Physician Office Home Medication Record

Patient Name___________________________________**DOB**____

List Any Drug Allergies and Reactions to them:

____

____

	MEDICATION NAME AND STRENGTH	DOSAGE	HOW LONG HAVE YOU BEEN ON THIS MEDICATION	PREFERRED PHARMACY	PHARMACY PHONE NUMBER
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					

Who is your primary care physician? ____

(To be filled out by office personnel): Am I a candidate for ANSAR Yes_______ No_______

MinuteMed Walk In Clinic

New Patient Information Form

=====================================PATIENT INFORMATION=====================================

Last Name: ___________________________ First Name: ____________________ Middle Initial: ____________

Address: ___________________________ City: ____________________ State_______ Zip __________

Home Phone: __________________________ Date of Birth: _______/_______/_______ SS# ______-______-______

Sex: Male/Female Emergency Contact: _________________________ Number: _______________________

Employer: _____________________________________ Employer Phone: _______________________________

=====================================INSURANCE INFORMATION=====================================

Do Not Fill This portion out if you have your insurance card with you.

Name of Insured: ___________________________________ Relationship to Patient: _________________________

Insured's Date of Birth: _______/_______/_______ SS# of Insured __________-__________-____________

Insurance Company: ______________________________________ Insurance Phone: ________________________

Insurance Claims Address: ____

Policy # ____ Group # ____________________________________

================================INJURY/ACCIDENTINFORMATION=================================

Motor Vehicle Accident: Yes/No Work Related Injury: Yes/No Date of Injury: _______/_______/_______

Is this Worker's Compensation: Yes/No W/C Company: ____

Contact Person: ____Phone Number: _______________________

Do you have an attorney: Yes/No Attorney Name: __________________________Phone #:___________________

Attorney Address: ____ Contact Person: _______________________

I acknowledge that the information I have provided is true and correct and I am ultimately responsible for payment of all charges incurred for my services. I hereby authorize and demand the assignment of my basic medical, auto medical, third party medical or any other medical benefits that may apply, herein specified and otherwise payable to me, directly to MinuteMed Walk in Clinic. I authorize MinuteMed Walk in Clinic to release my medical information acquired in the course of my treatment and examination to my insurance company. I authorize MinuteMed Walk in Clinic to render treatment to me and grant permission to MinuteMed Walk in Clinic to obtain medical records from other healthcare providers which whom I am under the care of. If for any reason the account should become delinquent, I agree to pay all rebilling charges, interest charges, cost of collections and reasonable legal fees. I have read and understood all of MinuteMed Walk in Clinic's payment policies.

Signature of Responsible Party: ____ Date: _____________________________

Patient Health History

Name: ________________________DOB:__________________ Age: _____________ Date: _______________________

CHIEF COMPLAINT: ____

Medical and Family History: Check off what applies to you or family member:

	Self-S	Family-F	None-N
High Blood Pressure	_____	_____	_____
Diabetes	_____	_____	_____
Heart Attack	_____	_____	_____
Heart Disease	_____	_____	_____
Stroke	_____	_____	_____
Seizures	_____	_____	_____
Cancer	_____	_____	_____
Serious Accident/Trauma	_____	_____	____
Blockages in arms/legs	_____	_____	____
Anxiety	_____	_____	_____
Heart Failure	_____	_____	_____
Attention Deficit Dis.	_____	_____	_____
Peptic Ulcer Disease	_____	_____	_____

	Self-S	Family-F	None-N
Lung Disease (Emphysema, Bronchitis, Asthma, TB)	_____	_____	_____
Hiatal Hernia, Umbilical Hernia, Inguinal Hernia	_____	_____	_____
Kidney Disease, Prostate, UTI	_____	_____	_____
Phlebitis, Deep Vein Thrombosis (Blood Clot)	_____	_____	_____
Bleeding Problems (Free Bleeder, Hepatitis, Sickle Cell)	_____	_____	_____
Alcohol or Drug Abuse	_____	_____	_____
Arthritis	_____	_____	_____
Glaucoma/Cataracts	_____	_____	_____
Depression	_____	_____	_____
Mental Illness	_____	_____	_____
Malabsorption Syndrome	_____	_____	_____
Thyroid Disease	_____	_____	_____
Liver Disease/Hepatitis	_____	_____	_____

Please place a mark next to any symptom which you are currently experiencing within the past six months:

Dizziness _____ Fatigue _____ Difficulty Walking ____ Cough _____ Constipation_____ Syncope_____

Headache _____ Diarrhea_____ Stomach Pains _____ Insomnia _____ Bloating_____ Neuropathy_____

Wheezing _____ Rhinitis _____ Runny Nose _____ Weigh Loss____ Weight Gain_____

Difficulty Sleeping _____ Racing Heart/Tachycardia _____ Heartburn/Reflux_____ Falls or imbalance______

Chronic Abdominal pain _____ Shortness of Breath_____ Passing Out_____

Previous Surgeries: ____

____

Are your immunizations up to date: Yes _______ No: _______ Have you had your preventive care visit this year Yes _______ No: _______

Do you use Tobacco now? Yes/No In the Past? Yes/No Amount Per Day? __________ How Long? ___________

Do you Drink Alcohol? Yes/No How Much? _________________________

Do you drink caffeine: Yes/No In the Past? Yes/No Amount Per Day? __________ How Long? ___________

Do you use illegal drugs? Yes/No In the Past? Yes/No For How Long? ___________

Any prior STD's? Yes/No

Married Single Divorced Widowed Seperated

Woman Only:

Are you pregnant or planning pregnancy? Yes/No Are you on Birth Control? Yes/No Do you still have a Menstrual Cycle? Yes/No

LMP____________________ Is your Mammogram up to date? Yes/No Is your Papsmear up to date? Yes/No

ASSIGNMENT AND RELEASE:

- I assign to MinuteMed Walk in Clinic my insurance benefits. Otherwise, services rendered will be payable by me.
- I understand that I am financially responsible for all charges whether or not paid by insurance.
- I hereby authorize MinuteMed Walk in Clinic to release all information necessary to secure the payment of benefits.
- I authorize the use of this signature on all insurance submissions.
- I understand that if, for any reason, this account is placed with a collection agency, any collection fee will be my responsibility.
- I also authorize this office to provide the necessary medical treatment to improve my health condition.

Responsible party: ____

Today's Date: _____________________________

Please Read and Sign Below:

MinuteMed Walk In Clinic Scope of Treatment

I understand that MinuteMed is a walk in clinic and not an **EMERGENCY ROOM**. I also understand that MinuteMed cannot treat life threatening or emergent conditions. I am also aware that if I am treated here at MinuteMed, I will follow up with my primary care physician or the local emergency room if my condition does not improve or if it worsens.

Responsible party: ____

Today's Date: _____________________________

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS.

- I hereby acknowledge that I have the right to request a copy of a written notice of my privacy rights and,
- I consent to MinuteMed Walk in Clinic using and disclosing my protected health information to carry out treatment, payment, or health care operations.
- I understand that I have the right to request a written copy of a *Notice of Privacy Practices,* which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent.
- I understand that MinuteMed Walk in Clinic reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by written request.
- I understand that I have the right to restrict how MinuteMed Walk in Clinic uses or discloses my protected health information to carry out treatment, and payment for provided services.
- I request the following restrictions to how my health information is used or disclosed: _______________

____

____ ________________________

Signature of patient or patient's representative **Date**

PATIENT'S RIGHTS AND RESPONSIBILITIES

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to be given by the health care provider information concerning planned course of treatment, alternatives, risk, and prognosis.
- A patient has the right to refuse treatment, except as otherwise provided by law.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to express grievances regarding any violations of his or her rights, as stated in Louisiana law, through and grievance procedure to the health care provider.
- A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A patient is responsible for following the treatment plan recommended by the health care provider.
- A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, must notify the health care provider.

I understand and agree with the above patient rights and responsibilities.

Signature: ____ Date: ____________________