

MEDICAL HISTORY FORM

Name _____ Home Phone _____
Address _____ Cell Phone _____
City _____ State _____ Date of Birth _____
Zip Code _____ DL# _____ Sex ___ M ___ F Age _____ SS# _____
Patient's Employer _____ Occupation _____
Employer's Address _____ Work Phone _____
City _____ State _____ Zip Code _____
Any other family members who have been treated here? ___ Yes ___ No Name _____
How did you find out about our practice? _____

INSURED'S INFORMATION

Name of Insured _____ Date of Birth _____
Address _____ Home Phone _____
Driver's License # _____ Social Security # _____
Relationship: Husband/Wife/Father/Mother/Son/Daughter _____ Occupation _____
Employer _____ Work Phone _____
Employer's Address _____
City _____ State _____ Zip Code _____

IN CASE OF EMERGENCY CONTACT

Name _____ Relationship _____
Address _____ Telephone _____

Our Notice of Privacy Practices (notice) provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As outlined in our notice, the terms of our notice may change. If our notice is changed or modified, you may obtain a revised copy by requested from the receptionist.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this Form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as though original.
3. I may revoke this consent at any time, except where information has already been released. This consent is valid until revoked by me in writing.

Signature

Date

PRIMARY INSURANCE CARRIER

Name of Primary Insurance Company _____

Mailing Address for Insurance Claim _____

Name of Policy Holder _____ Relationship to policyholder _____

Name of Employer _____ Group No. _____

Policy or ID No. _____ Effective Date of Policy _____

Phone Number for Verification _____

Phone Number for Pre-certification _____

SECONDARY INSURANCE CARRIER

Name of Secondary Insurance Company _____

Mailing Address for Insurance Claim _____

Name of Policy Holder _____ Relationship to policyholder _____

Name of Employer _____ Group No. _____

Policy or ID No. _____ Effective Date of Policy _____

Phone Number for Verification _____

Phone Number for Pre-certification _____

JENNIFER STALKUP, M.D.

Payment Policy

1. We will file insurance for our PPO patients. However, all co-payment and/or deductible amounts are due at the time of the service. Any disallowed amounts are due from the patient.
2. We do not file insurance for our indemnity patients. Payment in full is expected at the time of visit and a receipt will be given for you to file with your insurance carrier.
3. There will be a twenty-five dollar (\$25) fee assessed for any returned check. This fee is assessed regardless of whether the check is redeposited, because the bank has already charged us a fee for the returned item. You will subsequently receive a bill for this amount.
4. If your account has a credit balance of more than \$10.00, a refund will be mailed to you within thirty (30) days.
5. **Your insurance policy is a contract between you and your insurance company.** It is important that you understand what physician services are and are not covered before seeing your doctor. **We cannot guarantee payment of your claims** by your insurance company. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred.

Medicare

We accept assignment and will file insurance for our Medicare patients. However, any calendar year deductible amounts (up to the amount of the visit) are due at the time of the service. We will also file secondary insurance after payment from Medicare if we are contracted with your secondary plan. If there is no secondary insurance, the patient will be billed for any remaining balance.

Referral Authorization

Referrals must be obtained prior to the visit. If a referral is not received at the time of the visit, the patient is responsible for payment when services are rendered.

Authorization

I authorize release of medical records to determine liability for payments or treatment, and to obtain reimbursement.

I assign all medical benefits for office visits to Jennifer Stalkup, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this instrument will have the same validity as the original.

Signature

Date

Please complete the following questionnaire as this will help us properly address the issues important to your health:

Please list the purpose of your visit: _____

Review of Systems: Are you currently experiencing any of the following? (please check all that apply)

SYMPTOM (CHECK IF APPLIES)	SYMPTOM (CHECK IF APPLIES)	SYMPTOM (CHECK IF APPLIES)
Abdominal Pain	Headaches	Wheezing
Anxiety	Hay Fever	Immunosuppression
Bleeding Problems	Joint Aches	Significant UV Exposure
Bloody Stool	Muscle Weakness	Allergy to Adhesive
Bloody Urine	Neck Stiffness Night Sweats	Allergy to Lidocaine
Blurry Vision	Rash	Allergy to Topical Antibiotic
Changing Mole	Seizures	MRSA
Chest Pain	Shortness of Breath	History of Fainting
Cough	Sore Throat	History of Vasovagal
Depression	Thyroid Problems	
Fever or Chills	Unintentional Weight Loss	

Cautions: (please circle all that apply)

Have you ever had difficulty stopping bleeding?	Yes	No
Do you require antibiotics prior to a surgical procedure?	Yes	No
Have you had an artificial joint replacement?	Yes	No
If yes, when and what body locations? _____		
Do you have an artificial heart valve?	Yes	No
Do you have a pacemaker?	Yes	No
Do you have a defibrillator?	Yes	No

WOMEN ONLY

Are you pregnant or currently trying to get pregnant? Yes No
If you circled **No**, how are you preventing? _____
Date last period began? _____
Difficulties with periods? _____ Age at menopause: _____

PHARMACY NAME: _____
ADDRESS: _____
PHONE # _____
CROSS STREETS: _____

HISTORY	PERSONAL yes/no	FAMILY yes/no	specify member
Anemia			
Arthritis			
Asthma			
Auto immune disease			
Bladder disease			
Bleeding disorders			
Bowel disease			
Diabetes			
Dementia			
Epilepsy			
Glaucoma			
Hepatitis			
High blood pressure			
Hives			

HISTORY	PERSONAL yes/no	FAMILY yes/no	specify member
HIV/AIDS			
Intestinal disease			
Liver disease			
Lung disease			
Lupus			
Migraine			
Psoriasis			
Scarring, unusual			
Sinus problems			
Skin cancer			
Tuberculosis			
Thyroid problems			
Ulcer - stomach			

Social History: (please circle all that apply)

SMOKING STATUS: ALCOHOL USE:

Current More than 1/day

Former Less than 1/day

Never Never Drink

Medications

Please list any medications you take regularly. Prescription, non-prescription, vitamins, home remedies, birth control pills, and herbs: None

Medication (including strength)	How many times a day	How long taken

Are you allergic to any medications? (If yes, please list below) Yes No

Allergic to:

**Office
Use
Only**

Intake form reviewed	_____

I, _____ give the office of Dr. Jennifer Stalkup permission to speak with the following family members, spouse, roommates, etc. , regarding any billing issues, lab results, or any information pertaining to my treatment and care.

Please list the numbers yo would like for us to call YOU:

1. _____ Can we leave a message? Yes No

2. _____ Can we leave a message? Yes No

Signed: _____

Date: _____

(This will expire in 12 months from the above date.)