MEDFIRST
Primary & Urgent Care

Care for now. Care for life.

PATIENT INFORMATION SHEET

Location_____

Account # _____ Name of Employer: _____
First Name: _____ Middle Initial _____ Last Name: _____
Mailing Address: _____ Apt./Suite___City _____State ____ Zip_____
Home Phone: _____ Work Number: _____ Cell Phone Number: _____
Email Address: _____ Sex: ____ Marital Status: _____
Birth Date: ___ / ___ / _____ SSN: _____ / ____ / _____
Ethnicity: (check one) Hispanic or Latino_____ Not Hispanic or Latino_____ Declines to Respond_____
Race: (check one) American Indian / Alaskan Native_____ Asian_____ Black/African American_____
Native Hawaiian____ Other Pacific Islander____ White____ More than 1 Race____ Declines to Respond_____
Primary Care Provider_____
Preferred Language:_____ Preferred Med First Provider_____
How Did Your Hear About Us? ☐ Word of Mouth - ☐ In Community - ☐ Online/Social Media - ☐ Google Search
☐ Referral - ☐ At An Event - ☐ Website - ☐ Direct Mail - ☐ Print Ad - ☐ Drove By Office - ☐ Other_____

You may need to fill out additional information

Emergency Contact: _____ Relationship: _____ Phone: _____
If Patient is a minor:
Guarantor Name: _____ Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Name of Employer: _____ Cell Phone: _____

Do you authorize Med First to obtain the last 13 months of your medication history from your insurance carrier and or pharmacy?

☐ Yes ☐ No

****To Process your Insurance Claim, you must complete this section****

Health Insurance Information:
Name of Insurance: _____
Policy Number: _____ Group Number: _____
Policy Holder / Sponsor Name: _____
Policy Holder / Sponsor Date of Birth: ___ / ___ / _____ Policy Holder Employer: _____
Policy Holder / Sponsor Social Security: _____ / _____ / _____
Policy Holder / Sponsor relationship to patient: _____
Do you have your insurance cards today? Yes / No

Assignment of Benefits: I hereby authorize Med First to examine me, including x-ray and procedures deemed appropriate by the treating provider if indicated by my exam, and to release my records to anyone I designate. I further authorize treatments deemed necessary by the findings, and wish all my medical records to be held in strict secret confidence and not to be given to anyone without my written consent. I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by Med First Immediate Care. I understand my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal Law.

_____ ___ / ___ / ___

Patient / Representative Signature Date

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FAMILY PRACTICE HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any questions, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THE QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

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

Reason for today's visit: _____

Primary care physician: _____ **Preferred pharmacy:** _____

ALLERGIES

Please list anything you are allergic to (medication, food, bee stings, etc.) and how each affects you.

Allergy	Reaction
1.	
2.	
3.	

MEDICATIONS

Please list all the medications you are taking, Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

Drug name	Strength	Frequency Taken
1.		
2.		
3.		
4.		
5.		
6.		
7.		

FAMILY HEALTH HISTORY (Check all that apply, please specify type of cancers)

	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Father	Mother	Brother	Sister
Heart disease								
Cancer Type?⇨								
Diabetes								
Stroke								
Hypertension								
Depression								
Osteoporosis								
Other (please specify)								

IMMUNIZATION HISTORY (provide records if available)

☐ Pneumonia Date:_____ ☐ Flu Date:_____

☐ Zostavax (shingles) Date:_____ ☐ Tetanus Date:_____

Are you up to date on all of your childhood immunizations? **YES/NO** If not, please explain:_____

SOCIAL HISTORY

Current Occupation:_____

Education: ☐ less than 8th grade ☐ high school
☐ 2 year college ☐ 4 year college ☐ post grad

Do you use tobacco? YES/NO

If not currently, did you ever use tobacco? **YES/NO**

- ☐ Cigarettes____ pks/day
- ☐ Chew_____/day
- ☐ Cigars_____/ day

# of year's_____ or year quit_____

Marital status: ☐ married ☐ single ☐ divorced ☐ separated ☐ widowed

Do you have advanced directives? (living will) **YES/NO**

Exercise level: ☐ none ☐ occasional ☐ moderate ☐ heavy

Diet: ◯ regular ◯ vegetarian ◯ vegan ◯ gluten free ◯ diabetic

Caffeine: ☐ none ☐ occasional ☐ moderate ☐ heavy

Alcohol: ☐ none ☐ < 3x a week ☐ > 3x a week ☐ heavy

Stress level: ☐ low ☐ medium ☐ high

Drugs: Do you currently use recreational or street drugs? **YES/NO**

If yes, please specify _____

PAST SURGICAL HISTORY

	Reason	Year	Hospital
1.			
2.			
3.			
4.			

OBSTETRIC AND GYNECOLOGICAL HISTORY

Age of first menstrual period:_____

Age at first child:_____

Date of last menstrual period or age of menopause:_____

Date of Last pap smear:_____

Date of last mammogram:_____

Number of pregnancies:_____ births_____ miscarriages_____ abortions_____

Cesarean sections? _____ If yes, how many?____

Check all that apply:

- ☐ Bleeding between periods
- ☐ Heavy periods
- ☐ Vaginal itching, burning or discharge
- ☐ Wake in the night to go to the bathroom
- ☐ Breast lump or nipple discharge
- ☐ Hot flashes
- ☐ Extreme menstrual pain
- ☐ Painful intercourse

SEXUAL ACTIVITY

Are you sexually active? **YES/NO**

Current sexual partner is: **FEMALE/MALE**

Do you use condoms? **YES/NO**

Interested in being screened for STD's? **YES/NO**

Are you currently using birth control? **YES/NO** If yes, please specify type_____

PAST MEDICAL HISTORY (Check all that apply)

- ☐ ADD or ADHD
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bedwetting
- ☐ Bleeding disorder
- ☐ Blood clots or DVT
- ☐ Blood diseases
- ☐ COPD
- ☐ Developmental or behavioral disorders
- ☐ Diabetes – Insulin
- ☐ Diabetes - non-insulin
- ☐ Dialysis
- ☐ Diverticulitis
- ☐ Ear or hearing problems
- ☐ Eczema, hives or other skin conditions
- ☐ Erectile dysfunction
- ☐ Fibromyalgia
- ☐ GERD/reflux
- ☐ Gout
- ☐ Hospital admission (other than birth)
- ☐ High blood pressure
- ☐ Hyperthyroidism
- ☐ Hypogonadism
- ☐ Hypothyroidism
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Leg/foot ulcers
- ☐ Liver disease
- ☐ Muscle, joint or bone problems
- ☐ Cancer Type?
- ☐ Chicken pox
- ☐ Congenital abnormalities
- ☐ Constipation
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Pacemaker
- ☐ Heart attack
- ☐ Heart disease
- ☐ Heart problems
- ☐ Hiatal hernia or reflux disease
- ☐ High cholesterol
- ☐ Osteoporosis
- ☐ Pulmonary embolism
- ☐ Seizures/Epilepsy
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Vision or eye problems

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Location_____

Name:_____ **D.O.B.:**_____ **Date:**_____

Reason for Visit:

_____

_____

REVIEW OF SYSTEMS

Please check all that apply:

Allergic/Immunologic
- ☐ Frequent Sneezing
- ☐ Hives
- ☐ Itching
- ☐ Runny Nose
- ☐ Sinus Pressure

Cardiovascular
- ☐ Arm Pain on Exertion
- ☐ Chest Pain on Exertion
- ☐ Chest Heaviness/Pressure on Exertion
- ☐ Irregular Heart Beats (Palpitations)
- ☐ Known Heart Murmur
- ☐ Light-headed on Standing
- ☐ Shortness of Breath When Lying Down
- ☐ Shortness of Breath When Walking
- ☐ Swelling (edema)

Constitutional
- ☐ Exercise Intolerance
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Gain (____lbs)
- ☐ Weight Loss (____lbs)

Eyes
- ☐ Dry Eyes
- ☐ Irritation
- ☐ Vision Change

Date of Last Exam:_____

Ears/Nose/Mouth/Throat
- ☐ Bleeding Gums
- ☐ Difficulty Hearing
- ☐ Dizziness
- ☐ Dry Mouth
- ☐ Ear Pain
- ☐ Frequent Infections
- ☐ Frequent Nosebleeds
- ☐ Hoarseness
- ☐ Mouth Breathing
- ☐ Mouth Ulcers
- ☐ Nose/Sinus Problems
- ☐ Ringing in Ears

Endocrine
- ☐ Fatigue
- ☐ Increased Thirst/Hunger/Urination

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Black or Tarry Stool
- ☐ Blood in Stool
- ☐ Change in Appetite
- ☐ Frequent Indigestion
- ☐ Hemorrhoids
- ☐ Trouble Swallowing
- ☐ Vomiting
- ☐ Vomiting Blood

Genitourinary
- ☐ Blood in Urine
- ☐ Difficulty Urinating
- ☐ Incomplete Emptying
- ☐ Increased Urinary Frequency
- ☐ Urinary Loss of Control

Hematologic/Lymphatic
- ☐ Easy Bruising/Bleeding
- ☐ Swollen Glands

Integumentary (Skin)
- ☐ Changes in Moles
- ☐ Dry Skin
- ☐ Eczema
- ☐ Growth/Lesions
- ☐ Itching
- ☐ Jaundice (Yellow Skin/Eyes)
- ☐ Rash

Musculoskeletal
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Aches
- ☐ Muscle Weakness

Neurological
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Memory Loss
- ☐ Migraines
- ☐ Numbness
- ☐ Restless Legs
- ☐ Seizures
- ☐ Weakness

Psychiatric
- ☐ Alcohol Overuse
- ☐ Anxiety/Stress
- ☐ Depression
- ☐ Do Not Feel Safe in Relationship
- ☐ Mania
- ☐ Sleep Problems

Respiratory
- ☐ Cough
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Wheezing

Please add any other information about your health that you would like your provider to know here:

_____

_____

_____

_____

_____ _____

Parent, Guardian, or Caregiver Signature Date

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PROMISSORY NOTE

Name_____

Please choose your payment source

Private Pay:

I, _____ am acknowledging that I am a self paying patient seeking medical attention, I agree to pay my visit in full at the time of service and pay my remaining balance in full within 30 days or before my next scheduled appointment.

Insurance:

I, _____ acknowledge that my claim will be sent to my insurance carrier for reimbursement, I will be responsible for the remaining balance (if any) in accordance with my insurance plan. Such payments will be paid within 30 days of receipt of my statement.

Workman's Compensation:

I, _____ acknowledge that a claim will be filed with my workmans compensation carrier. If my claim is denied, I will be responsible for the charges n the account. Such payments will be paid within 30 days of receipt of statement. It is my responsibility to supply MFIC with the information needed to process any and all claims.

Personal Injury:

I, _____ acknowledge that a claim will be filed with my attorney, private insurance and/or claim adjustor. I will be responsible for all claims if payment is not received from the sources listed. Such payments will be paid within 30 days of receipt of statement. It is my responsibility to supply MFIC with the information needed to process any and all claims.

Signature of responsible party _____

Date ____ / ____ / ____

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Dear Patient:

Our goal at Med First is to provide the highest quality medical care to all our patients. Because our first concern is for you, your health, and the communities in which we practice, there are certain medications that we will not be able to prescribe for you on a chronic (long-term) monthly basis.

If you have an acute problem, these medications may be prescribed if appropriate in a moderate amount. Examples include but are not limited to the following pain medications:

- Bupap
- Fentanyl
- Demerol
- Fioricet
- Fiorinal
- Morphine
- Norco
- Hydrocodone
- Kadian
- Lortab
- Opana ER
- Oxycodone
- Oxycon□n
- Percoet
- Soma
- Tramadol
- Tylenol w/Codeine

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- Tylox
- Ultram

In addition, none of the above medications will be written on the first visit. We will require past medical records for review before any of the above medication will be written. We will check the Controlled Medication database prior to writing any such medication at any time. We may also request random drug tests to patients whom we supply prescriptions for such medications. If the test has discrepancies in drug testing, you will be discharged from the practice. Such drug tests are at your expense. However, under no circumstances will these types of medications be written past the first 90 days of your ongoing care. If needed, we will assist you in attempting to find you a provider to manage these medications if your need is truly chronic in nature. It is important to note that we will always continue to care for all your other primary care needs.

If you have any questions regarding this policy, please discuss them with your provider. Our goal is and always be your health and the health and safety of our community.

I, _____(patient name) have read and understand the above policy.

_____ _____
Patient Signature Date

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I. Patient's Name _____ DOB_____

Phone Number _____

If you want to allow others access to your personal health information please complete section II – IV otherwise proceed to section V

II. Please check one and provide the requested information:

_____ I hereby authorize the Med First Immediate Care & Family Practice and any of its Medical Providers to disclose my Protected Health Information to the following organization(s) and/or person(s):

Name: _____ Phone: _____ Fax: _____

Address: _____

III. I authorize the following information to be disclosed:

CHECK ONE	DATE(S)	
☐	_____	Complete Medical Record, including records from other providers and immunizations
☐	_____	Complete Medical Record while at Med First, not including records from other providers
☐	_____	GYN (Pap, Pelvic, Lab)
☐	_____	Lab
☐	_____	X-ray
☐	_____	Other or Relating to Particular Problem_____

IV. Purpose of the Requested Disclosure: Please check one and provide the requested information.

_____ At the request of the patient. _____(Patient's initials)_____

Other_____

(State specific purpose of requested disclosure)

V. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing in a letter provided to the Practice Manager or other health care provider identified in Section II above, as applicable. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my Protected Health Information have acted in reliance upon this authorization. I understand that I do not have to sign this authorization and that Med First Immediate Care & Family Practice may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I further understand that if the persons(s) or organization(s) authorized to receive the information is not a health plan or health care provider, the released information may be re-disclosed and would no longer be protected by federal privacy regulations. I understand that the information provided under this authorization may include Protected Health information which could contain diagnosis and treatment information including information pertaining to chronic and/or communicable diseases including but not limited to: alcohol or drug abuse; psychiatric or mental conditions; HIV or sexually transmitted disease; genetic disorders; and/or Sickle Cell.

Your provider and members of the practice staff may need to use your name, address, phone number, and you clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contract is made by phone and your not home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

I agree that a copy of this release or fax of this release shall be as valid as this original release. If I authorize Med First Immediate Care & Family Practice to fax the information, I realize there are inherent risks in faxing Protected Health Information.

This authorization expires upon_____

_____ _____

Signature of Patient or Patient's Representative Date

_____ _____

Printed Name of Patient's Representative Relationship to patient

Med First Immediate Care and Family Practice, PA

NOTICE OF PRIVACY PRACTICE AND PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME _____ **DATE** _____

I understand that under Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Med First Immediate Care and Family Practice, PA may use or disclose my protected health information for treatment, payment or health care operations-which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Med First Immediate Care and Family Practice, PA has a detailed document called the ***'Notice of Privacy Practices'.*** It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask, Med First Immediate Care and Family Practice, PA will provide me with the most current *Notice of Privacy Practices.*

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Med First Immediate Care and Family Practice, PA to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Med First Immediate Care and Family Practice, PA has taken action relying on this consent.

SIGNATURE (Patient or Legal Custodian/Authorized Representative) _____ **DATE** _____

Relationship to Patient if signed by another party _____ **DATE** _____

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our *'Notice'* at any time by contacting:

Med First Immediate Care and Family Practice, PA
609 Richlands Hwy #6
Jacksonville, NC 28540
or call (910) 455-7888