# *NORTH MACOMB MEDICAL ASSOCIATES, P.L.L.C.*

## PATIENT INFORMATION FORM

Please read & complete all necessary information accurately

### PATIENT INFORMATION

Name:_____ Date of Birth_____

Address: _____ City: _____ St. _____ Zip:_____

Hm phone: _____ Wk phone: _____ Cell #: _____

Patient's place of employment: _____ Phone# _____

Single _____ Married _____ Divorced_____ Other_____ Male _____ Female_____

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Spouse or Guardian Name: _____ Phone #_____

If patient is under 18 years of age, who is responsible for this bill? _____

What is their address: _____

What is their phone #: _____ Date of Birth_____ Relationship to patient_____

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### PRIMARY INSURANCE

Insurance Carrier: _____

Group #: _____ Contract ID #: _____

Subscriber's Name: _____ Date of Birth: _____

Phone # (if different than patients) _____

Address (if different than patients): _____

Relationship to patient: Self _____ Spouse _____ Parent _____ Legal Guardian _____ Other _____

Subscriber's Employer: _____

Employer's Phone #: _____

## SECONDARY INSURANCE

Insurance Carrier: _____

Group #: _____ Contract ID #: _____

Subscriber's Name: _____ Date of Birth: _____

Phone # (if different than patients) _____

Address (if different than patients): _____

Relationship to patient: Self _____ Spouse _____ Parent _____ Legal Guardian _____

Subscriber's Employer: _____

Employer's Phone #: _____

.

## EMERGENCY CONTACT

Whom may we contact in case of an emergency?

Name: _____ Phone #: _____

Relationship to patient: _____

Nearest relative not living with you: _____ Phone#: _____

Nearest friend not living with you: _____ Phone #: _____

## FINANCIAL RESPONSIBILITY

I understand that and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature: _____ Date:_____

(parents signature if patient is a minor)

# ***NORTH MACOMB MEDICAL ASSOCIATES, P.L.L.C.***

# PAYMENT POLICY

### PLEASE READ CAREFULLY BEFORE SIGNING

I authorize payment directly to Dr. Frocillo, Dr. Plumer-Haun, Dr. McCowan, Dr. Stratford, Deborah Berry PA-C, & Sarah Weymouth PA-C for surgical and/or medical services as described, but not to exceed reasonable and customary charges for those services. I authorize the above doctors to release any information acquired in the course of my treatment necessary to determine those benefits.

**OUR POLICY IS PAYMENT AT THE TIME OF SERVICE**. All applicable **copays, deductibles, and outstanding balances must be paid in full at the time of your visit**. Payment may be made by cash, check, or credit card.

It is understood that NMMA will bill the insurance company that I provide them with as a courtesy to me, and that a secondary insurance will also be billed if applicable. Please understand that this is not a guarantee of insurance benefits. Any questions you may have regarding insurance coverage should be directed to your insurer. I also understand that in the event that I do not provide current information to NMMA it is my responsibility to pay any outstanding balances to the office directly.

- I understand that I am responsible for the payment of any charges that are not covered by my insurance company and for charges resulting from deductibles or co-pays required by my insurance company. I understand that my payment responsibility extends to all those covered under my policy, regardless of age, relationship, or living arrangements unless otherwise specified.

- The parent accompanying a minor child is responsible for any and all charges incurred. We can not and will not bill the other parent.

- In the event that the amount owed can not be determined until after insurance billing, a statement will be sent. Payment in full is expected upon receipt of this statement. **Accounts that reach a past due status (any balance over 30 days old) will be assessed a statement fee.**

- I understand that s fee will be assessed for the completion of some forms, including disability forms, FMLA and sports physicals.

We make every attempt to have patients scheduled and seen by their physician in a timely manner. For this reason, **a 24 hour notice is required for all appointment cancellations, otherwise a $20 NO-SHOW fee will be applied to your account**.

Signature of patient (if minor, parents signature)_____

Date:_____ Witness Initials:_____

# ***NORTH MACOMB MEDICAL ASSOCIATES, P.L.L.C.***

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your NOTICE OF PRIVACY PRACTICES, containing a more complete description of the users and disclosures of my health information. I have been given the right to review such NOTICE OF PRIVACY PRACTICES prior to signing this consent. I understand that this organization has the right to change its NOTICE OF PRIVACY PRACTICES from time to time and that I may contact the organization anytime at the address below to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

I understand that I may request in writing that you restrict how my privacy information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relaying on this acknowledgement.

Patient Name: _____
Signature: _____ Date: _____

If Personal Representative's signature appears above, describe Personal Representative's relationship to the patient: _____.

The patient presented for treatment on this date and was provided with this acknowledgement for our NOTICE OF PRIVACY PRACTICES. A good faith effort was made to obtain a written acknowledgement of receipt of the notice. However, an acknowledgement was not obtained because:

☐ Patient refused to sign
☐ Patient was unable to sign because _____
☐ There was a medical emergency (the practice will attempt to obtain acknowledgement at the next available opportunity.

Signature of employee witnessing and/or completing form: _____

## ***NORTH MACOMB MEDICAL ASSOCIATES, P.L.L.C.***

# RELEASE OF INFORMATION

Date: _____

I _____ hereby authorize North Macomb Medical Associates, P.L.L.C. to release:

☐ Health/Treatment Information

☐ Billing/Payment Information

☐ Both Health & Billing Information

this information may be released to _____
(spouse, child, friend)

I understand that I may revoke this authorization at any time by giving written notice to North Macomb Medical Associates, P.L.L.C.

Patient Name (printed): _____

Patient Signature: _____

Signature of Witness: _____

# Health History
(Confidential)

Name: _____ Today's Date _____
Age_____ Birth Date_____ Date of last physical examination_____
What is your reason for initial visit? _____

**Symtoms:** Check (√) symptoms you currently have had in the past year.

| General | Gastrointestinal | Eye, Ear, Nose, Throat | MEN only |
|---|---|---|---|
| ☐ Anxiety | ☐ Appetite poor | ☐ Bleeding gums | ☐ Breast lump |
| ☐ Chills | ☐ Bloating | ☐ Blurred/double vision | ☐ Erection difficulties |
| ☐ Depression | ☐ Bowel changes | ☐ Crossed eyes | ☐ Lump in testicles |
| ☐ Dizziness | ☐ Constipation | ☐ Difficulty swallowing | ☐ Penis discharge |
| ☐ Fainting | ☐ Diarrhea | ☐ Glasses/contacts | ☐ Sore on penis |
| ☐ Fever | ☐ Excessive hunger | ☐ Earaches | ☐ Other _____ |
| ☐ Forgetfulness | ☐ Excessive thirst | ☐ Ear discharge | **WOMEN only** |
| ☐ Headaches | ☐ Gas | ☐ Hay fever | ☐ Abnormal pap smear |
| ☐ Loss of sleep | ☐ Hemorrhoids | ☐ Hoarseness | ☐ Bleeding between periods |
| ☐ Loss of weight | ☐ Indigestion | ☐ Loss of hearing | ☐ Breast lump |
| ☐ Nervousness | ☐ Nausea | ☐ Nosebleeds | ☐ Extreme menstrual pain |
| ☐ Numbness | ☐ Rectal bleeding | ☐ Persistent cough | ☐ Hot flashes |
| ☐ Sweats | ☐ Stomach pain | ☐ Ringing in ears | ☐ Nipple discharge |
| **Muscle/Joint/Bone** | ☐ Vomiting | ☐ Sinus problems | ☐ Painful intercourse |
| Any Pain, weakness, numbness in | ☐ Vomiting blood | ☐ Vision-Flashes | ☐ Vaginal discharge |
| ☐ Arms | **Cardiovascular** | ☐ Vision-Halos | ☐ Tubal ligation |
| ☐ Hips | ☐ Chest pain | ☐ Dentures | ☐ Other _____ |
| ☐ Back | ☐ High blood pressure | **Skin** | |
| ☐ Legs | ☐ Irregular heart beat | ☐ Bruise easily | Date of last menstrual period _____ |
| ☐ Feet | ☐ Low blood pressure | ☐ Hives | |
| ☐ Neck | ☐ Poor circulation | ☐ Itching | Date of last period _____ |
| ☐ Hands | ☐ Rapid heart beat | ☐ Change in moles | |
| ☐ Shoulders | ☐ Swelling of ankles | ☐ Rash | Have you had a mammogram? Y or N |
| ☐ Knees RT or LT | ☐ Varicose veins | ☐ Scars | Are you pregnant? Y or N |
| **Genito-urinary** | | ☐ Sore that won't heal | Number of children _____ |
| ☐ Blood in urine ☐ Frequent urination | | | Number of pregnancies _____ |
| ☐ Painful urination ☐ Difficult urination | | | |
| ☐ Lack of bladder control | | | |

**Conditions** Check(√) symptoms you currently have had in the past.

| | | | |
|---|---|---|---|
| ☐ Aids | ☐ Chemical Dependency | ☐ High Cholesterol | ☐ Prostate problems |
| ☐ Alcoholism | ☐ Chicken pox | ☐ HIV positive | ☐ Psychiatric care |
| ☐ Anemia | ☐ Diabetes | ☐ Kidney disease | ☐ Rheumatic fever |
| ☐ Anorexia | ☐ Emphysema | ☐ Liver disease | ☐ Scarlet fever |
| ☐ Appendicitis | ☐ Epilepsy | ☐ Measles | ☐ Stroke |
| ☐ Arthritis | ☐ Glaucoma | ☐ Migraine Headaches | ☐ Suicide Attempt |
| ☐ Asthma | ☐ Goiter | ☐ Miscarriage | ☐ Thyroid problems |
| ☐ Bleeding Disorders | ☐ Gonorrhea | ☐ Mononucleosis | ☐ Tonsillitis |
| ☐ Breast Lumps | ☐ Gout | ☐ Multiple Sclerosis | ☐ Tuberculosis |
| ☐ Bronchitis | ☐ Heart Disease | ☐ Mumps | ☐ Typhoid fever |
| ☐ Bulimia | ☐ Hepatitis | ☐ Pacemaker | ☐ Ulcers/irritable bowels |
| ☐ Cancer | ☐ Hernia | ☐ Pneumonia | ☐ Vaginal infections |
| ☐ Cataracts | ☐ Herpes | ☐ Polio | ☐ Venereal disease |

**Medications:** List **ALL** medications you are currently taking(include over-the-counter drugs)_____

_____

_____

**Allergies** to medications or substances:_____

_____

| **Relation** | **Age** | **State of Health good, bad, fair, poor** | **Age at Death** | **Cause of death** | **Diseases—**check(√) if your blood relative have any of the following | **Relationship to you** |
|---|---|---|---|---|---|---|
| Father | | | | | ☐ Arthritis, Gout | |
| Mother | | | | | ☐ Asthma, Hay fever | |
| Brothers | | | | | ☐ Cancer | |
| | | | | | ☐ Chemical dependency | |
| | | | | | ☐ Heart disease, strokes | |
| | | | | | ☐ High blood pressure | |
| Sisters | | | | | ☐ Kidney disease | |
| | | | | | ☐ Tuberculosis | |
| | | | | | ☐ Depression/psychological illness | |
| | | | | | | |

**HOSPITALI ZATIONS**

| **Year** | **Hospital** | **Reason for hospitalization** | **Complications, if any** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Illnesses/Injuries**

| **Date** | **Serious Illness/Injuries** | **Outcome** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Have you ever had a blood transfusion? ☐Yes ☐No If yes, please give approximate date(s)_____

**HEALTH HABITS** check (√) which substances you use and describe how much you use.

☐Caffeine how much?_____ how often?_____

☐Tobacco how much?_____ how often?_____

☐Alcohol how much?_____ how often?_____

☐Drugs how much?_____ how often?_____

☐Other _____ how much?_____ how often?_____

**OCCUPATIONAL CONCERNS** check (√) any of the following that you are exposed to at work.

☐ Stress ☐ Heavy lifting Your Occupation _____

☐ Hazardous Substances ☐ Other Your Education _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff resposible for any errors or omissions that I may have made in the completion of this form.

Patients signature _____ Date _____

Physicians signature _____ Date _____