PATIENT ACCOUNT INFORMATION

PATIENT

PATIENT NAME_____ ☐ MALE ☐ FEMALE
LAST FIRST M.I.
PATIENTS ADDRESS_____
STREET CITY STATE ZIP CODE
PATIENTS HOME PHONE (____) ____-_____ PATIENTS CELL PHONE (____) ____-_____
PRIMARY CARE PHYSICIAN_____
MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED DATE OF BIRTH____/____/____
PATIENT EMAIL ADDRESS: _____ SOCIAL SEC #_____-____-_____
RACE: _____ ETHNICITY: _____ LANGUAGE: _____
EMPLOYER NAME_____ OCCUPATION_____
EMPLOYER ADDRESS_____ EMPLOYER PHONE # (____) ____-_____

RESPONSIBLE PARTY

NAME _____ ☐ MALE ☐ FEMALE
LAST FIRST M.I.
ADDRESS_____
STREET CITY STATE ZIP CODE
HOME PHONE (____) ____-_____ CELL PHONE (____) ____-_____
MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED DATE OF BIRTH____/____/____
EMPLOYER NAME_____ SOCIAL SEC #_____-____-_____
EMPLOYER ADDRESS_____ OCCUPATION_____
EMPLOYER PHONE # (____) ____-_____

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY NAME_____ ☐ HMO ☐PPO ☐ PRIVATE
NAME OF INSURED_____
LAST FIRST M.I.
ADDRESS_____
STREET CITY STATE ZIP CODE
INSURED DATE OF BIRTH ____/____/_____ ☐ MALE ☐ FEMALE SOCIAL SEC #_____-____-_____
INSURANCE I.D#_____ GROUP # _____
RELATIONSHIP TO PATIENT ☐ SELF ☐CHILD ☐ SPOUSE ☐ OTHER:_____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY NAME_____ ☐ HMO ☐PPO ☐ PRIVATE
NAME OF INSURED_____
LAST FIRST M.I.
ADDRESS_____
STREET CITY STATE ZIP CODE
INSURED DATE OF BIRTH ____/____/_____ ☐ MALE ☐ FEMALE SOCIAL SEC #_____-____-_____
INSURANCE I.D#_____ GROUP # _____
RELATIONSHIP TO PATIENT ☐ SELF ☐CHILD ☐ SPOUSE ☐ OTHER:

EMERGENCY CONTACT INFORMATION

NAME OF CONTACT PERSON_____ RELATIONSHIP_____
ADDRESS_____
STREET CITY STATE ZIP CODE
HOME PHONE (____) ____-_____ CELL PHONE (____) ____-_____ WORK PHONE (____) ____-_____

I hereby assign my insurance benefits to be made directly to my physician and any assisting physicians, for services rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member and understand that **I am responsible for knowing my benefits/coverage and tests ordered by my doctor may NOT be covered.** I will be financially responsible for all charges that are not covered by my insurance company. I understand that I will be charged a 1% finance charge on all accounts over 90 days. I also hereby authorize the release of all information to other physicians and insurance carriers upon request for the purpose of payment for medical services and further treatment of care by another physician. I further agree that a photocopy of this agreement shall be as valid as the original. Payment is due at the time services are rendered. All charges are the direct responsibility of the patient. We cannot render services on the assumption that out charges will be paid by the Insurance Company. Insurance is an agreement between you and you insurance company. If we have problems collecting payment from you, we will also add attorney's fees, collection agency costs and any related fees to your bill. I hereby acknowledge that I have read, understand and agree to hereby give consent for treatment.

PATIENT'S SIGNATURE_____ DATE_____

HIPAA Notice of Privacy Practices - Acknowledgement of Receipt
Newport Pulmonary and Endocrine Associates

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted on the practice website, and that a copy of Privacy Practices will be available at each appointment.

Signed: _____ Date: _____
Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

☐ parent or guardian of minor patient

☐ guardian or conservator of an incompetent patient

Name and Address of Patient:

_____
_____
_____

COMMUNICATION OF PERSONAL HEALTH INFORMATION:
General office policy is that no information may be left with anyone but the patient. While total confidentiality cannot be guaranteed, there are several options for communication.

Please check the box that corresponds with an acceptable means of communication . Checking any/all of these boxes gives us permission to communicate any and all information to you in that manner.

- ☐ Home telephone/answering machine: phone # _____
- ☐ Office telephone/answering machine: phone # _____
- ☐ Cell phone/voicemail.: phone # _____
- ☐ Family member or other designated individual: Name: _____

Confidential

Patient Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

Symptoms

Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

Conditions

Check (✓) conditions you currently have or have had in the past year.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

Medications

List medications you are currently taking.

_____

_____

_____

_____

Pharmacy Name _____ Phone _____

Allergies

_____

_____

_____

_____

_____

Health History

Family History

Fill in health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if, your blood relatives had any of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates _____

Serious Illness/Injuries	Date	Outcome

Pregnancies

Year of Birth	Sex of Birth	Complications if any

Health Habits

Check (✓) which you use and how much you use.

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

Occupational

Check (✓) if your work exposes you to:

	Stress		Hazardous Substances
	Heavy Lifting		Other

Occupation

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Reviewed By

Date