WELCOME

BRUCE L. LINDEN, M.D., P.A.
DALE G. SWANHOLM, M.D., P.A.
JOHN M. TILLEY, M.D., P.A.

PATIENT INFORMATION

Date ______________________ Sex ______________

SS# ______________________ Birthdate ______________

Patient Name ______________________

Address ______________________

____

City ______________________

State ______________________ Zip ______________

Home (___) ______________ Cell (___) ______________

Email ______________________

What is your race? Circle one:

White African American Hispanic

American Indian Asian Other or Refused

What is your Ethnicity?

Hispanic, Non-Hispanic or Refused

What is your primary language? ______________

Local Pharmacy ______________________

Local Pharmacy Phone ______________________

Mail Order Pharmacy ______________________

Marital Status ______________________

Occupation ______________________

Patient Employer/School ______________________

Spouse's Name ______________________

Birthdate ______________________

SS# ______________________

IN CASE OF EMERGENCY, CONTACT

Name ______________________ Relationship ______________

Phone ______________________

Whom may we thank for referring you? ______________

INSURANCE

Who is responsible for this account? ______________________

Relationship to Patient ______________________

Insurance Company ______________________

Group # ______________________

Is Patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______________________

Birthdate ______________ SS# ______________

Relationship to Patient ______________________

Insurance Company ______________________

Group # ______________________

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with

____

Name of Insurance Company(ies)

and assign directly to Dr. ______________________
all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to

____

Name of Doctor or Clinic

for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers of Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services

____

Signature of Beneficiary, Guardian or Personal Representative

____

Please print name of Beneficiary, Guardian or Personal Representative

______________ ______________

Date Relationship to Beneficiary

FAMILY HISTORY

Date of last physical examination ______________________

What is the reason for visit? ______________________

ALIVE DECEASED	FATHER ☐ ☐	Present health or cause of death	MOTHER ☐ ☐	Present health or cause of death	SPOUSE ☐ ☐	Present health or cause of death
BROTHERS	NO. ALIVE	HEALTH		NO. DECEASED	CAUSE OF DEATH	
SISTERS	NO. ALIVE	HEALTH		NO. DECEASED	CAUSE OF DEATH	
CHILDREN	NO. ALIVE	AGES & HEALTH		NO. DECEASED	AGES & CAUSE OF DEATH	

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES

☐ Diabetes ☐ Cancer ☐ Bleeding tendency ☐ Kidney disease ☐ Tuberculosis
☐ Heart disease ☐ Stroke ☐ High blood pressure ☐ Nervous illness ☐ Allergy ☐ Other ______________

HEALTH HISTORY

All information is strictly confidential.

Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression/Nervousness
- ☐ Dizziness/Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:
- ☐ Arms
- ☐ Hips
- ☐ Back
- ☐ Legs
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ Shoulders

GENITOURINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High/Low blood pressure
- ☐ Irregular/Rapid heart beat
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache/Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision - Flash/Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching/Rash
- ☐ Change in moles
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period ________

Date of last Pap smear ________

Have you had a mammogram? ________

Are you pregnant? ________

Number of children ________

Check (✓) symptoms you currently have or have had in the past.

- ☐ AIDS
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Describe serious illnesses or operations ________________________________

MEDICATIONS/ALLERGIES

List name, strength & directions to prescribed and non-prescribed medications currently taking: ________________________________

____

____

List allergies to medications or substances: ________________________________

____

HEALTH HABITS

Check (✓) which you use and how much:

- ☐ Caffeine ________
- ☐ Tobacco ________
- ☐ Alcohol ________
- ☐ Street Drugs ________
- ☐ Other ________

SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

________________________________ Signature of Patient, Parent, Guardian or Personal Representative

________ Date

________________________________ Please print name of Patient, Parent, Guardian or Personal Representative

________ Relationship to Patient

________________________________ Reviewed By

________ Date

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DIPLOMATES OF THE AMERICAN BOARD
OF FAMILY PRACTICE

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your continued good health. Please understand that payment of your bill is considered a part of your relationship with your doctor. The following is a statement of our Financial Policy. We require you read and sign this prior to your visit. Also, all patients must complete our Information and Insurance form before seeing the doctor.

Managed Care Plans in which we participate
Our office accepts insurance for payment of services on plans for which we are participating providers. However, all co-payments, co-insurance and deductibles must be paid prior to seeing the physician. Also, all charges for non-covered services must be paid at the time of service. You will be obligated to pay in full if you cannot verify your insurance coverage with a current insurance card. You will be reimbursed when your carrier makes payment on your account. You may be charged for after hour non-emergency calls, prior authorizations, x-ray duplication, controlled substance prescriptions, rewritten prescriptions, work in appointments, after 5pm and Saturday appointments, filling out forms and letters and other services that may arise.

Other Insurance Plans
If we are not providers for your insurance plan we require payment in full at the time of service. Our fees are in line with the usual and customary charges in the area, and you are responsible for full payment regardless of your insurance company's determination of usual and customary rates.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

WE ACCEPT CASH, CHECKS, DEBIT AND ALL MAJOR CREDIT CARDS.

Minor Patients
The adults accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized with a major credit card, or payment by cash or check at the time of service.

Missed appointments
Unless canceled prior to appointment time, our policy is to charge $25 for missed acute care and recheck appointments. If you are scheduled for a consult, procedure or physical exam a $50 charge will be assessed for a missed appointment. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy:

X______________________________ ________________
Signature of Patient or Responsible Party Date

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