# NEW PATIENT APPLICATION

AMERICAN FAMILY MEDICAL

Current date: _____

Requested Provider:
(Circle One) Dr. David Oliver, D.O.
Dr Rafael Rosa-Algarin, M.D.
Dr. Charles Overturf IV, D.O.

## PATIENT INFORMATION

**By what name do you like to be called:** _____

**Patient's Last Name:** **First Name:** **MI** Mr.__ Miss__ Mrs.__ Ms.__ Dr.__

**Sex:** Male__ Female__ Other__

**Patient's Date of Birth:** _____ **Marital Status**

**Patient's Social Security #:** _____ Single__ Married__ Widowed__ Divorced__ Lives with Significant other __

**Phone # :** _____ **Email:** _____

**Patient's Primary address:**
Street City State Zip Code

_____

**Patient's Secondary address:**
Street City State Zip Code

_____

**Do you want to receive text messages:** Yes No

**Occupation:** _____

Employer: _____ Work Status: Full-time Part-time Retired Disabled
Occupation: _____

Name of spouse: _____ Spouse's Date of Birth: _____

Spouse's Employer: _____ Spouse's SS#: _____

Spouse's Occupation: _____

**INSURANCE INFORMATION** **(Please provide your insurance card to our receptionist)**

**Primary Insurance Name:** _____ Subscriber's Name: _____

Social Security #: _____

Relationship to Patient: _____ Date of birth: _____

Policy #: _____ Copayment: _____

Group#: _____

**Secondary Insurance Name:** _____ Subscriber's Name: _____

Social Security #: _____

Relationship to Patient: _____ Date of birth: _____

Policy #: _____ Copayment: _____

Group#: _____

**Person responsible for the bill:** _____

Address: _____

Phone #: _____

Whom may we thank for referring you? Advertisement Friend Internet Family Other: _____

I herby give consent for treatment and herby authorize any physician, hospital, or medical facility to release any information concerning my medical history and treatment.

**I hereby authorize release of medical information including positive exposure to HIV infection, ARC, AIDS, alcohol or drug dependency, mental and nervous disorders to other physicians, hospital, or medical facilities that may be included in my care.**

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize American Family Medical, LLC or my insurance company to release any information required to process claims.

_____ _____

Parent/Guardian Signature Date

**IN CASE OF EMERGENCY:**

Name of a friend or relative (not living at the same address): _____

Phone #: _____ Relation to patient: _____


**Dear Patient:**

In an effort to make our office as efficient as possible, and to reduce waiting time for you the patient, please review the following suggestions. We have found that when patients' follow these simple steps we are able to provide better care in a more timely and efficient manner.

**KNOW YOUR MEDICATIONS:** The name of the medication, what the medication is being taken for, and also the strength and dose. Keep an updated list of your medications with you for quick reference. This includes any supplements that you may be taking. Please bring all of your prescription medications to every visit.

**REFILLS:**

Advise the medical assistant of any refills you need and whether your insurance prefers 30 or 90 day refills. Also, provide a name and phone number of your pharmacy, as we send all prescriptions electronically. When calling in for a prescription refills, please check your prescription bottle first to avoid any confusion or delay in refill. Allow 3 business day for all refill request to be completed. If your prescription requires prior authorization for refill, it is your responsibility to notify the practice. Authorization of a medication can take up to two weeks for approval or denial by insurance company.

**INSUANCE FORMULARY:**

Become familiar with your insurance formulary plan for prescriptions. If we prescribe a medication for you that is not on your formulary and you don't inform us, there will be need for you to schedule an appointment with the provider to select another medication that is best suited for your medical condition.

**OFFICE VISITS:** Our office tries, if possible, to evaluate only one-two medical problems per patient, per visit.

This allows our appointment schedule to run at a manageable rate and has proven to be the fairest to all concerned. Emergencies and exceptions do arise some problems take longer to evaluate than others. We make every effort to minimize our patients waiting time.

**SCHEDULING APPOINTMENTS:** Allow yourself sufficient time when scheduling office appointments; realizing that due to the nature of our office we do handle medical emergencies when they arise, this may cause our schedule to run behind.

Thank you so much for your attention to these important matters. If you have any further questions or comments, please bring them to the attention of the receptionist. Thank you again for choosing our office, and we look forward to treating you.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

**YOUR INSURANCE:**

We have made prior arrangements with many insurers and health plans. We will bill those plans whom we have an agreement, and will collect any required copayment, coinsurance, or deductible **AT THE TIME OF SERVICE.** Copayment, coinsurance, and/or deductible will collected upon sign in for your appointment time without exceptions. Payment may be made via cash, check, or debit. In the event your health plan determines a service "not covered", you will be responsible for the complete charge. **PLEASE INFORM US WHEN YOUR INSURANCE PLAN CHANGES.**

**MINOR PATIENTS:**

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment in full at the time of service, regardless of who is legally responsible. All minors mist be accompanied by a parent or legal guardian unless prior arrangement for another party to be present of children under 12 years old to be seen alone has been made in writing by a parent or legal guardian.

**MISSED APPOINTMENTS:**

In order to provide the best possible service and availability to all our patients, it is our policy to charge a $20.00 fee for missed lab appointments, $60.00 fee for any missed "brief" appointments **NOT** cancelled 24 hours in advance, and $150.00 for missed physicals. Please call us as early as possible if you know you will need to reschedule your appointment.

**MEDICAL RECORDS:**

Medical records maybe released with a signed consent from the patient only, and maybe charged $1.00 per copy. There is also a $40.00 charge for completion of medical forms(i.e. FMLA, Medication Authorization, Supply Forms)

**COMPLIANCE:**

In an effort to maintain optimal health, each patient is expected to comply with the physicians advice regarding their health care needs. Failure to do so may result in our inability to continue providing your health care. In order to maintain continuity of

**FINANCIAL AGREEMENT:**

We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. You mut realize, however that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services that will not be covered(e.g. yearly physicals, pap smears, mammograms, urinalysis, hemoccult, blood work). It is YOUR responsibility to be familiar with your health insurance plan.

We must emphasize that as your medical care providers, our relationship and concern with you and your health, not your insurance company. ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE OF SERVICE RENDERED. For your convenience we accept VISA, MASTERCARD, PERSONAL CHECKS, and DEBIT CARDS. There will be a $45.00 charge on all returned checks. All past due accounts over 60 days will be charged a late fee of 5% of the unpaid monthly balance. On any balance on your account over 90 days, including those that insurance has not paid, collection action will be taken. If it becomes necessary to collect any sum due through an attorney, then the patient/guarantor agrees to pay all reasonable costs of collection, including attorney's fees, whether suit is filed or not. If you have any questions about the above information or uncertainty regarding insurance coverage, please do not hesitate to ask us, as we are here to assist you.

**I have read and understand the policies of American Family Medical, LLC. I understand and agree that such terms may be amended from time-to-time by the practice.**

Signature of Patient/Parent _____ Date _____

# MEDICAL HISTORY FORM

Patient Name: _____ Date of Birth: _____

Spouse: _____

Children: 1. 2. 3. 4.

Ages: _____

## Medical Problems/Diagnosis:

_____

_____

_____

_____

**Specialist Involved in your care:** _____

_____

**Current Medications/Supplements Presently Taking:**

| Name | Dose | How Often |
|---|---|---|
| | | |
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| | | |

**Medication Allergies:** **Type of Reaction:**

_____

_____

**Food Allergies:** **Type of Reaction:**

_____

_____

**Other Allergires:** **Type of Reaction:**

_____

| Surgeries | Date | Reason |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Hospitalizations (Other than for surgery)**

| Reason | Place and Date |
|---|---|
| | |
| | |
| | |

| Serious Accidents/Fractures | Date | Lasting complications(if any) |
|---|---|---|
| | | |
| | | |
| | | |

**Family Medical History**

| Relative | Living/Deceased | Medical Problems | Age |
|---|---|---|---|
| Mother | | | ___ |
| Father | | | ___ |
| Brothers | | | ___ |
| | | | ___ |
| | | | ___ |
| Sister | | | ___ |
| | | | ___ |
| | | | ___ |

**List Anyone in The Family With:**

High Blood Pressure: _____ Diabetes: _____

Heart Disease: _____ Cancer: _____

Kidney Disease: _____ Lung Disease: _____

Tuberculosis: _____ Addictions: _____

Permature Death(before 60): _____ Mental Illness: _____

**Review of Systems**

Would you describe your general health as: Excellent Good Fair Poor (circle one)

Have you experienced any unexpected weight loss or weight gain: ___Yes ___No If YES, how much_____

**Last EKG:_____Last Chest X-ray_____ Last Tetanus_____ Prevnar Vaccine _____**

**Pneumonia Vaccine_____ Shingles Vaccine_____ Flu Vaccine_____**

**FEMALES ONLY:**

**Total number of: Pregnancies:_____ Births:_____ Miscarriages:_____**

Complications of pregnancy and labor, if any: _____

**Menstral Cycle:** How often:_____ Durations:_____, Heavy___ Moderate___ Light___

When was you last pap smear:_____ Type of Birth Control Used:_____

**Post Menopausal:** Yes/No Year_____