MLM Family Medicine

Name: _____

Last First Middle

Marital Status:

☐ Single ☐ Divorced

☐ Married ☐ Widowed

Address: _____ City: _____

State: _____ Zip: _____

Preferred Phone Number: _(_____)_____

Additional Phone Number _(_____)_____

Email Address: _____

Date of Birth: _____ Social Security Number: _____-_____-_____

Responsible Party (if other than patient)

Name: _____ Relation: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _(___)_____

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Employer Information:

Name of Employer: _____ Phone: __(____)_____

Occupation: _____

Preferred Pharmacy:(very important that you supply us with this information; we use ePrescribe

Name: _____

Address (or cross-streets):_____

Insurance Information:

Name of Insurance:_____

Claims Address: _____

City: _____ State: _____ Zip:_____

Phone Number: _(____)_____

Policyholder Name: _____

Policyholder Birth date: _____ Social Security Number: _____-_____-_____

Does your insurance require referrals?

☐ Yes

☐ No

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This part of the medical record is strictly confidential. It will not be released to any other person or entity without your written prior authorization

PAST MEDICAL HISTORY: Do you have or have you ever had any of the following?

- ☐ Angina
- ☐ Atrial Fibrillation
- ☐ Congestive Heart Failure
- ☐ Coronary Heart Disease
- ☐ High Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Past Heart Attack
- ☐ Palpitations
- ☐ Peripheral Vascular Disease
- ☐ Stroke
- ☐ Asthma
- ☐ Other_____
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Thyroid Nodule
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Colon Polyps
- ☐ Crohn's Disease
- ☐ Diverticulosis
- ☐ Diverticulitis
- ☐ Gallstones
- ☐ GERD
- ☐ Hepatitis
- ☐ Hernia
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis
- ☐ COPD
- ☐ Cancer
- ☐ BPH/Enlarged Prostate
- ☐ Frequent UTI
- ☐ Incontinence
- ☐ Kidney Stones
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Allergic Rhinitis
- ☐ Chronic Sinusitis
- ☐ Sleep Apnea
- ☐ Chronic Bronchitis

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SURGICAL HISTORY:

- ☐ Appendix
- ☐ Gallbladder
- ☐ Colon Resection
- ☐ Gastric Bypass
- ☐ Hernia repair
- ☐ Hemorrhoidectomy
- ☐ Laparoscopy
- ☐ CABG
- ☐ Valve Repair
- ☐ Pacemaker
- ☐ Other_____
- ☐ Cataract
- ☐ C-Section
- ☐ D&C
- ☐ Hysterectomy
- ☐ Tubal Ligation
- ☐ Mastectomy
- ☐ Breast Augmentation
- ☐ Skin Cancer
- ☐ Vein Stripping
- ☐ Hip Replacement
- ☐ Knee Replacement
- ☐ Back Surgery
- ☐ Neck Surgery
- ☐ Tonsillectomy
- ☐ Sinus Surgery
- ☐ Thyroid Removed

MEDICATIONS:

Name of Medication_____ Dose: _____ Times a day:_____

Name of Medication_____ Dose: _____ Times a day:_____

Name of Medication_____ Dose: _____ Times a day:_____

Name of Medication_____ Dose: _____ Times a day:_____

Name of Medication_____ Dose: _____ Times a day:_____

Name of Medication_____ Dose: _____ Times a day:_____

Name of Medication_____ Dose: _____ Times a day:_____

Name of Medication_____ Dose: _____ Times a day:_____

Name of Medication_____ Dose: _____ Times a day:_____

Name of Medication_____ Dose: _____ Times a day:_____

ALLERGIES: No ☐ Yes ☐

If yes, please list: _____

FAMILY HISTORY:

- ☐ Coronary Artery Disease
- ☐ High Blood Pressure
- ☐ High cholesterol
- ☐ Stroke
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Cancer
- ☐ Mental Illness
- ☐ Other

If yes, please list relation to you:

_____

_____

_____

_____

_____

_____

SOCIAL HISTORY

	Current	Former
Tobacco	○	○
Alcohol	○	○
Recreational Drugs	○	○

Reason for your visit today:

FINANCIAL POLICY

The following information is provided to make our financial policies clear and avoid any possible misunderstandings concerning the payment of professional services.

INSURANCE
Our practice participates in a variety of insurance plans. It is your responsibility to:
1) Bring your insurance card to every visit
2) Be prepared to pay for any co-pays and deductibles that apply
3) Payment in full is due at the time of service for any medical care not covered by your insurance

SELF PAY PATIENTS
Payment for office visits is due at the time of service.

REFERRALS
Please allow three business days from the date requested.

LAB FEES
Please be aware that lab fees for blood work and pathology (including PAP smears) are separate from our office charges and may be billed directly to you by the lab company.

Insurance coverage is complicated and each policy is different. If you have any questions about your insurance we are happy to help you. However, details about your particular coverage must be directed to your Insurance company's member service department. Their number is usually found on the back of the insurance card.

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to MLM Family Medicine for services rendered. I understand that I am responsible for all charges not covered by my medical insurance. In addition, I am responsible for any deductible, co-pay and co-insurance amounts.

_____
Signature

_____ _____
Name Date

MLM Family Medicine

Dear New Patient,

We would like to take this opportunity to welcome you as a patient and to thank you for choosing MLM Family Medicine. It is our goal to provide you with outstanding medical care and services. We wish to make your visits informative, pleasant, and worthwhile.

In order to better serve you, please complete the enclosed patient paperwork prior to your upcoming appointment. As a reminder, all new patients are asked to arrive at least 15 minutes prior to your scheduled appointment time with your insurance card and photo ID.

Also, please bring a list of medications or your medicine bottles to your appointment.

Sincerely,

The Staff at MLM Family Medicine