

SOUND MEDICAL FAMILY PRACTICE

Patient Information

Patient's Last Name: _____	First: _____	Middle I: _____	Social Security # _____ - _____ - _____
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Mailing Address: _____	City _____	State _____	Zip _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Age _____	Birth Date: _____ - _____ - _____
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<p>May we leave a medical message about your healthcare on Your voice mail? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Home Phone () _____ - _____</p> <p><input type="checkbox"/> Cell Phone () _____ - _____</p>	<p>Employment Information: <input type="checkbox"/> Retired</p> <p>Employer: _____</p> <p>Occupation: _____</p> <p>Work Phone: _____ EXT _____</p>
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<p>Emergency Contact Information:</p> <p>Name _____</p> <p>Relationship _____</p> <p>Phone # () _____</p> <p>Phone # () _____</p>	<p>May this emergency contact have Access to your medical records? <input type="checkbox"/> Yes <input type="checkbox"/> No Initial _____</p> <hr/> <p>What is your preferred pharmacy? _____</p>	<p>Email Address: (used for office communication)</p> <p>_____</p> <p>Would you like to have access to our patient portal? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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<p>Race:</p> <p><input type="checkbox"/> White/Caucasian</p> <p><input type="checkbox"/> Black</p> <p><input type="checkbox"/> African American</p> <p><input type="checkbox"/> Asian</p> <p><input type="checkbox"/> Native Hawaiian</p> <p><input type="checkbox"/> Other Pacific Islander</p> <p><input type="checkbox"/> American Indian</p> <p><input type="checkbox"/> Alaska Native</p> <p><input type="checkbox"/> Other Race</p> <p><input type="checkbox"/> Decline</p>	<h3 style="text-align: center;">HIPAA Acknowledgements:</h3> <p style="text-align: center;">Please initial each line:</p> <p>_____ I hereby acknowledge that I have been provided with a copy of the privacy policy</p> <p>_____ I elect the following people below to have access to my medical records:</p> <table style="width: 100%;"> <tr> <td style="width: 60%;">Name _____</td> <td>Relationship _____</td> </tr> <tr> <td>Name _____</td> <td>Relationship _____</td> </tr> <tr> <td>Name _____</td> <td>Relationship _____</td> </tr> </table>	Name _____	Relationship _____	Name _____	Relationship _____	Name _____	Relationship _____
Name _____	Relationship _____						
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Deemed Consent-Consent for treatment-Release of Medical Information-No Guarantee-Electronic Communications

I hereby authorize medical treatment by any Sound Medical Family Practice Physician, Physician Assistant, and or affiliated medical staff member. I further authorize release of any and all medical and/or billing information as is necessary for reimbursement from any insurance carrier. I accept responsibility for payment of all treatment that the insurance carrier determines does not constitute as covered services. I understand that no guarantee or assurance has been made as to the results which may be obtained from any exam, testing or treatment. I agree that Sound Medical may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit organizations for treatment purposes. We will send you appointment reminders and other important electronic messages by text and email.

By providing your email address and cell phone number, you consent to receive electronic messages by such means. We will not share your information. You may opt out of electronic communication at any time.

If the patient is a minor or has a power of attorney, who is the responsible party for this patient:

Name: _____ Relationship to patient _____ Birth Date _____ - _____ - _____

Signature of Patient or Responsible Party X _____ **Date** _____ - _____ - _____



Sound Medical

Family Practice

Thank you for choosing Sound Medical Family Practice as your medical home. Please read this policy carefully, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

- 1. Insurance.** We participate in many insurance plans, including Medicare and Medicaid. We are happy to file your insurance for your claims. If you are not insured by a plan we participate with, payment in full is required at each visit. Knowing your insurance plan is your responsibility, please contact your insurance company if you have questions about coverage and participation.
- 2. Co-payments and deductibles.** All co-payments and deductibles will be collected at the time of service. This is a contractual agreement that you have with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud.
- 3. Non-covered services.** Please be aware that some services you receive may not be covered or may not be considered reasonable or necessary by Medicare or other insurance companies. We will only perform or request services that we feel are medically necessary and appropriate in order to provide you with the best medical care we can. You will be asked to sign an Advanced Beneficiary Notice (ABN) if there is a likelihood that your insurance will not pay for services that your provider feels are medically necessary and appropriate. If your insurance does not pay for these services, you will be responsible for the payment.
- 4. Proof of insurance.** We must obtain a copy of a valid insurance card as well as a valid photo ID. Failure to provide us with this information, you may be personally responsible for payment in full for your visit. If your insurance coverage changes, please notify us before your next appointment so we can make the appropriate changes to your account.
- 5. Claims submission.** We will submit your claims to your insurance company and assist you in any way we reasonably can to help get your claim paid. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

Financial Policy

- 6. **Missed appointments.** Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. We encourage you to keep your regularly scheduled appointment.

- 7. **Special circumstances.** In the vent that you have a financial hardship situation and need to make special arrangements for payment of your bill, please speak to one of our billing specialist as soon as possible.

- 8. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments cannot be accepted unless specifically negotiated with Sound Medical’s financial manager. Please be aware that if a balance remains unpaid we may refer your account to a collection agency and you and your immediate family members may be discharged from our practice. If a discharge occurs, you will be notified via certified mail that you have 30 days to find alternative medical care. During that 30-day period, our providers will only be able to treat you on an emergency basis.

Thank you for taking the time to read and understand our financial policy. Please let us know if you have any questions or concerns.

PATIENT INSURANCE INFORMATION

Name of Primary Insurance _____

Name of Secondary Insurance _____

I have read and understand the financial policy and agree to abide by its guidelines.

I agree to provide Sound Medical with a current copy of my insurance card (s) for scanning and claims submission at every office visit.

X _____ Date _____ - _____ - _____



Sound Medical Family Practice

MEDICAL HISTORY

Date: _____ - _____ - _____

Patient Name: _____ DOB: _____ - _____ - _____

Sex: Male Female

Prior Family Physician/Provider

Physician/Provider Name: _____ Phone () _____ - _____

Address _____ City _____ Zip _____ Fax () _____ - _____

(Please obtain medical records from this provider. Please bring records on your first appointment)

Medication allergies and type of reaction:

Name of medication	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Medications and doses you are currently taking:

Please list over the counter meds/supplements also

Name of Medication	MG	Directions
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Preferred Pharmacy: _____ City _____ Phone () _____ - _____

Past Medical History Please check all that apply to you

Cardiovascular High blood pressure Heart Arrhythmia what kind _____
 Congestive Heart Failure
 High cholesterol Heart attack when? _____
 Peripheral vascular disease

Pulmonary Asthma Bronchitis COPD Pneumonia
 Pulmonary embolism what year? _____ age _____

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____ Tuberculosis what year? _____ age _____

Gastrointestinal _____ GERD what year? _____ age _____

____ Crohn's Disease what year? _____ age _____

____ diverticulosis _____ Hepatitis (circle) A B C what year? _____ age _____

____ Stomach ulcers _____ Heartburn

Renal _____ Acute renal failure what year? _____ age _____ _____ Kidney disease –Stage _____ what year? _____

____ Kidney stone what year? _____ age _____ Current Creatinine level? _____

Musculoskeletal _____ Rheumatoid arthritis _____ Gout _____ Osteoporosis _____ Osteoarthritis

Endocrine _____ Prediabetes _____ Diabetes I or II what year? _____ age _____

____ Thyroid disease what year? _____ _____ Osteoporosis

Neurological _____ ADD what year? _____ age _____ _____ Alzheimer's/Dementia what year? _____ age _____

____ Cerebral Palsy _____ Stroke what year _____ what age? _____

____ Tension headaches _____ Migraine headaches

____ Multiple Sclerosis _____ Restless leg syndrome _____ Seizure disorder

Hematologic _____ Hemolytic anemia _____ Iron deficiency anemia _____ Pernicious (b12 deficiency) anemia

____ Sickle cell anemia _____ Myelofibrosis

Allergy/Immunology _____ Seasonal allergies testing year _____ what triggers _____

____ Eczema what year? _____ age _____ _____ Sinusitis

Cancers What part of the body _____ what year? _____ Status? _____

Vision _____ Cataract _____ Right _____ Left _____ Bilateral _____ Glaucoma

Hearing _____ Loss of hearing _____ Right _____ Left _____ Bilateral

Weight Current Weight # _____ as of what date? _____ / _____ / _____

Hospitalizations _____ check here if you have never been hospitalized

Date ____ / ____ / ____ For what? _____ Name of hospital _____

Date ____ / ____ / ____ For what? _____ Name of hospital _____

List any other specialist you are currently seeing

Name _____ Speciality _____

Name _____ Speciality _____

Advanced Directives Do you have any of the following?

____ Living Will _____ Durable Power of Attorney _____ Do Not Resuscitate

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Preventative Health Screening Please provide the date you last had the following test or service

Flu Shot ___/___/___ Pneumonia 23 Shot ___/___/___ Pevnar 13 ___/___/___

Zostavax (shingles vaccine) ___/___/___ Tetanus Shot ___/___/___

Colonoscopy ___/___/___ Bone Density ___/___/___ Eye Exam ___/___/___

Women: Last Mammogram ___/___/___ (please circle) Normal Abnormal
Last Pap Smear ___/___/___ (please circle) Normal Abnormal

Men: Last PSA ___/___/___

Surgical History Check all that apply

- Appendix what year? _____
- Arthroscopy which joints _____ what year? _____
- Biopsy –what part of body _____ what year? _____
- Coronary Bypass - What year? _____
- Cataract
- Hysterectomy __ Total __ Partial Year _____ Why? _____
- Gallbladder
- Joint Replacement Which joint (s) _____
- Other _____ what year? _____

Family Medical History

Father

- Medical History Unknown
- Medical History Unremarkable
- Deceased Cause of death? _____ what age? _____

Check any that apply to your father’s health

Heart - What type of heart problems _____

Stroke Cancer - What kind of cancer _____

Lungs Alzheimer’s/Dementia Diabetes I or II

Alcoholism Drug abuse what drugs _____ Depression Bipolar Mental Illness

Mother

- Medical History Unknown
- Medical History Unremarkable
- Deceased Cause of death? _____ what age? _____

Check any that apply to your Mother’s health

Heart –What type of heart problems _____

Stroke Cancer - What kind of cancer _____

Lungs Alzheimer’s/Dementia Diabetes I or II

Alcoholism Drug abuse what drugs _____ Depression Bipolar Mental Illness

Sound Medical

Family Practice

Last Name _____, First _____

Brother - How many brothers do you have? _____

- Medical History Unknown
- Medical History Unremarkable
- Deceased Cause of death? _____ what age? _____

Check any that apply to your brother's health

__ Heart – What type of heart problems _____
__ Stroke __ Cancer - What kind of cancer _____
__ Lungs __ Alzheimer's/Dementia __ Diabetes I or II
__ Alcoholism __ Drug abuse-what drugs _____ Depression __ Bipolar __ Mental Illness

Sister - How many sisters do you have? _____

- Medical History Unknown
- Medical History Unremarkable
- Deceased Cause of death? _____ what age? _____

Check any that apply to your sister's health

__ Heart – What type of heart problems _____
__ Stroke __ Cancer - What kind of cancer _____
__ Lungs __ Alzheimer's/Dementia __ Diabetes I or II
__ Alcoholism __ Drug abuse -what drugs _____ Depression __ Bipolar __ Mental Illness

Social History

What's your occupation: _____ o Current o Retired year? _____

Marital Status: o Single o Married o Separated o Divorced o Widowed o Widowed/Remarried
Number of children _____ Step Children _____ Foster Children _____

What are your hobbies: _____
What kind of exercise do you do? _____ How often? _____ day or week

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacist? (Please circle one below)

1. Never 2- Rarely 3- Sometimes 4- Often 5- Always

Tobacco/ Caffeine/Alcohol/ Supplements

Tobacco use o Never Smoked o Past Smoker Quit Date __/__/__ Smoked how many years?__

Type of tobacco

- Cigarettes –how many per day _____ cigarettes / packs (please circle)
- Cigars- how many per day _____
- Pipe-how many per day _____
- Smokeless Tobacco –how many per day _____
- Marijuana- how many times per day _____

Caffeine use

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- Coffee – servings per day _____
- Tea- servings per day _____
- Soda- servings per day _____ o Chocolate – how many servings per day _____

Alcohol Consumption o Never o Social o Regular Use o Member of AA
o Former member of AA

Type of Alcohol

- o Beer – servings per day _____ per week _____
- o Malt Liquor – servings per day _____ per week _____
- o Wine – servings per day _____ per week _____
- o Liquor – servings per day _____ per week _____

Supplements o None o Appetite Suppressants o Multivitamins

Do you follow a specialized diet? o Yes o No o If yes, which one? _____

Substance use

Do you use recreational drugs? o Never o Regular Use o Past –what year? _____

o Narcotics o Marijuana o Cocaine o Heroin o Opium o Other _____

How often do you use _____ times a **day or week** (circle one)

Method of use o Smoke o Injection o Snort o Huff

Mental Health History

Do you suffer from any of the following?

- Anxiety** o Acute Stress Disorder o Panic Attacks o PTSD o Phobias
- Cognitive Disorder** o Alzheimer’s o Dementia
- Eating Disorder** o Anorexia o Bulimia
- Mood Disorder** o Depression o Bipolar o Manic Episode
- Schizophrenia/Psychosis** o Paranoid o Disorganized o Residual
- Sleep Disorder** o Insomnia o Narcolepsy

Have you ever had environmental/chemical exposures or communicable diseases?

o Yes o No

If yes, what were you exposed to or what communicable disease? _____

To the best of my knowledge, I have provided you my medical history.

X _____ Date / /

Patient’s Signature