

Patient Information Sheet

1. PATIENT INFORMATION

Patient Name: _____
Date of Birth: _____ Age: _____ Sex: _____
Address: _____
City: _____ State: _____ Zip: _____
E-Mail: _____
Home Phone: () _____ Work Phone: () _____
Cell Phone: () _____
Social Security Number: _____ Driver's License: _____
Name & Address of Employer: _____

Marital Status: Married ___ Single ___ Divorced ___ Widowed ___

2. SPOUSE INFORMATION

Spouse Name: _____
Spouse Social Security Number: _____
Spouse Date of Birth: _____
Spouse Address: _____
Spouse Employer & Address: _____

Spouse Work Phone: _____ Day Phone: _____

3. RESPONSIBILITY

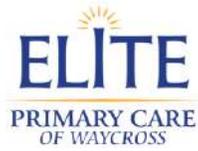
Person Responsible for Account: _____
Relationship: _____
Address: _____
Work Phone: _____ Day Phone: _____
Social Security Number: _____ Driver's License: _____
Employer: _____ Occupation: _____
Employer's Address: _____

4. EMERGENCY INFORMATION

Person to contact in case of emergency: _____
Phone: _____ Relationship: _____

5. IF STUDENT, PERMANENT/PARENT'S NAME & ADDRESS:

Pharmacy: _____



Insurance Information

As a courtesy to our patients, we will file your insurance claim at no charge; however this information must be complete.

6. INSURANCE INFORMATION

Primary insurance is through: Self ___ Spouse ___ Mother ___ Father ___

Name of Insured: _____ Social Security Number: _____

Date of Birth: _____

Name of Insurance Company: _____

Group #: _____ ID#: _____ Policy #: _____

Billing Address: _____

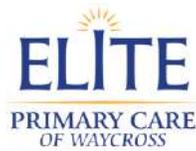
Phone Number: _____

7. MEDIGAP (SECONDARY INSURANCE)

Name of Beneficiary: _____

Health Insurance Company: _____

Medigap Policy Number: _____



We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service. We accept Cash, Personal Checks, Visa and MasterCard
If you are a new patient: We require that your first visit be paid by Cash, Visa or MasterCard.
2. Keep in mind that your Insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor – in other words, if you agree to have your insurance pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you. We have made prior arrangements with many insurance companies and health plans to accept an assignment of benefits. We will bill them, and you are required to pay a copayment or percentage at the time of your visit.
3. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you. Our charges for your care are due at the time of service. If the insurance carrier sends the office a check, we will in return send you a refund check.
4. Not all insurance plans cover all services. In the event your insurance plan determines a service to be “not covered”, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

I have read and understand the practice’s financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

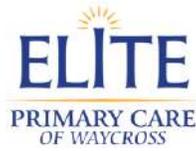
Signature of Patient (or responsible party, if minor)

Date

Please print name of the patient

IF YOU MISS AN APPOINTMENT WITHOUT CALLING TO RESCHEDULE OR CANCEL YOU WILL BE CHARGED A \$50.00 NO SHOW FEE

ALL RETURN CHECKS HAVE A \$25.00 RETURN FEE

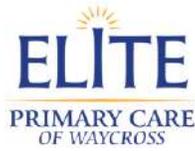


Narcotic Agreement and Refill Policy

This is an agreement between _____
and Elite Primary Care.

Pain management is an individual process. A plan that works for one person can be different for that of another. As part of our treatment, our physicians may prescribe narcotic medications for you. Many of these medications may have serious side effects if not taken properly. It is your responsibility to understand the prescribed medication regimen, take medicines only as directed, and communicate their effectiveness to our provider. Your health and safety are important to us, and we need your help in following our guideline. If we have any questions or concerns regarding your healthcare, including medications, we reserve the right to contact your other treating physicians and pharmacies. Please review and sign below:

- I agree to follow the dosing schedule prescribed to me by my doctor.
- I agree to never share my medications with others, nor will I sell or exchange my medications for any reason.
- I agree to notify my doctor if I experience any adverse effects or dosage problems with my prescribed medications.
- I agree that if I receive any narcotic prescriptions from prescriber, I am not allowed to receive the same type of medications or other narcotics from another physician without consent from my prescriber. This includes ER visits. Before accepting and narcotic medicine from other physician, I will ask that physician to contact prescriber for approval.
- I agree to be evaluated at regular intervals for continuous narcotic treatment as advised by the medical staff or prescriber.
- I agree to use only one pharmacy, which is _____, for my pain related medications unless extenuating circumstances prevent this from being possible. In this event, I will notify prescriber of all information pertaining to additional pharmacies, mail-order, or other sources.
- I agree to bring medications I am currently taking to each appointment and/or procedure with prescriber. This includes all prescription medications, vitamins, and herbal supplements.
- I understand that I should not drive or operate heavy machinery while I am taking medications that may effect my cognitive function and/or cause drowsiness.



- I understand that I am solely responsible for the safekeeping of my medications and I must treat my medications as I would my money or valuable possessions. Under NO circumstances will prescriber replace lost or stolen prescriptions or medications.
- In the event that my physician feels that my dose of pain medication is excessive or makes the diagnosis of addiction, he/she will reduce the medicine over a period of time as necessary to avoid withdrawal symptoms. A drug-dependence treatment or detoxification program may be recommended.
- I understand that abusive behavior or harassment toward any provider or staff will not be tolerated.
- I understand that dealing with a forged or falsified prescription will result in immediate dismissal from prescriber.
- Prescription Refills – You must call 3-5 business days before your medication runs out during office hours only. You must call to request the refill yourself and the staff will ask questions to establish your identity. Pain medication prescriptions are written in 30 days supplies and will be filled on the same day every month unless this date falls on a weekend or holiday.
- Prescription Pickups – Once the refill has been approved by the doctor or provider, they will be available for pickup. Only the patient may pick up the prescription and the staff will request a photo ID. We will not mail any pain medication prescriptions.
- I understand that prescriber will require me to submit to a urine drug screen at random intervals. If my screen tests positive for unprescribed substances, illicit drugs, or is negative for medications that I have been prescribed, I understand that this is possible grounds for dismissal from the practice. If the physician feels a repeat drug screen is indicated, I understand that I may be responsible for the payment of this test if denied for payment by my insurance company.

By signing this agreement, you affirm that you have the full right and power to be bound by this agreement and that you have read, understood, and accepted these terms. NO pain medications will be prescribed without the acceptance of this agreement.

Patient Signature: _____

Date: _____

Patient Account #: _____

Date: _____

Witness Signature: _____

Date: _____



Elite Primary Care Medical History

Name: _____

Date: _____

1. Check all the following that you have or have had:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Breast Problems |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Inflammatory Bowel | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Lumps or Bumps |
| <input type="checkbox"/> Hormonal Problems | <input type="checkbox"/> Trauma | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Gallbladder Probs. | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Skin Growths | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> GI Bleed | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> AIDS | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Herpes | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Hernias | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Abnormal Pap | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> TMJ Problems | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Ob/Gyn Problems | <input type="checkbox"/> Diabetes | | |

Additional Remarks:

2. Please list all previous surgeries:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Hernia Surgery | <input type="checkbox"/> Pediatric Surgery | <input type="checkbox"/> Hand Surgery | <input type="checkbox"/> Gallbladder Surgery |
| <input type="checkbox"/> Lung Surgery | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Foot Surgery | <input type="checkbox"/> Vascular Surgery |
| <input type="checkbox"/> Kidney Surgery | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Colon Surgery |
| <input type="checkbox"/> Surgery for Bowel Obstructions | <input type="checkbox"/> Surgery for Trauma | <input type="checkbox"/> Laparoscopic Surgery | <input type="checkbox"/> Hysterectomy or Ovary Surgery |
| <input type="checkbox"/> Tubal Ligation | <input type="checkbox"/> Vasectomy | <input type="checkbox"/> Testicular Surgery | <input type="checkbox"/> Ob/Gyn Surgery |
| <input type="checkbox"/> Breast Surgery | <input type="checkbox"/> Cancer Surgery | <input type="checkbox"/> Head and Neck | <input type="checkbox"/> Cosmetic Surgery |
| <input type="checkbox"/> Plastic Surgery | <input type="checkbox"/> Skin Cancer Surgery | <input type="checkbox"/> Ear Surgery | <input type="checkbox"/> Eye Surgery |

Additional Remarks:

3. Family history (Check all that apply):

- | | | | |
|--|-----------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Migraine | <input type="checkbox"/> Hyperlipemia | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | |

Additional Remarks:

4. Do you smoke (circle)? Yes No If "Yes", how many packs per day? Number of years? ____
 Do you drink (circle)? Yes No If "Yes", how many packs per day? Number of years? ____

5. Do you have allergies to any medications? Yes No If "yes", please list

6. Review of Systems (Check all that apply):

| Constitutional Systems: | | Cardiovascular: | | Gastrointestinal: | | Musculoskeletal: | |
|--|--------------------------|---|--------------------------|--|--------------------------|--|--------------------------|
| Have you had recent fever? | <input type="checkbox"/> | Do you have a heart murmur? | <input type="checkbox"/> | Poor Appetite? | <input type="checkbox"/> | Physically Handicapped? | <input type="checkbox"/> |
| Have you had recent chills? | <input type="checkbox"/> | Do you have heart disease? | <input type="checkbox"/> | Heart Burn? | <input type="checkbox"/> | Muscle Problems? | <input type="checkbox"/> |
| Have you had constipation? | <input type="checkbox"/> | Chest pressure, tightness, or pain? | <input type="checkbox"/> | Nausea or Vomiting? | <input type="checkbox"/> | Joint Problems? | <input type="checkbox"/> |
| Have you had recent weight loss? | <input type="checkbox"/> | Palpitations? | <input type="checkbox"/> | Vomiting blood or coffee ground type material? | <input type="checkbox"/> | Trouble with walking? | <input type="checkbox"/> |
| Have you had diarrhea? | <input type="checkbox"/> | Skipped beats? | <input type="checkbox"/> | Stomach Pain? | <input type="checkbox"/> | Neck Problems? | <input type="checkbox"/> |
| Ears, Nose, Mouth, Throat: | | Blood clots or inflammation in leg veins? | <input type="checkbox"/> | Ulcers? | <input type="checkbox"/> | Skin: | |
| Nosebleeds? | <input type="checkbox"/> | Varicose Veins? | <input type="checkbox"/> | Liver disease or Jaundice? | <input type="checkbox"/> | Moles that are changing? | <input type="checkbox"/> |
| Hoarseness? | <input type="checkbox"/> | Swollen ankles or feet? | <input type="checkbox"/> | Gallstones? | <input type="checkbox"/> | Moles with different colors? | <input type="checkbox"/> |
| Swallowing Problems? | <input type="checkbox"/> | Fainting? | <input type="checkbox"/> | Change in bowel habits? | <input type="checkbox"/> | Moles with irregular borders? | <input type="checkbox"/> |
| Mouth Problems? | <input type="checkbox"/> | Do you sit up to sleep? | <input type="checkbox"/> | Pancreas problems? | <input type="checkbox"/> | Neurological: | |
| Ear Problems? | <input type="checkbox"/> | Out of breath quickly? | <input type="checkbox"/> | Black or tarry stools? | <input type="checkbox"/> | Fainting? | <input type="checkbox"/> |
| Eyes: | | Bleeding problems? | <input type="checkbox"/> | Blood in stools? | <input type="checkbox"/> | Numbness anywhere? | <input type="checkbox"/> |
| Do you wear Contacts or Glasses? | <input type="checkbox"/> | Respiratory: | | Do you use enemas or laxatives? | <input type="checkbox"/> | Convulsions or Seizures? | <input type="checkbox"/> |
| Vision Changes? | <input type="checkbox"/> | Do you have a cough? | <input type="checkbox"/> | Greasy, frothy stools? | <input type="checkbox"/> | Tremors? | <input type="checkbox"/> |
| Blurred Vision? | <input type="checkbox"/> | Productive cough? | <input type="checkbox"/> | Rectal pain, burning? | <input type="checkbox"/> | Paralysis or weakness? | <input type="checkbox"/> |
| Double Vision? | <input type="checkbox"/> | Cough blood? | <input type="checkbox"/> | | | Coordination Problems? | <input type="checkbox"/> |
| Eye Surgery? | <input type="checkbox"/> | Wheezing? | <input type="checkbox"/> | | | Stroke? | <input type="checkbox"/> |
| Episodes like a window shade coming over your eyes? | <input type="checkbox"/> | Breathing problems? | <input type="checkbox"/> | | | | |
| Hematology/Lymphatic: | | Allergic/Immunologic: | | Genitourinary: | | Psychiatric: | |
| Do you have a blood disorder? | <input type="checkbox"/> | Do you have any allergic conditions? | <input type="checkbox"/> | Prostate Problems? | <input type="checkbox"/> | Do you have a mental disorder or disease? | <input type="checkbox"/> |
| Do you, or have you ever had abnormal or enlarged lymph nodes? | <input type="checkbox"/> | Do you have any immunological conditions? | <input type="checkbox"/> | Menstrual Problems? | <input type="checkbox"/> | Do you have mood swings? | <input type="checkbox"/> |
| Have you ever had Lymphoma or Leukemia? | <input type="checkbox"/> | Do you have a skin rash? | <input type="checkbox"/> | Vaginal discharge? | <input type="checkbox"/> | Do you suffer from depression? | <input type="checkbox"/> |
| Are you taking any blood-thinning pills? | <input type="checkbox"/> | | | Testicular pain or swelling? | <input type="checkbox"/> | Do you, or have you ever had an alcohol problem? | <input type="checkbox"/> |
| | | | | Sexual Problems? | <input type="checkbox"/> | Do you, or have you ever had a drug problem? | <input type="checkbox"/> |
| | | | | Penile Discharge? | <input type="checkbox"/> | | |
| | | | | Impotency? | <input type="checkbox"/> | | |
| | | | | Do you have any urinary or bladder problems? | <input type="checkbox"/> | | |

