

PATIENT NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_

**PLEASE PROVIDE THE FOLLOWING MEDICAL INFORMATION TO THE BEST OF YOUR ABILITY:**

What problems are you here for today?	List any allergies to meds.	List Current Medications

Past Medical History(MA to elaborate on "YES" responses)

**Please check the "Yes" or "No" box to indicate if you have/had any of the following illnesses.**

	YES	NO		YES	NO
Arthritis/Joint Pain	___	___	Stomach or Intestinal Problems	___	___
Diabetes	___	___	Allergy Problems	___	___
High Blood Pressure	___	___	Kidney Problems	___	___
Thyroid Problems	___	___	Neurological Problems	___	___
Heart Disease/Cholesterol Prob.	___	___	Stroke	___	___
Respiratory Problems	___	___	Skin Cancer	___	___
Bleeding Disorder	___	___	Skin Disease	___	___
Cancer Other Than Skin	___	___			

**PLEASE LIST YOUR CURRENT PRIMARY CARE PHYSICIAN \_\_\_\_\_**

Please list any OPERATIONS/HOSPITALIZATIONS (and dates) you have ever had:

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**SOCIAL HISTORY:**

Do you smoke? ___YES ___NO: IF YES, AMOUNT ___	Have you been exposed to Hepatitis B/C? ___YES ___NO
If NO, Did You Smoke Previously? _____	Have you ever had a blistering sunburn? ___YES ___NO
Do you drink alcoholic beverages? ___YES ___NO	Do you use sun screen? ___YES ___NO
If YES, frequency _____	If YES, what SPF _____
Have you been exposed to HIV? ___YES ___NO	Have you been exposed to T.B.? ___YES ___NO
OCCUPATION: _____	HOBBIES/LEISURE ACTIVITIES: _____

**FEMALE PATIENTS CHILD BEARING AGE PLEASE ANSWER THE FOLLOWING:**

Are you pregnant? \_\_\_YES \_\_\_NO Breast feeding? \_\_\_YES \_\_\_NO Planning a pregnancy? \_\_\_YES \_\_\_NO

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**FAMILY HISTORY:**

Please check the "YES" or "NO" box to indicate whether any relatives have OR had any of the following illnesses.

If YES, please circle which relative(s) have the problem:

	YES	NO	MOTHER	FATHER	SIBLINGS	COMMENTS
DIABETES	___	___	MOTHER	FATHER	SIBLINGS	
SKIN CANCER	___	___	MOTHER	FATHER	SIBLINGS	
BLEEDING DISORDER	___	___	MOTHER	FATHER	SIBLINGS	
SKIN DISEASES	___	___	MOTHER	FATHER	SIBLINGS	
ECZEMA	___	___	MOTHER	FATHER	SIBLINGS	
PSORIASIS	___	___	MOTHER	FATHER	SIBLINGS	
CANCER (TYPE IF KNOWN)	___	___	MOTHER	FATHER	SIBLINGS	

PATIENT QUESTIONNAIRE

Page # 2

PATIENT NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_

**Please provide the following medical information to the best of your ability:**

Review of Systems:

1. Please check the "YES" or "NO" box to indicate if you have any of the following symptoms.

2. For any "YES" responses, check the "CURRENT" box if this symptom relates to the reason for your visit today.

		YES	NO	CURRENT			YES	NO	CURRENT
<b>GENERAL</b>	CHILLS				<b>HEME/LYM</b>	SWOLLEN GLANDS			
	FEVER					BLEEDING PROBLEMS			
	WEIGHT LOSS/GAIN					RECURRENT INFECTIONS			
<b>ALLERGY</b>	ITCHY EYES					SWEATING AT NIGHT			
	WATERY EYES					EASY BRUISING			
<b>NEURO</b>	HEADACHES				<b>NAILS</b>	DISCOLORED			
	SEIZURES					PAINFUL			
	WEAKNESS IN LIMBS					BRITTLE			
	NUMBNESS/TINGLING					LOOSE			
<b>EYES</b>	VISION CHANGES				<b>PSYCH</b>	DEPRESSION			
	PAIN/PRESSURE					ANXIETY			
<b>ENT</b>	HEARING LOSS				<b>SKIN</b>	RASH			
	DIZZINESS					MOLE CHANGES			
	LIGHTHEADEDNESS					REDNESS			
<b>RESPIRATORY</b>	COUGH					RAISED SCALY AREAS			
	SHORTNESS OF BREATH					OPEN SORES			
<b>CVS</b>	CHEST PAIN					ACNE			
	VARICOSE VEINS					GROWTHS/SPOTS			
	ANKLE SWELLING					HAIR LOSS			
<b>G.I.</b>	HEARTBURN					SUN SUSCEPTIBILITY			
	DIFFICULTY SWALLOWING					ITCHING			
<b>G.U.</b>	PROSTATE PROBLEMS					HIVES			
	FREQUENT URINATION					BLISTERING SUNBURN			
<b>MUSK</b>	JOINT ACHES					KELOIDS SCARS			
	BACK PAIN				DRY MOUTH/NOSE				
<b>ENDO</b>	EXCESSIVE SWEATING				DRY SKIN				
	EXCESSIVE THIRST				JAUNDICE				
	INTOLERANCE HEAT/COLD				EVER HAD A SKIN BIOPSY?				

My signature affirms that I have completed pages 1 and 2 of this form accurately and completely to the best of my ability.

**PATIENT SIGNATURE:**

**DATE:**

COMMENTS:

**SEE ATTACHED DICTATION**

PG 1 & 2 REV'D BY:

DATE:

MEDICAL ASSISTANT

PG 1 & 2 REV'D BY:

DATE:

PHYSICIAN SIGNATURE

Updated May 2013 gjk



### PATIENT CONSENT- HIPAA

With my consent, JENNIFER CAUDILL, MD PLLC may use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations. Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures- available upon request. Our office reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the office of JENNIFER CAUDILL, MD PLLC.

By signing this form, I am consenting to the use and disclosure of my Protected Health Information (PHI) to carry out treatment, payment and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon prior consent. If I do not sign this consent, JENNIFER CAUDILL, MD may decline to provide treatment to me.

PLEASE CHECK BOXES THAT APPLY:

- I **DO** give consent to leave **voicemail messages** on the phone numbers provided regarding results or any medical information about my care, appointments, and payment information.
- I **DO** give consent to correspond with the office by **text messages** regarding results or any medical information about my care, appointments, and payment information.
- I do **NOT** give consent to leave detailed voicemail and/or text messages. Messages may contain ONLY call back information.

I give special permission to the person(s) named below to receive medical information regarding my care and treatment in this office, including biopsy results, lab results, and other medical information.

NAME	Relationship	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature of patient or legal guardian

Date

Print name of patient\_\_\_\_\_



## FINANCIAL ARRANGEMENT AND INSURANCE

It is our goal to help you to understand the policies and requirement of our office. It is important to note that our relationship is with you. YOUR INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY, not between us and your insurance company.

We participate with many insurance companies, and these companies offer different lines of coverage- PPO's, HMOs and Traditional coverage. We also do participate with MEDICARE, but not participate with any form of MEDICAID! Please be aware of your own policy benefits. Every insurance policy is different. It is YOUR responsibility to obtain insurance referrals from your Primary Care if they are required by your insurance policy. The referral needs to be in our office prior to your appointment. Please be aware of the expiration of your referral, as you may need to obtain a new one from your Primary Care for your next visit.

We are very happy to submit a claim to your insurance company for your visit to our office. However, many insurance plans have higher out-of-pocket expenses. These could include deductibles and copayments that are the patients responsibility. If the insurance company does not cover the services for any reason, it is your responsibility to pay us promptly for any service rendered. If a payment to us becomes 30 days past due, it is considered delinquent. If an overpayment is made on your account, we do not issue refund checks for any balance less than \$30. We will apply the credit to your next balance due.

### \*LABORATORY SERVICES\*

We may sometimes use an OUTSIDE LABORATORY to perform certain tests. Lab tests are not included in the physician's fees. You are responsible for all costs incurred by the lab which are not covered by your insurance, and you will be billed separately by the lab themselves. Please contact the laboratory directly for any questions you may have.

I understand that it is my responsibility to be aware of my insurance benefits. If, for any reason, any portion of my bill is not paid by my insurance company, I further agree to pay any **outstanding amounts not covered by my insurance promptly**. In the event of non-payment, I will bear the cost of collection proceedings should this be required.

If you have any questions about the above information please do not hesitate to ask.

PLEASE LIST PERSON RESPONSIBLE FOR COPAYS & DEDUCTIBLE \_\_\_\_\_

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_



**PLEASE FILL IN ALL BLANKS**

DATE \_\_\_\_\_

PATIENT NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ M F

PATIENT HOME ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

CELL PHONE \_\_\_\_\_

SECOND PHONE \_\_\_\_\_

MAY WE CONTACT YOU BY TEXT? **YES** OR **NO**

PARENT OF PATIENT **(IF MINOR)** \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_

INSURED POLICY HOLDER NAME \_\_\_\_\_

PATIENT RELATIONSHIP TO POLICY HOLDER \_\_\_\_\_

POLICY HOLDER DATE OF BIRTH \_\_\_\_\_

PRIMARY CARE PHYSICIAN \_\_\_\_\_

YOUR PHARMACY \_\_\_\_\_

PHARMACY PHONE NUMBER \_\_\_\_\_

PATIENT OCCUPATION \_\_\_\_\_

PATIENT EMPLOYER \_\_\_\_\_

HOW REFERRED \_\_\_\_\_