3190 Irvine Road **PH: 859-369-0070**
Richmond, KY 40475 **Fax: 859-369-0073**

THE FAMILY CLINIC

New Patient Intake: Date: _____

First Name: _____ MI: _____ Last Name: _____
DOB: _____ SSN: _____
Street Address: _____
City: _____ State: _____ Zip:_____
Cell Phone: _____ Home Phone: _____ Work Phone:_____
Email: _____

Please list all other medical providers that you see: _____
_____
_____

Allergies: _____
_____

Emergency Contact:
Name: _____ Relation: _____ Phone: _____

Guarantor Name (Person financially responsible): _____
Guarantor SSN: _____ Phone:_____

Insurance:

Primary Insurance Company:_____
Policy Number: _____ Group Number: _____
Subscriber Name: _____ SSN: _____

Secondary Insurance Company:_____
Policy Number: _____ Group Number: _____
Subscriber Name: _____ SSN: _____

Tertiary Insurance Company:_____
Policy Number: _____ Group Number: _____
Subscriber Name: _____ SSN: _____

Past Medical History:

	Yes	No		Yes	No		Yes	No
Acid Reflux	☐	☐	Depression	☐	☐	HIV/AIDS	☐	☐
Anxiety	☐	☐	Diabetes	☐	☐	Migraines	☐	☐
Asthma	☐	☐	High Blood Pressure	☐	☐	Peripheral Artery Dis	☐	☐
Bipolar Disorder	☐	☐	High Cholesterol	☐	☐	Rheumatoid Disease	☐	☐
Blood Clot (DVT/PE)	☐	☐	Enlarged Prostate	☐	☐	Seizure Disorder	☐	☐
Cancer	☐	☐	Heart Attack	☐	☐	Stroke	☐	☐
Chronic Pain	☐	☐	Heart Valve Problem	☐	☐	Seasonal Allergies	☐	☐
COPD	☐	☐	Hepatitis	☐	☐	Substance Abuse/Alcoholism	☐	☐
Coronary Artery Disease	☐	☐	Hemophilia (Free Bleeder)	☐	☐	Thyroid Problem	☐	☐
Crohn's Dis/Ulcerative Colitis	☐	☐	Kidney Disease	☐	☐	Tuberculosis	☐	☐

Surgical History:

	Year		Year
Appendix Removed		Heart Bypass	
Back Surgery		Hernia Repair (Type)	
Bladder Surgery		Hysterectomy: Partial or Complete	
Cataract		Orthopedic Surgery	
C Section		Tonsils Removed	
Ear Tubes		Tubal Ligation	
Heart Catheterization		Vasectomy	
Gallbladder Removal		Other	

Family History:

	None	Mother	Father	Sister	Brother	Other
Cancer Type:_____	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐
Diabetes Mellitus	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Substance Abuse/Alcoholism	☐	☐	☐	☐	☐	☐
Other (specify):	☐	☐	☐	☐	☐	☐

Social History:

☐Married ☐Single ☐Widow ☐Divorced

Do you have children? ☐Yes ☐No # of children: ____ Do you have custody? ☐Yes ☐No

Occupation:_____ ☐Disabled ☐Retired

Tobacco Use: ☐None ☐Quit (date)_____ ☐Still use: ☐Cigarettes ☐Chew ☐Cigars ☐Vape

Amount of tobacco you use(d) each day. ☐1/2 pack/can ☐1 pack/can ☐2 packs/cans ☐more

Alcohol Use: (A drink is 1 shot of liquor, 1 glass of wine, or 1 bottle/can of beer.) ☐None

☐Less than 1 drink/month ☐1-15 drinks/month ☐4-14 drinks/week ☐more than 2 drinks/day

Drug Use: ☐Yes ☐No ☐Quit (date)_____ If yes, what do you use?_____

HIV/AIDS Screening: ☐Yes ☐No If yes, where and when?_____

Health Maintenance:

Do you wear seatbelts? ☐Always ☐Sometimes ☐Never

Have you seen a dentist in the past year? ☐Yes ☐No

Date of your last colonoscopy:_____ Date of your last pneumonia shot:_____

Date of your last tetanus shot:_____ Date of your last shingles shot:_____

Date of your last flu shot:_____ Date of your last eye exam:_____

Women ONLY:

Date of your last mammogram:_____Date of your last pap smear:_____

Number of pregnancies?_____

Current Medications:

☐None

Name of Medication	Strength (mg)	How Often	Reason for taking

Drug Allergies:

☐None

Name	Reaction

Preventive Care:

☐None

GME	
Colonoscopy	
Mammogram	
Prostate Exam/PSA	
PAP	
DEXA Scan	
LD Chest CT	
AAA Screen	
Hep C Screen	
Eye Exam	
Other	
Vaccines	
Flu	
Pneumonia	
Shingles	
Td/Tdap	
Hep A	
Other	

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Confidential Communications

In order to protect your privacy, we ask that you complete this form so we know the ways in which we may communicate with you regarding your health information. Please mark as many of the communication options below you feel comfortable with so we have multiple ways to reach you regarding important matters concerning your health care.

Patient Name:_____**DOB:**_____

I prefer to receive my appointment reminders in the following method: ☐**Text** ☐**Phone call**

I authorize Family Clinic, its providers and employees, to do the following:

	Yes	No
Leave a message on my phone regarding appointment reminders/scheduling.	☐	☐
Send me a letter in the mail regarding appointment reminders, test results and /or scheduling needs.	☐	☐
Leave my test results in a message at my home/cell number.	☐	☐
Send my appointment reminders in a text message.	☐	☐

I authorize Family Clinic to discuss my healthcare as indicated with the following individuals:

Name:	Name:	Name:
Relationship:	Relationship:	Relationship:
Phone:	Phone:	Phone:

	Yes	No		Yes	No		Yes	No
Appointment reminders	☐	☐	*Appointment reminders*	☐	☐	*Appointment reminders*	☐	☐
Test results	☐	☐	*Test results*	☐	☐	*Test results*	☐	☐
Billing Information	☐	☐	*Billing Information*	☐	☐	*Billing Information*	☐	☐

I understand that I have the right to change or cancel this request at any time by notifying Family Clinic. I also understand that the changes or cancellation will not affect action taken based on this request prior to the change or cancellation.

_____

Signature of Patient/Representative and Date Printed Name of Patient/Representative

_____

Relationship to Patient Witness Signature and Date

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Assignments and Authorizations

Patient Name:_____DOB:_____

On behalf of myself or other patient named above;

Consent to Treat:

I hereby give my permission to Family Clinic for the evaluation and treatment of the presented medical condition. I am requesting that health care services be provided to me (or the patient named above) at Family Clinic. I voluntarily consent to all treatment and healthcare services that the caregivers at Family Clinic consider to be necessary for me (or the patient named above). I am aware that the practice of medicine is not an exact science; no guarantees have been made to me about the results of treatments, examinations, or services.

_____

Financial Responsibility:

Subject to applicable law and the terms and conditions of any applicable contract between Family Clinic and a third-party payer, and in consideration of all health care services rendered or to be rendered to me (or the above-named patient), I agree to be financially responsible and obligated to pay Family Clinic for any balance not paid under the “Assignment of Benefits” paragraph below. Subject to applicable law, and in consideration of all health care services rendered or to be rendered to me (or the above named patient), I agree to be financially responsible and obligated to pay Family Clinic for the patient balances due.

_____

Consent to Retrieve Medical Information:

As a patient of Family Clinic, I authorize Family Clinic to retrieve and use my medication history from SureScripts, an electronic prescription network. This is an electronic way for Family Clinic to access patient prescription benefit information and patient medication history. Family Clinic can only retrieve medication history from offices that support SureScripts. Utilizing this method is the best way to obtain the most up to date information so that your healthcare provider can deliver the best care to you.

_____

Assignment of Benefit:

In consideration of all health care services rendered or to be rendered to me (or the above named patient), I hereby assign to Family Clinic all rights, title, and interest in and to any third-party benefits due from any and all insurance policies and/or responsible third-party payers of an amount not exceeding Family Clinic's regular and customary charges for the health care services rendered. I authorize such payments from applicable insurance carriers, third party payers, and other third-parties. I consent to any request for review or appeal by Family Clinic to challenge a determination of benefits made by a third-party payer. Except as required by law, I assume responsibility for determining in advance whether the services provided are covered by insurance or other third-party payer. I understand that my current insurance must be on file with Family Clinic for my insurance to be billed and as such I will be expected to present my insurance card at each visit to verify my insurance coverage. If I do not provide Family Clinic with insurance information, I will be considered a self-pay patient and obligated to pay all fees associated with the services rendered.

_____

Notice of Privacy Practice

I have received a copy of the Family Clinic Notice of Privacy Practices. The Notice of Privacy Practices explains how Family Clinic may use and disclose confidential health information that identifies me (or the above named patient). I consent to let Family Clinic use and disclose health information about me (or the above named patient) as described in the Notice of Privacy Practices. In doing so I consent to the release of my (or the above named patient's) health information and financial account information to all third-party payers and/or their agents that are identified by Family Clinic, its billing agents, collection agents, attorneys, consultants, and/or other agents that represent Family Clinic or provide assistance to Family Clinic for the purposes of securing payment from all parties who are potentially liable for payment for my (or the above named patient's) health care. I can revoke my consent in writing at any time except to the extent that Family Clinic has already relied on my consent. I consent to receive text messages and/or telephone calls or other communications using live, artificial or prerecorded voices, automatic telephone dialing systems, or any other computer-aided technologies from Family Clinic and its affiliates, clinical providers, and business associates, along with any billing services, collection agencies, agents, or other third parties who may act on their behalf. Such text messages and/or telephone calls may be related to any purpose, including those related to my account and/or the care rendered.

_____

_____

Patient/Legal Guardian Signature Relationship to Patient

_____

Witness Signature Date

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Release of Protected Health Information

Patient Name:_____DOB:_____

I request that my protected health information (PHI) be ☐disclosed to ☐obtained from
Recipient Name:_____
Street Address:_____City:_____State:_____Zip:_____
E-mail Address:_____Phone:_____
Fax (healthcare provider only): _____

I authorize the following PHI to be released from my medical record(s):
____All records covering the period of healthcare from _____to_____
____Only Family Clinic records
____Records regarding treatment of specific illness, condition, or injury
____Other (please specify)_____

Purpose for requesting information: ☐Legal ☐Insurance ☐Personal ☐Continuation of Care
☐Other (please specify):_____

By signing this authorization form, I confirm I have been made aware of the rights and conditions listed below:

_____
Patient or Authorized Representative Signature Date

_____
Print Name Relationship to Patient (if other than self)

_____
Witness Signature (Verified by) Witness Signature Date

Rights and Conditions:

- I am authorizing Family Clinic to disclose/obtain certain protected health information (PHI) about me to the party or parties listed above.
- I have the right to change or cancel this authorization at any time by notifying Family Clinic.
- I understand that unless otherwise revoked, this authorization will expire 1 year from the date signed.
- I understand that information used or disclosed based on this authorization may be subject to additional disclosure by the recipient named above and may not be protected by federal laws and regulations regarding the privacy of the medical PHI. I understand that I have the right to inspect and copy the information to be disclosed.