NEW PATIENT INFORMATION

Patient Full Name: _____

Age: _____ Date of Birth: _____ Sex: _____

SSN: _____-____-_____ Marital Status: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer's Name: _____ Address: _____

Supervisor Name: _____

Primary Care Doctor's Name: _____ Phone Number: _____

Patient's Spouse: _____ Phone Number: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Who is responsible for payment, if not patient

Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient: _____

Primary Insurance: _____ ID#: _____

Subscriber Name: _____ SSN: _____ DOB: _____

Secondary Insurance: _____ ID#: _____

Subscriber Name: _____ SSN: _____ DOB: _____

I hereby authorize East Main Family Medical Clinic to release any information concerning my illness/accident and treatment to Insurance Carriers. I hereby assign East Main Family Medical Clinic, LLC payments for Medical services rendered to my dependents or myself. I understand that I am financially responsible for all charges whether or not covered by insurance. You will be responsible for any returned check fees.

_____ _____

Signature of Patient or Guardian Date

MEDICAL HISTORY

	Name of Operation	Date	Doctor	Reason	Hospital
1					
2					
3					
4					
5					

Past Surgical History

Have you or a family member had problems with anesthesia? ____No ____Yes Explain: _____
Have you or a family member had problems with bleeding? ____No ____Yes Explain: _____
Do you have a sensitivity or allergy to Latex? ____No ____Yes Explain: _____

Past Medical Illness (check all that apply)

____NONE ____Diabetes ____Heart Attack (Date: _____) ____Lung Disease
____Angina ____Stroke (Date: _____) ____Congestive Heart Failure ____Heart Disease
____Gastric Reflux ____Ulcers ____Thyroid (Treatment _____) ____Arthritis
____Hepatitis/jaundice (Date: _____) ____High Cholesterol/lipids ____Asthma
____Depression ____Kidney Disease ____Cancer: (Date, type & treatment: _____)
____ Anxiety ____Blood transfusion/reaction (Date: _____)
____Others: _____

Drug Allergies ____None Known

	Name of Medication	What happens when you take this drug?
1		
2		
3		

What Medication are you taking now? ____None

	Name of Medication	Strength (? Mg)	Reason	How many times a day?
1				
2				
3				
4				
5				
6				
7				
8				

Social History

1. Are you: ____Married ____Single ____Divorced ____Widowed
2. How many children do you have? _____ Are you currently pregnant? YES NO Due Date: _____
3. Current Occupation _____ How long? _____ Noise exposure: Mild, Moderate, Severe
4. Do/did you smoke or chew tobacco? YES NO How much? _____
5. When did you quit smoking or chewing tobacco? _____
6. How much alcohol do you drink per week? _____ What type? _____

East Main Family Medical Clinic
1424 East Main Street
Tupelo, MS 38804
Phone: 662-350-3550
Fax: 662-350-3549

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____
Social Security Number: _____ Home #_____ Cell# _____
Emergency Contact:_____ Phone #_____ Relationship_____
I authorize _____to disclosure the information from my records to the East Main Family Medical Clinic, Inc.
I authorize the East Main Family Medical Clinic, Inc. to disclose the information from my records to:

_____

I authorize the disclosure of:

- o Verbal / Written Treatment Progress Notes
- o Medications
- o Disability
- o Progress Notes
- o Lab Results
- o X-Rays
- o Psychiatric / Psychological Evaluations

The Purpose of the disclosure:

- o Continuity of Care
- o Determine Eligibility for
- o For Health / Life Insurance
- o Legal
- o My Personal Records
- o Other

I understand that the information in my health record may include information relating to sexually transmitted disease; acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that the revocation will not apply to information that has already been used or disclosed under this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If this authorization has not been revoked, it will terminate on the following date in the event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will automatically expire in six (6) months.

I understand that I can refuse to sign the authorization, I need not sign this form to obtain treatment, payment, or health pan enrollment or eligibility. I understand that any disclosure of information carries with it the potential for redisclosure by the recipient and that the information may then be no longer protected by federal confidentiality rules.

_____
Signature of Patient or Representative Print Name of Patient Representative

_____
Date Relationship to Patient

EAST MAIN FAMILY MEDICAL CLINIC

PATIENT FINANCIAL RESPONSIBILITY & AUTHORIZATION FORM

Thank you for choosing **East Main Family Medical Clinic** for your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Copays are due at the time of service.
- Self-pay patients must pay basic visit fee of $60.00 prior to being seen. Fee accumulated for lab tests/xrays/shots/other services provided during visit will be due at time of checkout.
- Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:
    - Charge for returned checks - $30.00

By my signature below, I hereby authorize assignment of financial benefits directly to **East Main Family Medical Clinic** and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Patient Acknowledgement and Authorization

- We respect patient confidentiality and only release personal health information about you in accordance with the State and federal law. The attached notice describes our policies related to the use of the records of your care and how you may get access to this information. Please review this policy carefully.

By my signature below, I acknowledge that I have received and read the privacy notice provided by **East Main Family Medical Clinic**. I hereby authorize **East Main Family Medical Clinic** and the physicians, staff, and hospitals associated with **East Main Family Medical Clinic** to release medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care.

Patient Name _____

Patient/Guardian Signature _____ Date _____

East Main Family Medical Clinic
1424 East Main St.
Tupelo, MS 38804
Phone: 662-350-3550
Fax: 662-842-3061

PATIENT CONSENT FOR TREATMENT ASSIGNMENT OF INSURANCE BENEFITS AUTHORIZATION TO RELEASE INFORMATION

CONSENT FOR MEDICAL TREATMENT

(This is good for my lifetime)

My permission is given today for any medical treatment, including but not limited to, examination, injections, Diagnostic testing, and medical procedure, as may be deemed advisably by members of the staff of **East Main Family Medical Clinic.**

AUTHORIZATION TO RELEASE INFORMATION

(This is good for my lifetime)

I authorize **East Main Family Medical Clinic** to release any medical information necessary to process this claim (Medicaid, Medicare, Insurance). I authorize any holder of medical or the fiscal agent for Medicare or Medicaid, any information needed to determine these benefits or the benefits payable for related services.

ASSIGNMENT OF BENEFITS

(This is good for my lifetime)

I requested and authorized payment of medical benefits to the **East Main Family Medical Clinic** for services provided. I request that payment of authorization Medicare and Medicaid (for any insurance company that will pay benefits on my behalf) benefits made on my behalf to **East Main Family Medical Clinic**.

NOTICE OF PRIVACY PRACTICES

(This is good for my lifetime)

I have received the notice of Privacy Practices and I have been provided an opportunity to review it.

Signature of Patient or Patient Representative:_____

Relationship: _____

Patient is unable to sign because: _____

East Main Family Medical Clinic

1424 East Main Street
Tupelo, Ms 38804
Ph: 662-350-3550
Fx: 662-842-3061

I approve of East Main Family Medical Clinic to send me a reminder of text or voice message of my appointment to the phone number(s) below:

_____

_____

Name : _____

DOB : _____

Signature : _____

Date : _____