Lexington Primary Care

777 Athens Rd. Suite 102 Lexington, GA 30648-1905
Phone: 866-439-6084 Fax: 404-891-6084

New Patient Registration Date: ___/___/_____

Patient Information: Please Print

How did you hear about us: _____

_____

Last Name:_____ First Name:_____ MI:_____

Address:_____

City:_____, State:_____, Zip:_____

Home Phone :_____, Mobile Phone:_____

Sex:_____, Date of Birth:_____ SSN:_____

Patient Email:_____

Required by government mandate (although you may refuse):Ethnicity:_____

Language:_____, Race:_____, Marital Status:_____

Guarantor Information if not self

Name:_____ First Name:_____MI:_____

Address:_____
Relationship to Patient:_____, Date of Birth:_____
Phone:_____, SSN:_____

Emergency Contact

Name:_____, Relationship:_____
Phone:_____, Mobile Phone_____

Pharmacy Information

Pharmacy Name:_____, Phone:_____

Fax Number:_____
Address:_____

Primary Insurance Information

Insurance Name:_____, Policy Number/Member ID:_____

Policy Holder Name:_____, DOB:_____, Sex:_____

Policyholder Employer:_____

Patients relationship to policyholder:_____

Secondary Insurance Information

Insurance Name:_____, Policy Number /Member ID:_____

Policy Holder Name:_____, DOB:_____, Sex:_____

Policyholder Employer:_____

Patients relationship to policyholder:_____

To the best of my knowledge the above information is complete and correct.

Signature:_____
Date:_____

INTERNAL MEDICINE HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider understand your medical concerns and conditions. If you're uncomfortable with any questions, do not answer them. If you cannot remember specific details please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit:

_____

Other concerns:

_____

ALLERGIES:

List anything that you are allergic to (Medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1. _____	_____
2. _____	_____
3. _____	_____

MEDICATION LIST

Drug Name	Strength	Frequency taken
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____

Last Pap: _____ **Abnormal Pap test:** Y/ N **Last Mammogram:** _____ **Abnormal:** Y /N
Colonoscopy: _____ **Age of first menstrual period:** _____
Date of Last Menstrual period or age of menopause: _____
Number of pregnancies: _____ **Births:** _____ **Miscarriages:** _____
Abortions: _____ **Cesarean sections:** Y/ N **If yes how many:** _____

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

Social History

Education

- ☐ Less than 8th grade
- ☐ High School
- ☐ 2 yr college/ 4 yr college
- ☐ Post graduate

Exercise Level

- ☐ None
- ☐ Occasional
- ☐ Moderate
- ☐ High level

Caffeine

- ☐ None
- ☐ Occasional
- ☐ Moderate
- ☐ Heavy

Of cups/cans per day

_____

Tobacco use

Y/N

If yes, list what and how often

Marital status

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Domestic partner

Alcohol

Do you drink alcohol?

Y/N

If so, how often?

Drugs

Do you currently use recreational or street drugs?

Y/N

If yes, list:

_____

PAST MEDICAL HISTORY

Please check all that apply:

- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots (or DVT)
- ☐ Cancer
- ☐ Coronary Artery Disease
- ☐ Claustrophobic
- ☐ Diabetes-Insulin
- ☐ Diabetes-Non-Insulin
- ☐ Dialysis
- ☐ Diverticulitis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Has Pacemaker
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hiatal Hernia or Reflux
- ☐ HIV or AIDS
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Overactive Thyroid
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Leg/Foot ulcers
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Polio
- ☐ Pulmonary Embolism
- ☐ Reflux or Ulcers
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Other

Check if any family has ever had the following and write the relation to person:

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Anemia
- ☐ Heart Disease
- ☐ Cancer (type)
- ☐ Bleeding disorder
- ☐ Stroke
- ☐ Migraines
- ☐ Obesity
- ☐ Thyroid disease
- ☐ Elevated Cholesterol
- ☐ Kidney Disorder
- ☐ Gout
- ☐ Asthma
- ☐ Arthritis
- ☐ Mental illness
- ☐ Allergies
- ☐ Other

Patient Signature: _____ Date: _____

Lexington Primary Care

Patient Authorization Form

Authorization to release information to family members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request tests, procedures and financial information. Under the requirements of HIPPA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnoses, test results and/or financial information released to any family members, you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent

I, _____, authorize Lexington Primary Care, LLC to release my records and any other information to the following individuals:

	Name	Relation to Patient	Phone number
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Authorization Regarding Messages (please check all that apply)

___ I authorize Lexington Primary Care LLC, to leave a detailed message on my home or cell number voicemail regarding appointments.

___ I authorize Lexington Primary Care LLC, to leave a detailed message on my home or cell number Voicemail regarding medical treatment, care, test results, or financial information.

___ I authorize Lexington Primary Care LLC, to leave a detailed message with anyone who answers the phone.

___ Messages may only be left with _____

Patient Name (please print): _____ **DOB:** _____

Patient Signature: _____ **Date:** _____

LEXINGTON PRIMARY CARE

HIPPA PRIVACY AND RELEASE OF INFORMATION AUTHORIZATION

Patient Name:_____
Patient DOB: _____

I hereby authorize Lexington Primary, LLC and its affiliates, its employees and agents, to use and disclose protected health information (information relating to the diagnoses, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have the right to revoke this authorization by providing a written notice. However, this authorization may not be revoked if its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary. My refusal to sign will halt claim processing with my insurance company causing me to have to file the claim myself and having to pay the practice out of pocket. I have been advised of this practice's Privacy Policy, Release of Billing information policy, Assignment of Benefits policy, and grant the practice Medication History and Authority.

By signing this form, I agree to the above statement

Signature: _____ Date: _____

Patient Financial Policy

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Full payment is due at the time of service unless your health insurance carrier has made prior arrangements. For your convenience we accept cash, checks or credit cards.

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized payment depending on insurance and your plan. This office's policy is to collect the authorized payment when you arrive for your appointment.

- If you have Medicare you are responsible for your Medicare Deductible and your 20% of the charges at the time of service.

- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of services.

- In the event that your health plan determines a service to be "not covered" you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

- We will bill your health plan for all services provided in the office. Any balance due is your responsibility and due upon receipt from our office.

- Lexington Primary Care charges a $45.00 fee for any returned checks

- Lexington Primary Care charges a $35.00 fee for failure to cancel your appointment within 24 hours of your scheduled appointment.

I have read and understand the financial policy of Lexington Primary Care, LLC and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to time by the practice.

Signature: _____ **Date:** _____