

WELCOME



222Route 299 Highland, NY 12528
845-691-DOCS (3627)

Patient # _____ Arrival Time _____

PATIENT INFORMATION Date _____

NAME _____

Street _____

City, State, Zip _____

Home Phone # _____

Cell Phone # _____

SEX: M F Birth date _____ Age _____

Single Married Partnered Widowed Separated Divorced

Race White Black/African American Asian Other

Ethnicity Hispanic Origin Non Hispanic Origin

Language English Other _____

Occupation/ Employer _____

SS# _____

Email Address (for health newsletter & medical alerts) _____

In case of emergency contact:

Name _____

Address _____

Phone _____ Relationship _____

ARE WE ABLE TO RELEASE YOUR HEALTH INFORMATION TO THIS PERSON? _____ YES _____ NO, EMERGENIES ONLY

SELF PAY PATIENTS ONLY: By signing below I certify that I do not currently have health care insurance.

x _____

Primary Care Physician _____

Address _____

Local Pharmacy _____

Address _____

How did you hear about us? _____

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION

Insurance Co. _____

Group # _____ ID# _____

Policy Holders Name _____

Date of Birth _____

Relationship to Patient _____

Is patient covered by additional Insurance? YES NO

SECONDARY INSURANCE INFORMATION

Insurance Co. _____

Group # _____ ID# _____

Policy Holders Name _____

Date of Birth _____ SS# _____

Relationship to Patient _____

Please complete the reverse side of this form

Medical History

Patient Name: _____

Primary reason for your visit today: _____

Check all symptoms that apply for today's visit

- | | | |
|---|---|--|
| <input type="checkbox"/> Aches/Pains | <input type="checkbox"/> Eye Irritation | <input type="checkbox"/> Nose Bleeds |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Painful Urination |
| <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Fever | <input type="checkbox"/> Poor Appetite |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Change in Moles | <input type="checkbox"/> Headache | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Rectal Bleeding |
| <input type="checkbox"/> Congestion | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Chills/Sweats | <input type="checkbox"/> Hives | <input type="checkbox"/> Sore Throat |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Sore that will not heal |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Itching | <input type="checkbox"/> Stomach Pain |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Loss of Hearing | <input type="checkbox"/> Swelling of Extremities |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Ear Ringing | <input type="checkbox"/> Loss/Gain Weight | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Earache/Discharge | <input type="checkbox"/> Nausea | |

MEN

- Erection Difficulty
 Lump in Testicles
 Penis Discharge
 Sore on Penis

WOMEN

- Abnormal Pap
 Bleeding between periods
 Breast Lump
 Vaginal Discharge
Currently Pregnant? YES
Date of last Period _____
Date of last PAP _____
Date of last Mammogram _____

List any medications you are currently taking: _____

List any allergies to medications or substances that you have: _____

Check which substances you use and how much you use them.

- Caffeine _____ Drugs _____ Tobacco _____
 Alcohol _____ Other _____

Check if your work exposes you to any of the following:

- Stress Heavy lifting Hazardous Substances
 Other _____

PAST MEDICAL HISTORY (Check all that apply for yourself)

- | | | | | | | |
|--|--|--|--|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Breast lump | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Cancer - Type _____ | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Herpes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Measles | <input type="checkbox"/> Polio | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> HIV positive | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |
| | <input type="checkbox"/> COPD | | | <input type="checkbox"/> Mumps | <input type="checkbox"/> Scarlet Fever | |

Last Physical Exam _____ Past Surgeries _____

FAMILY HISTORY

Father Alive Deceased Present Health or cause of death _____
Mother Alive Deceased Present Health or cause of death _____
Brothers No. Alive _____ Health _____ No. Deceased _____ Cause of death _____
Sisters No. Alive _____ Health _____ No. Deceased _____ Cause of death _____
No. of Children _____ Name(s) and age _____

Have any of the above persons have or have had any of the following conditions: Diabetes Cancer Heart disease
 Stroke High blood pressure Nervous illness Bleeding tendency Nervous illness Allergy kidney disease other _____

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 responsible for any errors or omissions that I may have made in the completion of this form.

SIGNATURE _____ DATE _____



FirstCare Billing Policies and Procedures

Welcome to FirstCare and thank you for allowing us the opportunity to participate in your care.

We have streamlined our billing process to reduce expenses and allow us to deliver quality care to all, including those without insurance.

Insured Patients:

Insurance is a contract between you and your insurance company. We are not a party to this contract. We will bill your insurance company, and it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and or/pre authorization, you are responsible for obtaining it. Failure to obtain the referral and or preauthorization may result in a lower payment from the insurance company.

Any co-payments required by your insurance company must be paid at the time of service.

When your insurance company reimburses us for your visit, your responsible balance will be billed to you. If payment is not received before the next billing cycle (30 days) and a second bill needs to be sent a \$5.00 charge will be added. If this payment is not received within the next billing cycle the bill is sent to a collection agency and you and your immediate family will not be able to receive services at FirstCare until the balance (plus any collection agency or legal fees) is paid.

Self pay Patients:

Payment for services can be with cash, check or credit card (MC,VISA,American Express or Discover) and must be paid at the time of service. If for any reason you need to be billed for your services a \$5.00 fee will be applied to your outstanding balance.

Returned Checks: There is a \$25.00 fee for any returned checks by the bank for any reason.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received services at our office may become a matter of public record.

Medical offices often incur significant expenses trying to collect payment for services rendered. This is one of the reasons medical care is so expensive in our country. We appreciate your understanding.

Thank you.

Signature: _____ Date: _____