Bennett Family Medicine

Adult History Form

Name: _____ Today's Date: _____
(first) (middle) (last)

Age: _____ Birth Date: _____ Marital Status: S M D W Do you have a living will? Y or N

Prior Physician(s): _____ Occupation: _____

List all persons who live in your household

	Name	Relation	Age
1)			
2)			
3)			
4)			
5)			

Surgery History

	What Kind	Year
1)		
2)		
3)		
4)		
5)		

Health History (yourself and blood relatives)

Have you or a family member had the following:

Condition	You	Date	Relative	Relationship
Asthma				
Cancer:				
Chronic Back Pain				
Depression/Anxiety				
Developmental Delay				
Diabetes				
Heart Disease				
High Blood Pressure				
High Cholesterol				
Migraines				
Obesity				
Thyroid Disorder				
Seasonal Allergies				
Other:				
Other:				
Other:				

Hospitalizations (other than operations or childbirth)

	Hospital	Reason	Month/Year
1)			
2)			
3)			

Medication Allergies **Reaction**

1) _____
2) _____
3) _____

Medications/Supplements **Dose(mg)/How Often**

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____

(for additional space, please use back side of form)

Health Maintenance

When was your last:

Cholesterol Test _____
General Bloodwork _____
Eye Exam _____
Tetanus Shot_____
Pap Smear (women) _____
- Abnormal Exams? _____
Mammogram (30 and older)_____
- Abnormal Exams? _____
Bone Density Scan (40 and older) _____
Colonoscopy_____
Rectal Exam _____
PSA Test (men 40 and older) _____

Habits

Do you eat well balanced meals every day? Y or N
Do you smoke? Y or N or Former - how much?_____
Drink alcohol? Y or N or Former - how much? _____
Do you use any recreational drugs? Y or N or Former
Exercise regularly? Y or N - how often?_____
What form of exercise? _____

Females Only

Date of last menstrual period_____
Method of contraception _____
Number of times pregnant _____
full term _____ preterm _____ vaginal deliveries ___
cesareans _____ abortions _____ miscarriages ____

PLEASE PRINT AND FILL OUT COMPLETELY

Today's Date_____ ___New Patient ___Update

Patient Name_____ Marital Status S M D W
(First) (Middle) (Last)

Street Address_____ Apartment #_____

City_____State_____Zip_____

Home # _____Cell #_____

Email address: _____

Birth Date_____ Age _____ M or F Social Security #_____

Your Employer_____Occupation_____

If patient is a minor, Guardianship to Patient:_____

Guardian's Name & Address:_____

Who referred you to the practice_____

Emergency Contact_____ Daytime Phone #_____
Relationship_____

INSURANCE INFORMATION MUST BE COMPLETED

PRIMARY INSURANCE_____ ID#_____ Group #_____
Copay_____ Deductible_____ Co-Insurance_____ HSA or HRA (circle one)

Policyholder's Name_____ Birth Date_____
Relationship to Patient_____
Address, _____
(street address) (city & state) (zip)

SECONDARYSURANCE_____ID#_____Group#_____
Policyholder Name_____DOB_____

AUTHORIZATION AND CONSENT TO TREAT/FINANCIAL AGREEMENT

I hereby authorize the providers of Bennett Family Medicine and their designates to provide medical treatment and release of information pertaining to my treatment for insurance purposes. I understand I am financially responsible for all professional services rendered. I authorize my insurance company to pay benefits directly to the physician. I understand I am responsible to supply all necessary information, such as insurance information and current copy of my card, so that insurance can be properly filed. I further agree to pay 30% collection costs, reasonable attorney fees, and other collection costs that may be incurred to enforce collection of any amounts outstanding.

_____ _____
Patient's Signature (or Minor's Representative) **Date**

BENNETT FAMILY MEDICINE
Policy

Please read carefully & sign

Thank you for choosing Bennett Family Medicine. We are committed to providing you personalized care for you and your family. Please read our policy and sign in the space provided. A copy will be provided to you upon request.

1. Insurance: You must have a current insurance card and driver's license at the time of your visit. If you are insured by a plan we are contracted with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. **Knowing your insurance benefits is your responsibility**. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered **fraud**. Please help us in upholding the law by paying your co-payment at each visit. We accept Visa, Master-card, debit or cash. No Personal checks

3. Non-covered services: Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurance companies. This includes, preventative care with sick visit, (i.e., strep throat, chest pain, high blood pressure, skin tags, ear lavage, hemocults) etc. In the event that your insurance company does not cover the service does not mean that you shouldn't receive it. There are legitimate reasons your provider may order particular items or services that are not covered. By signing this form, you are agreeing to pay for services rendered that are not covered by your insurance company.

4. Nonpayment: If your account is over 60 days past due, you will receive a $10 per month late fee. If a balance remains unpaid, we will refer your account to Bureau of Medical Economics and a 30% fee will be added to your statement. You and all immediate family members will be discharged from this practice. If this is to occur, you will be notified by mail that you have 15 days to find alternative medical care.

6. Missed appointments: There is a $50 charge for all missed appointments or appointments not cancelled without 24 hour notice. This includes anyone being seen for the Apple Wellness Weight Loss Program as well.

7. Form Fees: There is a $50 form fee payable in advance for any form that needs to be completed. This includes FMLA, disability, school, sports or work physicals, or any other form.

8. Apple Wellness Program: If you are participating in the program you will not be seen for any other medical issues without another scheduled appointment. We are no longer taking walk-ins. You must schedule an appointment even if it's for the shot only.

9. There are no refunds on supplements or any other services.

10. Test Results: Patients must make an appointment for test results. No results will be given over the phone.

11. Zero Tolerance Policy: Bennett Family Medicine has a zero tolerance policy for aggressive behavior directed by patients against our staff. This includes use of profanity, shouting, intimidating or harassing staff, making threats of violence in person, telephone or written communication. Violators are subject to removal from the facility, discharge from the practice and can be reported to authorities for verbal abuse of a healthcare worker. We do not allow possession of firearms.

12. Prescriptions: Please plan ahead for prescription refills. Address refills at the time of your visit. Change in medication, new prescriptions or mail order prescriptions will require an office visit. No prescription refills will be granted on weekends or after hours. It is the policy of this office that

NO NARCOTICS WILL BE CALLED INTO THE PHARMACY—NO EXCEPTIONS.

_____	_____	_____
Printed Name of Patient	**Signature**	**Date**

Patient No-Show/Cancellation Policy

In keeping with our goal to provide each patient with the highest standard of care possible, we ask that you make every effort to keep your scheduled appointments and arrive in a timely manner. "No-shows" or last minute cancellations leave empty appointment times for other patients in need of medical care.

For this reason, a fee of $50 will be imposed for missed or cancelled appointments with less than 24 hours notice.

Please note that no-show/late cancellation fees are patient responsibility and will not be billed to your insurance company.

Thank you in advance for your consideration and for allowing us to partner in your healthcare needs.

Bennett Family Medicine

ACKNOWLEDGEMENT OF RECEIPT PRIVACY NOTICE

I acknowledge that I have read the attached Privacy Notice.

_____
Printed Patient Name

_____
Patient or Personal Representative Signature

_____
Date

RELEASE OF INFORMATION

The following information will assist the providers and staff in contacting you with any diagnostic test or procedure results.

Patient Name_____ Date of Birth_____

Please check the following:

___ I give my consent to the staff of Bennett Family Medicine to relay any lab, diagnostic test results or any other imperative information to:

_____

Name Relationship Phone Number

Can we call you or leave a message at:				Preferred Number
Home	Yes	No	_____ Phone number	☐
Work	Yes	No	_____ Phone number	☐
Cell phone	Yes	No	_____ Phone number	☐

I hereby authorize the providers of Bennett Family Medicine to provide medical treatment and release information pertaining to my treatment for insurance purposes. I understand I am financially responsible for all professional services rendered. I authorize my insurance company to pay benefits directly to the physician. I understand I am responsible to supply all necessary information, such as insurance information and current copy of my card, so the insurance will be filed properly.

_____ _____

Signature Date

EMERGENCY CONTACT ONLY _____

NAME PHONE

PATIENT EASY PAY CONSENT FORM
PLEASE PRINT

Patient Name _____

I authorize **BENNETT FAMILY MEDICINE** to maintain my credit/debit card on file for any balances that I owe them due to services render on my behalf.

I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to the Health Care Provider.

_____

Cardholder Signature Date

If Minor, Parents Name _____

Cardholder Name_____

Cardholder Address_____

City_____State_____Zip_____

Card Number _____-_____-_____-_____ MC/Visa

Expiration Date_____ V Code_____

Please be assured that we are bound by HIPPA regulations and all information is confidential as is your medical record. Upon request a receipt will be sent.