Affinity PRIMARY CARE

PATIENT INFORMATION **Date:** _____

Name: First _____ MI_____ Last _____

SS# _____ DOB: _____ Gender: ☐ M ☐ F

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Life Partner

Occupation (if applicable): _____

Parent / Legal Guardian Name if patient is minor _____ DOB _____

Race: ☐ White / Caucasian ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native

☐ Native Hawaiian/Pacific Islander ☐ Declined

Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined

Preferred Language: ☐ English ☐ Spanish Other _____

Do you have any communication difficulties/ special needs? ☐ Hearing Loss ☐ Interpreter Required

☐ Reading Difficulty ☐ Sight Impaired ☐ Other _____

Address: _____ Apt # _____

City _____ State _____ Zip _____

Phone: Home _____ Cell _____

Work _____Email: _____

Best Contact Method: ☐ Home ☐ Cell ☐ Work ☐ EMail ☐ Mail

OK TO LEAVE NORMAL TEST RESULTS ON VOICEMAIL? ☐ YES ☐ NO

FINANCIALLY RESPONSIBLE PARTY

☐ Same as Patient Information (If different, please complete section below)

Name: First _____ MI_____ Last _____

Relationship: Spouse Parent Guardian Other (Please Specify): _____

Address: _____Apt #_____

City _____State _____Zip _____

Phone: Home_____Cell_____

Work _____ Email Address _____

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____

Phone: _____ Home _____

Cell _____ Work _____

MEDICATION REFILL

Please review your medications before coming to the office visit to get sufficient refills until your next visit. Please contact your pharmacy for medication refills. Your Pharmacy will fax us a medication refill request which the physician will review. Refill authorizations may require up to 72 hours. Please allow sufficient time for us to process your refill request. Controlled drug substances (narcotic) prescriptions must be filled during office visits and WILL NOT BE REFILLED AFTER HOURS, ON WEEKENDS, OR BY THE ON-CALL PHYSICIAN. ANY LOST OR STOLEN CONTROLLED MEDICATION PRESCRIPTIONS WILL NOT BE REPLACED.

Pharmacy Name/Location _____

_____

Do we have permission to receive medication history on patient via electronic prescription?☐YES ☐NO

_____ Date: _____

Patient's Signature (Required)

OPTIONAL AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO OTHERS

☐ Do Not Release Information

☐ I authorize **Affinity Primary Care, LLC** and its representatives to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, billing information and/or medical care. This authorization will remain in effect until I provide written notification to **Affinity Primary Care** of any changes or updates. I authorize **Affinity Primary Care** to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, insurance, billing information, test results and/or medical care.

Name_____Relationship_____

Phone_____

You may release the following information to the person named above:

☐ Appointments ☐ Billing Information ☐ Medical Care ☐ Leave Message

Name_____Relationship_____

Phone _____

You may release the following information to the person named above:

☐ Appointments ☐ Billing Information ☐ Medical Care ☐ Leave Message

FINANCIAL AND PAYMENT GUIDELINES

Notice: Our office does NOT file Auto Insurance claims for visits relating to motor vehicle accidents or Worker's Compensation.

Payment is due at the time of service. This includes all co-pays, deductibles and co-insurance. I authorize direct payment of my insurance benefits to **Affinity Primary Care, LLC** for services rendered to myself or dependents. Insurance will be filed for services rendered. Any charges for services not covered by insurance will be the responsibility of the patient or his/her guardian. I understand that it is my responsibility to know my insurance benefits and whether or not the services rendered are covered benefits. Patient or guardian is responsible for notifying our office of any changes to demographics or insurance and billing information. Out of Network services not paid by the health insurance company will be the responsibility of the patient or his/her guardian**. Affinity Primary Care** or its authorized agent will provide medical information to the insurance company as required for payment of claims for services rendered.

CONSENT FOR TREATMENT, RELEASE OF INFORMATION, AUTHORIZATION & ASSIGNMENT OF BENEFITS

I consent to treatment necessary to the care which has been discussed and directed by the provider. I authorize the release of all medical records to specialists and/or consulting physicians if applicable to my care and condition. I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, its intermediaries, its carriers, or any other insurance carrier any information needed for this or any other related claim to be processed. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to me or to the party who accepts the assignment. I understand it is mandatory to notify the health care provider of any party who may be responsible for paying for my treatment. I further authorize and request that insurance payments be directed to **Affinity Primary Care, LLC.**

Authorization to Treat a Minor (Ages 0-17 th Birthday)

If there are circumstances when I am unable to bring my child to the office for his/her evaluation and treatment, I give my permission and authorization for the following persons (over the age of 18) to obtain medical care for my child or my child has permission to be seen without a parent. I also authorize the providers of **Affinity Primary Care** to discuss or disclose information regarding any matters relating to my child's appointment, insurance, test results or medical care to those listed below. This authorization will remain in effect until I provide written notification to **Affinity Primary Care** of changes or updates. I authorize **Affinity Primary Care** to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, insurance, billing information, test results and/or medical care.

Name_____ Relationship_____

Phone _____

Name_____ Relationship_____

Phone _____

Name_____ Relationship_____

Phone _____

I have read, fully understand and agree to the above medication refill guidelines, financial responsibility statement, payment guidelines, consent for treatment and release of medical information & insurance authorization. I also certify that all of the information provided is complete and accurate.

Patient Name _____Signature _____ Date _____

Patient Name:_____ Date of Birth: _____

Other specialists involved in your medical care:
Name/Specialty:_____

_____

PAST MEDICAL HISTORY *(Please circle if you have any of the below.)*

ADHD/ADD	Diverticulitis	MI (Heart Attack)
AIDS/HIV	DVT (Blood Clot in Legs)	Migraine Headache
Asthma	Eczema	Neurological Disorder
Atrial Fibrillation	GI Bleed	Osteoarthritis
Anemia	Gerd (Acid Reflux)	Osteoporosis
Anxiety	Hemochromatosis	Peripheral vascular disease
Autoimmune Disease (Lupus)	High Blood Pressure	PUD (Stomach Ulcers)
Bipolar Disorder	High Cholesterol	Rheumatoid Arthritis
Brain Tumor	Hypothyroidism	Seizure Disorder
Cirrhosis	Hyperthyroidism	Thyroid Nodule
CVA/Stroke	Goiter	Tuberculosis
COPD	Hepatitis A	Valvular Heart Disease
Colon Cancer	Hepatitis B	UTI - Recurrent
Coronary Heart Disease	Hepatitis C	Varicose Veins/Phlebitis
Crohn's Disease	Infertility	AbnormalPapSmear
Chronic Kidney Disease	Insomnia	Breast Disease
Depression	Kidney Stones	Breast Cancer
Diabetes Type 1	Liver Disease	Cervical Cancer
Diabetes Type 2	Lung Cancer	Gestational Diabetes

Other: _____

PAST SURGICAL HISTORY:

_____

_____

_____

_____

_____

FAMILY MEDICAL HISTORY:

_____

_____

ALLERGIES AND MEDICATION REACTIONS: (Please mention the type of medication reaction)

_____

_____

_____

Smoker: ☐ YES ☐ NO Date Quit (if applicable):

Alcohol Consumption: ☐ YES ☐ NO How Often (if applicable):

Recreational Drug Use: ☐ YES ☐ NO Please describe (if applicable):

Exercise: ☐ YES ☐ NO Duration: _____mins Times per week _____

When was your last vaccine on the following:

	Date	Would you like one?
Flu Vaccine	_____	Yes / No
Hepatitis B Vaccine	_____	Yes / No
Tetanus Vaccine	_____	Yes / No
Pneumonia Vaccine	_____	Yes / No
Shingles Vaccine	_____	Yes / No

CURRENT MEDICATIONS: (skip if you have a list or brought bottles)

MEDICATION	DOSAGE	DIRECTIONS	NOTES

Please enter the most recent date and results of the following:

	Date	**Results**	**Performed by (who/where)**
Colonoscopy	_____	_____	_____
Pap Smear	_____	_____	_____
Mammogram	_____	_____	_____
Bone Density Scan	_____	_____	_____
PSA (Prostate Screen)	_____	_____	_____
Eye exam	_____	_____	_____