SOUND MEDICAL FAMILY PRACTICE
Patient Information

Patient's Last Name: First: Middle I: Social Security # ___-___-___

Marital Status S / M / D / W

Mailing Address: City State Zip Sex: ☐ M ☐ F Age Birth Date: ___-___-___

May we leave a medical message about your healthcare on Your voice mail? ☐ Yes ☐ No

☐ Home Phone ( ) ___-___

☐ Cell Phone ( ) ___-___

Employment Information: ☐ Retired

Employer:___

Occupation:___

Work Phone:___ EXT___

Emergency Contact Information:

Name___

Relationship___

Phone # ( ) ___

Phone # ( ) ___

May this emergency contact have Access to your medical records?

☐ Yes ☐ No Initial___

What is your preferred pharmacy?

___

Email Address: (used for office communication)

___

Would you like to have access to our patient portal? ☐ Yes ☐ No

Race:
- ☐ White/Caucasian
- ☐ Black
- ☐ African American
- ☐ Asian
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ American Indian
- ☐ Alaska Native
- ☐ Other Race
- ☐ Decline

Ethnicity:
- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino
- ☐ Decline

HIPAA Acknowledgements:

Please initial each line:

____ I hereby acknowledge that I have been provided with a copy of the privacy polic

____ I elect the following people below to have access to my medical records:

Name___Relationship___

Name___Relationship___

Name___Relationship___

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 guaran 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 an use my prescription
medication history from other healthcare providers or third-party pharmacy benefit organizations for treatment purposes. We will send you appointm 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 informa 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___-___-___

Financial Policy

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

PATIENT MEDICAL HISTORY

Date: _____-_____-_____

Patient Name: _____DOB:____-____-_____

Sex: ☐ Male ☐Female

Prior Physician/Provider

Provider Name: _____ Phone (___) _____-_____

Address _____City_____ Zip_____ Fax (___)_____-_____

(Please obtain medical records from this provider. Please bring past records to 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 – use back of page if additional space is needed

Name of Medication	Dose/MG	Directions
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Supplements ☐ None ☐ Appetite Suppressants ☐ Multivitamins

Others: _____

_____

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

Preferred Pharmacy: _____ City_____

Mail Order Pharmacy: _____

Sound Medical
Family Practice **Last Name**_____, **First**_____

Past Medical History (Please check all that apply to you)

Cardiovascular: __High blood pressure ___Heart Arrhythmia what kind_____
___Congestive Heart Failure (CHF) ___Heart attack - when?_____
___ High cholesterol ___Peripheral vascular disease

Pulmonary: ___Asthma ____ Chronic Bronchitis ___COPD ___ Emphysema
___Pulmonary embolism what year? _____age_____
___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

Kidneys: ___Acute kidney failure age: _____ ___Kidney stones what year? _____age____
___Chronic Kidney disease – Stage___ 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 __ 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?_____

Eyes/Vision: ___Cataracts __Right __Left __Bilateral ___Glaucoma Glasses or contact lenses?

Ears/Hearing: ___Loss of hearing __Right __Left __ Bilateral Do you wear hearing aids? _____

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_____

Please list any specialists you are currently seeing

Name_____Speciality_____
Name_____Speciality_____

Sound Medical
Family Practice **Last Name**_____, **First**_____

Immunizations/Preventative Health: Please provide the date you last had the test or service

__Flu Shot ___/___/____ __Pneumonia 23 Shot ___/___/____ __Prevnar 13 ___/___/____

__Zostavax (shingles vaccine) ___/___/____ __Tetanus Shot ___/___/____

__COVID-19 Vaccine 1st date ___/___/___ 2nd ___/___/___ Circle One: Moderna Pfizer J&J

__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?_____

Advance Directives:

Do you have any of the following?

____Living Will ____Healthcare Power of Attorney ___Do Not Resuscitate Order ____ MOST Form

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?_____

Sound Medical
Family Practice **Last Name**_____, **First**_____

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

Brother(s) - 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(s) - How may 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 is your occupation: _____☐ Current ☐ Retired year? _____

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

What are your hobbies: _____
What kind of exercise do you do? _____How often?_____ days/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

Tobacco use ☐ Never Smoked ☐ Past Smoker - Quit Date __/__/__ How many years have you smoked? _____

Sound Medical
Family Practice **Last Name**_____, **First**_____

Type of tobacco

- ☐ Cigarettes - how many per day _____ cigarettes/packs (please circle)
- ☐ Cigars - how many per day _____ or per week? _____
- ☐ Pipe - how many bowls per day_____
- ☐ Smokeless Tobacco – how many per day_____
- ☐ Marijuana - how many times per day_____

Caffeine use

- ☐ Coffee – servings per day _____
- ☐ Tea - servings per day _____
- ☐ Soda - servings per day _____
- ☐ Chocolate – servings per day_____

Alcohol Consumption

☐ Non-drinker ☐ Social Use ☐ Regular Use ☐ AA Member ☐ AA Former Member

Type of Alcohol

☐ Beer – beers per day_____ or per week_____
☐ Malt Liquor/Craft Beer – servings per day _____ or per week_____
☐ Wine – glasses per day _____ or per week _____
☐ Liquor – ounces per day _____ or per week _____

Substance use

Do you use recreational drugs? ☐ Never ☐ Occasional/Regular Use ☐ Past use – what year?_____

☐ Narcotics ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Other _____

How often do you use _____times a **day or week** (circle one)
Method of use ☐ Smoke ☐ Injection ☐ Snort ☐ Huff

Mental Health History

Do you suffer from any of the following?

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

Have you had environmental/chemical exposures? ☐ Yes ☐ No
Have you had communicable disease exposures? ☐ Yes ☐ 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