SYNERGY
Health Solutions

Patient Information Forms

☐ **New Patient** ☐ **Updating Information**

Patient Full Legal Name: _____ Goes By: _____
Date of Birth: _____/_____/_____ SSN: _____-_____-_____ Gender: ☐Male ☐Female
Preferred Language: ☐English ☐Spanish ☐Other: _____ Race: _____
Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino ☐Other: _____

Address: _____
Phone Number: (_____)_____-_____Home/Work/Cell Phone Number: (_____)_____-_____Home/Work/Cell
Email Address: _____

Employer: _____ Occupation: _____
Marital Status: ☐Single ☐Married ☐Live with partner ☐Separated ☐Divorced
Emergency Contact Name: _____ Relationship: _____ Phone: (_____)_____-_____

Guarantor Name (person responsible for bill): ☐ Self
Name (if other than self): _____ Relationship: _____
Guarantor DOB: _____/_____/_____ Guarantor SSN: _____-_____-_____ Also insurance policy holder? ☐ Yes ☐No
Address: _____
Phone Number: (_____)_____-_____Home/Work/Cell Email Address: _____

Insurance Information: (leave blank if you don't have insurance)
Primary Insurance Company: _____ Policy Effective Date: _____/_____/_____
Policy Holder Name: _____ DOB: _____/_____/_____ Relationship: _____

Financial Responsibility: I will be financially responsible for any and all charges for services rendered at Vickery Family Medicine that are not paid by my insurance company. I agree that I will make full payment for my visit today depending on what my insurance policy requires. It is my responsibility, and not the responsibility of Vickery Family Medicine to know if my insurance will pay for my office visit or medical services. It is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network amounts, usual and customary limit, or any other type of benefit limitation. It is my responsibility to know if the provider I am seeing is a contracted in-network provider recognized by my insurance company. It is also my responsibility to know if my choice of primary care physician has been processed by my insurance company. **Initial: _____**

24 Hour Appointment Cancellation Policy: I acknowledge that Vickery Family Medicine has a 24 hour cancellation / rescheduling policy. If I miss my appointment, cancel, or change your appointment less than 24 hours from my appointment, I will be charged $35.00. This policy is in place out of respect for our providers and other patients. Cancellations with less than 24 hours' notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to use the open time slot. **Initial: _____**

Ancillary Services: Your physician may refer you to one or more "ancillary services" which is a service relating to your medical care or treatment. Ancillary services may include, but are not limited to, MRI, CT scan, x-ray, or audiology testing. You are not obligated to use to provider/facility that your physician refers you to. You are free to choose the provider/facility of your choice. I understand that I may receive a separate bill if my medical care includes labs, radiology, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balances due for these services if they are not reimbursed by my insurance for whatever reason. **Initial: _____**

Assignment of Insurance Benefits: I hereby authorize direct payment of my insurance benefits to Vickery Family Medicine, PLLC or the physician individually for services rendered to my dependents, or me, by the physician or those under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Vickery Family Medicine, PLLC is unable to collect from my insurance carrier for whatever reason. **Initial: _____**

Medicare/Medicaid/CHAMPUS Insurance Benefits: I certify that that information given by me in applying for payment under these programs is correct. I authorize the release of any of my, or my dependent's records that these programs may request. I hereby direct that payment of my, or my dependent's authorized benefits be made directly to Vickery Family Medicine, PLLC or the physician on my behalf. **Initial: _____**

Authorization to Release Non-Public Personal Information: I certify that I have been offered and read a copy of the "HIPPA Notice of Privacy Practices". I hereby authorize Vickery Family Medicine, PLLC or the physician individually to release any of my, or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits. **Initial: _____**

Authorization to Mail, Call, Text, or E-Mail: I certify that I understand the privacy risks of mail, phone calls, texts, or emails. I hereby authorize the staff of Vickery Family Medicine, PLLC to mail, call, text, or email me in regards to my healthcare, including but not limited to, appointment reminders, referral arrangements, and diagnostic test results. I understand that I have the right to rescind this authorization at any time by notifying Vickery Family Medicine, PLLC of this change in writing. **Initial: _____**

Collections: VFM partners with Professional Recovery Consultants for any outstanding claims. Claims will be turned over to PRC if a bill has not been paid within 90 days from the date of service and no payment arrangements have been made with VFM billing department. I agree in order for Vickery Family Medicine, PLLC and Professional Recovery Consultants to be able to service my account or collect any amounts I may owe, that I may be contacted by telephone at any telephone number associated with my account, including wireless numbers, which could result in charges from my wireless carrier. Methods of contact may include re-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. **Initial: _____**

HIPAA Information Release: IN ORDER TO PROTECT YOUR PATIENT CONFIDENTIALITY, WE NEED TO KNOW IF THERE IS A PHONE NUMBER (WITH VOICEMAIL) FOR YOU WHERE WE LEAVE RESULTS OF YOUR LABORATORY TESTS OR OTHER SENSITIVE INFORMATION. BY INDICATING THE INFORMATION BELOW, I GIVE VICKERY FAMILY MEDICINE EMPLOYEES PERMISSION TO LEAVE CONFIDENTIAL HEALTH CARE INFORMATION FOR ME AT THE FOLLOWING PHONE NUMBER(S):

Phone Number: (_____)_____-_____Home/Work/Cell Phone Number: (_____)_____-_____Home/Work/Cell

☐ I do NOT wish to have any of my information recorded on my personal voicemail.

I HEREBY AUTHORIZE ONE OR ALL OF THE PARTIES BELOW TO REQUEST AND RECEIVE ANY PROTECTED HEALTH INFORMATION VERBALLY OR IN A VOICEMAIL MESSAGE AS DESIGNATED BELOW. I UNDERSTAND THAT THE INDENTITIES OF EACH DESIGNATED PARTY MUST BE VERIFIED BEFORE THE RELEASE OF ANY INFORMATION.

☐ I do NOT wish to have any of my information released to someone other than myself.

Name: _____ Relationship: _____ Phone Number: (_____)_____-_____
May speak with them in regards to: ☐Appointments ☐Treatments ☐Payments/Billing ☐Diagnostic Test Results

Name: _____ Relationship: _____ Phone Number: (_____)_____-_____
May speak with them in regards to: ☐Appointments ☐Treatments ☐Payments/Billing ☐Diagnostic Test Results

Name: _____ Relationship: _____ Phone Number: (_____)_____-_____
May speak with them in regards to: ☐Appointments ☐Treatments ☐Payments/Billing ☐Diagnostic Test Results

I UNDERSTAND THAT THE INFORMATION ABOVE WILL BE USED UNTIL I NOTIFY VICKERY FAMILY MEDICINE IN WRITING IF A CONTACT(S) SHOULD NO LONGER BE USED.

Signature: _____ Date: _____/_____/_____

Name if parent/guardian signature (please print): _____

Patient Name: _____ DOB: _____

Allergies to Medications: ☐ No known drug allergies
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Other Allergies: _____

Family Medical History:
Mother's Health Conditions: _____
Living? Y / N If deceased, what was her cause of death, at what age? _____
Father's Health Conditions: _____
Living? Y / N If deceased, what was his cause of death, at what age? _____
Sibling's Health Conditions: _____

Tobacco Use: ☐ Never smoked
☐ Current cigarette smoker Start year: _____ Packs per day: _____
☐ Current e-cigarette/vapor Start year: _____ Times per day: _____
☐ Smokeless tobacco Start year: _____ Times per day: _____
☐ Former tobacco user Start/Quit year: _____ Packs per day: _____
Caffeine Use: ☐ None ☐ Coffee ☐ Tea ☐ Soda ☐ Energy drink Servings per day: _____
Drug Use: ☐ Never ☐ Current drug use ☐ Past drug use, quit date: ____/____/_____
Drug used: _____ ☐ Rarely 1-2/year ☐ 1-2/day ☐ 3-4/week ☐ 1-2/month
Drug used: _____ ☐ Rarely 1-2/year ☐ 1-2/day ☐ 3-4/week ☐ 1-2/month
Alcohol Use: ☐ Never ☐ Rarely 1-2/year ☐ 1-2 drinks/day ☐ 2-3 drinks/day ☐ 4+ drinks per day
Living Situation: Who lives at home with you? _____
Exercise: _____ minutes/day _____days/week Activity type: _____

Are you currently sexually active? ☐ No ☐ Previously ☐ Yes, number of partners in past 3 months: _____
Do you have a history of STIs? ☐ No ☐ Chlamydia ☐ Herpes ☐ Gonorrhea ☐ Syphilis ☐ HIV ☐ AIDs
Have you traveled outside the U.S in the past year? ☐ No ☐ Yes, date of travel: ___/____/____ Country: _____

Medications: Please list any prescription medications you take on a daily basis.
☐ None
Name: _____ Strength: _____ Frequency: _____
Name: _____ Strength: _____ Frequency: _____
Name: _____ Strength: _____ Frequency: _____
Name: _____ Strength: _____ Frequency: _____
Name: _____ Strength: _____ Frequency: _____
Vitamins/Supplements: Please list any over the counter vitamins or supplements you are currently taking.
☐ None
Name: _____ Strength: _____ Frequency: _____ Reason: _____
Name: _____ Strength: _____ Frequency: _____ Reason: _____
Name: _____ Strength: _____ Frequency: _____ Reason: _____

Preferred local pharmacy: _____ **Mail Order (if applicable):** _____

Previous surgeries or hospitalizations: ☐ None
Procedure/Reason: _____ Date: ____/____/____Hospital/Surgeon: _____
Procedure/Reason: _____ Date: ____/____/____Hospital/Surgeon: _____
Procedure/Reason: _____ Date: ____/____/____Hospital/Surgeon: _____

Specialists: Do you see any other medical providers? (Dermatologist, ophthalmologist, cardiologist, gynecologist, etc.)
Office/Doctor: _____ Why? _____ Date of last visit: ____/____/____
Office/Doctor: _____ Why? _____ Date of last visit: ____/____/____
Office/Doctor: _____ Why? _____ Date of last visit: ____/____/____

Preventive Screenings:
Last annual physical, Date: ____/____/_____ Office: _____
Colonoscopy, Date: ____/____/_____ Office: _____ Results: ☐ Normal ☐Abnormal
DEXA (bone density), Date: ____/____/_____ Office: _____ Results: ☐ Normal ☐Abnormal
PAP Smear, Date: ____/____/_____ Office: _____ Results: ☐ Normal ☐Abnormal
Mammogram, Date: ____/____/_____ Office: _____ Results: ☐ Normal ☐Abnormal

Immunizations:
Hepatitis B: ☐No ☐ Yes, date: ____/____/_____ Pneumonia: ☐No ☐ Yes, date: ____/____/_____
HPV: ☐No ☐ Yes, date: ____/____/_____ Zostavax (Shingles): ☐No ☐ Yes, date: ____/____/_____
Influenza: ☐No ☐ Yes, date: ____/____/_____ Tetanus: ☐No ☐ Yes, date: ____/____/_____

Do you wear your seat belt? ☐ Yes ☐ No Are there smoke detectors in your home? ☐ Yes ☐ No
Do you have any advanced directives? (living will, durable power of attorney for medical decisions) ☐ Yes ☐ No

Past Medical History: PLEASE CHECK ANY CONDITIONS YOU HAVE BEEN DIAGNOSED WITH IN THE PAST.

☐ Asthma	☐ CVA (stroke)	☐ GERD
☐ Bleeding disorder	☐ Diabetes	☐ High blood pressure
☐ Cancer	☐ Depression	☐ High cholesterol
☐ Heart Disease	☐ DVT or PE (blood clots)	☐ Kidney disease
☐ COPD	☐ Digestive disorder	☐ Thyroid disease

Review of Systems: Please check any of the following symptoms you are experiencing today or have in the past month that you would like to discuss with the provider.

General: ☐Fever ☐Fatigue ☐Weight Gain ☐Weight Loss
Skin: ☐Change in wart or mole ☐Rash ☐New lesion of concern
EENT: ☐Visual Loss ☐Hearing Loss ☐Ringing in Ears ☐Nose Bleed ☐Sore Throat
Respiratory: ☐Cough ☐Difficulty Breathing ☐Shortness of Breath ☐Snoring ☐Wheezing
Cardiovascular: ☐Chest Pain ☐Heart Murmur ☐Irregular Heartbeat ☐Leg Pain / Swelling
Gastrointestinal: ☐Abdominal Pain ☐Blood in Stool ☐Constipation ☐Diarrhea ☐Heartburn ☐Nausea
Females: ☐Vaginal Bleeding ☐Irregular Periods ☐Currently Pregnant ☐Last Menstrual Period: ____/____/_____
Males: ☐Change in stream ☐Difficulty with erection ☐Hesitancy ☐Urethral Discharge ☐Testicular Mass/Pain
Musculoskeletal: ☐Back Pain ☐Joint Pain ☐Joint Stiffness ☐Joint Swelling ☐Muscle Weakness ☐Muscle Pain
Neurological: ☐Decreased Memory ☐Dizziness ☐Headache ☐Numbness ☐Seizures ☐Tremor ☐Weakness
Psychiatric: ☐Anxiety ☐Depression ☐Hallucinations ☐Insomnia ☐Mood Changes ☐Nervousness ☐Panic Attack
Endocrine: ☐Cold Intolerance ☐Excessive Thirst ☐Excessive Urination ☐Hot Flashes ☐Libido Changes
Hematology: ☐Blood Clots ☐Bruise Easily

Consent to Treatment: By signing below I verify that the information above is true and complete to the best of my knowledge. I hereby consent to evaluation, testing, and treatment as directed by the medical providers at Vickery Family Medicine, PLLC.

Signature: _____ Date: _____/_____/_____

Name if parent/guardian signature (please print): _____