Newton Medical Center Clinics

Family friendly. First class.

Date: _____

New Patient Demographics

Patient Name: _____ _____ _____ _____ **Preferred Name:** _____
(First) (MI) (Last) (Suffix)

Home Address: _____ **P.O. Box:** _____

City: _____ **State:** _____ **Zip Code:** _____

How did you hear about our practice? ☐TV ☐Internet ☐Magazine ☐Newspaper ☐ Physician: _____
☐Other: _____

Gender: M F **Marital Status:** ☐Single ☐Married ☐Divorced ☐Widowed **Date of Birth:** ____/____/____ **SS#** _____

Race: ☐ African American ☐ Asian/Pacific Islander ☐ Caucasian ☐Hispanic ☐ Native American ☐Other:_____

Ethnicity: ☐Hispanic ☐Non-Hispanic **Preferred Language:** ☐English ☐Spanish ☐Other:_____

Home Phone: (_____)_____ **Cell Phone:** (_____)_____ **Work Phone:** (_____)_____

Email: _____ **Employer:** _____

Primary Care Provider (PCP): _____ **Referring Provider:** _____

Emergency Contact

By listing the individual below as an emergency contact, you are authorizing our staff to release information regarding the nature of the emergency and your location.

Emergency Contact: _____ **Relationship:** _____

Home Phone: (_____)_____ **Cell Phone:** (_____)_____ **Work Phone:** (_____)_____

Person Responsible for Payment of Account

Please complete if patient is under the age of 18 or if you would like billing information sent to someone other than the patient.

Name: _____ Relationship: _____ SS#: _____

Home Address: _____ P.O. Box: _____

City: _____ State: _____ Zip Code: _____

Contact Number: (_____)_____ Employer: _____ Employer Phone: (_____)_____

Insurance Information *Not needed if you present card(s)*

1 Insurance: _____ Policy #: _____ Group #: _____

Insurance Address: _____ Ins. Phone: (_____)_____

Insurance Policyholder Name (If different than patient): _____ Policyholder DOB: _____

2 Insurance: _____ Policy #: _____ Group #: _____

Insurance Address: _____ Ins. Phone: (_____)_____

Insurance Policyholder Name (If different than patient): _____ Policyholder DOB: _____

Patient Portal Registration

This security question will be used to complete your Patient Portal registration. In the event you need to reset your password, this will be the information. Check ONE question and fill in the answer below.

☐ What is the name of the city in which you were born?

☐ What is your mother's maiden name?

☐ What is the name of your paternal grandfather?

☐ What was the make and model of your first car?

Answer: _____

Release of Information

By listing the following names, you are granting permission for us to share your information with them

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Permission to leave messages for you regarding healthcare, prescriptions, test results or appointments on your phone? **YES NO**
Permission to send messages to you regarding healthcare, prescriptions, test results, or appointments on the Patient Portal? **YES NO**

_____ _____ _____

Signature of Patient or Legal Representative | Relationship to Patient | Date

NMC CLINICS CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours notice. We understand that unavoidable circumstances may cause you to cancel within 24 hours. These situations will be considered on a case by case basis.

Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered a **NO SHOW**. Patients that No Show two (2) times will be subject to **a $50.00 fee.** Patients who No Show three (3) times may be dismissed from the practice, thus they will be denied any future appointments.

The No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. Fees may be paid with cash or credit card; no checks will be accepted.

Please sign that you have read, understand, and agree to this Cancellation and No show Policy.

_____ _____ _____

Signature of Patient or Legal Representative | Relationship to Patient | Date

If you would like a copy of the Cancellation and No Show policy to retain for your personal records, please let the receptionist know.

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AUTHORIZATIONS AND AGREEMENTS

INSURANCE REQUIREMENTS: Health insurance plans often have special requirements or limitations. I understand my insurance may refuse to pay for part of my entire bill because:

- The requirements of my insurance were not met,
- My insurance decided the tests or services provided to me were not medically necessary according to its criteria, and/or
- The services were not covered under my insurance plan.
- I did not obtain referral

If my insurance limits or denies payment, I understand I will be responsible for that payment.

MEDICARE DRUG DENIAL: Medicare does not pay for drugs and biologicals given to outpatients. If I have Medicare, I understand I will be responsible for payment of medications I receive as an outpatient.

MEDICARE/MEDICAID BENEFITS: Medicare, Medicaid, the Social Security Administration of their representatives including peer review organizations may request to review my medical records. I understand Newton Medical Center Clinics will release my records as requested.

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize Newton Medical Center Clinics to release medical and/or billing information in the following situations:

- To those who provide medical care and/or services to me,
- To pay insurance claims for the services I receive,
- To any third party who has agreed to pay for the services I receive, or
- As needed for health care operations.

Further details about the release of information practices and the methods used to protect the privacy of your health information are found in the Newton Medical Center, HIPAA Notice of Privacy Practices.

DIRECT PAYMENT OF INSURANCE BENEFITS INCLUDING MEDICARE AND MEDICAID: I authorize insurance payments for services provided to me at Newton Medical Center Clinics to be paid directly to Newton Medical Center Clinics and to physicians and specialists who may be doing their own billing.

AGREEMENT TO PAY FOR SERVICES: I agree that as the patient, or agent of the patient, I will pay the charges of Newton Medical Center Clinics according to its regular rates and terms. *As posted at Newton Medical Center, any patients presenting for services to the emergency department or in labor will have a medical screening examination performed regardless of the ability to pay the bill.*

Newton Medical Center Clinics are not responsible for valuables and personal items. Please leave valuable such as jewelry, cash, and other personal items at home or with a family member.

AS THE PERSON SIGNING BELOW, I CERTIFY THAT I AM THE PATIENT OR THE AUTHORIZED REPRESENTATIVE OF THE PATIENT. I AGREE TO THESE TERMS UNLESS SPECIFIED IN WRITING.

Patient Signature: _____ Date: _____

Agent/Representative/Guardian Signature: _____

Relationship to Patient: _____ Date: _____

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NEWTON MEDICAL CENTER CLINICS CONSENT TO TREATMENT

I consent to examination and/or treatment provided by Newton Medical Center Clinics under the instructions of a physician. This may include radiologic examination, laboratory procedures, anesthesia, medical and surgical treatment, or other services provided by the clinics. I understand that additional consents may be required for specific procedures and/or treatments.

I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of treatments or examination in the clinic/hospital.

In the event that an individual is suspected to be exposed to my blood or body fluid, I consent to be tested to determine whether or not my blood contains contagious viruses, including Hepatitis B and Human Immunodeficiency Virus. I understand there will be no charge to me for such laboratory testing done as a result of exposure.

This consent has been fully explained to me and I understand its conditions.

Patient Signature: _____ Date: _____

Agent/Representative/Guardian Signature: _____

Relationship to Patient: _____ Date: _____

Reason Patient is Unable to Sign: _____

Witness: _____ Date: _____

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Staff Only: Height: _____ Weight: _____ BP: _____

Visit Date: _____

New Patient Medical History

(Please use the "Additional Comments" field on the last page for extra space or fields not available)

Patient Name: _____ **Preferred Name:** _____ **DOB:** _____ **Age:** ____

Chief Complaint/Reason for Visit: _____

Preferred Pharmacy: _____
Name Address

Medications *Please list current medications.*			☐ NO current medications
Medication (include over-the-counter, vitamins, herbs)	**Strength (mg)**	**Quantity (ex. 2 tablets)**	**Times/day**

Allergies *Please list allergies and type of reaction.*

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ In a relationship

How many children do you have? _____ **Age(s)?** _____

Household Members: _____

Occupation: ☐ Working ☐ Retired ☐ Student ☐ Disabled ☐ Unemployed ☐ Stay at home

Grade (if student): _____ **(Prior) Occupation:** _____

Have you ever used tobacco on a regular basis? ☐No ☐Yes Quit: _____

If yes, how much do/did you smoke/chew per day? _____

If you use tobacco currently, would you like to quit? ☐No ☐Yes

Do you drink alcohol? ☐No ☐Yes Quit: _____

If yes, how often? ☐ Daily ☐ Weekly ☐ Socially ☐ Occasionally

Do you use recreational drugs? ☐No ☐Yes Quit: _____

Do you exercise regularly? ☐No ☐Yes ***If yes, how many times per week?*** _____

Do you drink caffeine? ☐No ☐Yes ***If yes, how many cups per day?*** _____

Personal Medical Problems (Current and Prior) *Please circle all that apply.*		☐NO Medical Problems
Cardiovascular (Heart/Blood Vessels)	**Eyes**	**Mental Health**
Angina (Chest Pain)	Blindness	Anxiety
Atrial Fibrillation	Cataracts	Depression
Congenital Heart Defects	Glaucoma	**Muscular/Skeletal**
Congestive Heart Failure (CHF)	Macular Degeneration	Bone/Muscle Disorder
Coronary Artery Disease	**GI (Stomach/Bowel/Liver)**	Osteoarthritis/Rheumatoid Arthritis
Heart Attack	Liver Disease / Cirrhosis	Osteoporosis
Heart Stents	Colon Polyps	**Neurological (Nerves/Brain)**
High Blood Pressure	GERD (Acid Reflux)	Migraine Headaches
High Cholesterol	Inflammatory Bowel Disease	Neuropathy
Pacemaker	Stomach or Duodenal Ulcers	Seizure Disorder / Epilepsy
Peripheral Artery Disease	**GU (Kidney/Bladder/Prostate)**	Stroke
Cancer	Kidney Disease / Dialysis	Tremor / Balance Disorder
Type:	**Hematologic (Blood)/Infectious**	**Respiratory (Lungs)**
Treatment:	Anemia	Asthma
Endocrine	Bleeding Disorder	Bronchitis
Adrenal Disease	Blood Clots / DVT / PE	COPD / Emphysema
Diabetes - Type I / Type II	Hepatitis - Type:	Pneumonia
Thyroid Disease	MRSA Infection	Obstructive Sleep Apnea
Other Medical Problems/Major Illnesses/Hospitalizations:		

Prior Surgeries and Procedures *Please include year or age of occurrence.*	☐NO Prior Surgeries

Family History	☐Adopted ☐Family History Unknown		
***F** = Father, **M** = Mother, **S** = Sister, **B** = Brother, **A** = Aunt, **U** = Uncle, **PGM** = Paternal Grandmother, **PGF** = Paternal Grandfather, **MGM** = Maternal Grandmother, **MGF** = Maternal Grandfather, **C** = Child*			
	Family Member(s) affected		**Family Member(s) affected**
Aneurysm		Dementia	
Arthritis		Diabetes	
Bleeding Disorders		Heart Attack	
Blood Clots/DVT		Heart Failure	
Cancer - Breast		High Blood Pressure	
Cancer - Colon		High Cholesterol	
Cancer - Lung		Inflammatory Bowel Disease	
Cancer - Melanoma		Kidney Disease/Dialysis	
Cancer - Ovarian		Liver Disease/Cirrhosis	
Cancer - Thyroid		Muscle/Nerve Disease	
Cancer - Other:		Stroke	
Colon Polyps		Thyroid Disease	
COPD/Emphysema		Other:	