: Diabetes
□ Family History: Prostate Cancer □ Family History: Kidney Disease □ Family History:Thyroid Disease
□ Family History: High Cholesterol

Your Social History:

□ Married Alcohol? □ Current – Everyday □ Former Amount_____
□ Divorced □ Current – Some Days □ Never
□ Single
□ Widowed Tobacco? □ Current – Everyday □ Former Amount_____
□ Current – Some Days □ Never

I Certify that the above information is accurate to the best of my knowledge. I understand withholding information be it intentional or by negligence to fill out this form, could result in improper medical care and could be a detriment to my health or even life threatening. I also understand that it can be caused for the termination of my employment.

Signature:_____

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Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge receipt of Alabama Specialty Clinic Notice of Privacy Practices.

Print Name:_____**Signature:**_____**Date:**____/____/____

Medical Care/Treatment Financial Policy

Unless you are here for employer paid services, you will be responsible for either full payment or payment as indicated by your insurance plan.

If you have insurance……. If Alabama Specialty Clinic / aka ..Professional Medical Services has a contract with your insurance company we will file todays charges with that insurance company, you will be responsible today for your co-payment, coinsurance and / or deductible, and the cost of any services not covered by insurance. You may receive a bill from Alabama Specialty Clinic/ aka .. Professional Medical Services for any unpaid balance.

If you do not have Insurance…… If you do not have insurance coverage or Alabama Specialty Clinic/ aka.. Professional medical services does not have a Direct contract with your insurance company, you will be required to pay in full for your visit today. You can expect to pay an initial payment for the office visit upon check-in. If your treatment requires lab tests, vaccines, injectable medications, x-rays, braces, casts, splints, or other supplies, you will be charged for those at check out.

Release of Medical Records, Assignment Of Benefits, Financial Responsibility…… I authorize Alabama Specialty Clinic/ aka..Professional Medical Services to submit claims to my insurance carrier as well as medical records needed to evaluate these claims for payment. I understand that if my employer is responsible for paying all or part of this claim, they will receive the medical information needed to pay this claim and I authorize release of this information. I further authorize payment of benefits, otherwise payable to me, to be made payable to Alabama Specialty Clinic/ aka .. Professional Medical Services. I understand that I am financially responsible for all charges not covered by my insurance.

If my insurance company is not in network or I have no insurance coverage, I understand that I am financially responsible For all charges.

Signature of Patient / Guardian:_____ **Date:**_____/_____/_____

Consent for Medical Treatment…… I give permission to Alabama Specialty Clinic/aka… Professional Medical Services to perform the medical and surgical processes, treatment, and / or procedures that the physician and other non-physician providers and assistants may deem to be necessary. In addition, I authorize the clinic to release any information obtained during the course of my examination and / or treatment to my health care insurer or other payer.

Signature of Patient / Guardian:_____ **Date:**_____/_____/_____

I give my permission for the Physician and / or staff members of Alabama Specialty Clinic/ aka… Professional Medical Services to discuss my account and medical conditions which may include, but is not limited to , request for prescription changes or refills, appointment times, test results, symptoms, treatments, diagnosis, medications, billing or insurance information, or any type of protected health information with myself or the person (s) listed below in order to facilitate and coordinate my care, treatment, and payment. I understand that signing this form is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to the clinic or by completing a new form at any time. I also give my permission for any of the above information to be left on an answering machine or voicemail at any of the listed numbers below.

(Please print a list of names that we may speak to or release any supplies or information to)

Name:_____**/Relationship:**_____**/Phone Number:**_____

Name:_____**/Relationship:**_____**/Phone Number:**_____

Name:_____**/Relationship:**_____**/Phone Number:**_____

Name of Patient:_____**Date of birth:**_____/_____/_____

Signature of Patient:_____**Todays Date:**_____/_____/_____

If personal representative, relationship to patient:_____