Sage Medical Center New Patient Forms

Patient Name:_____DOB:_____

Providers and Suppliers of Your Medical Care:
Please list all providers and suppliers of your medical care such as primary care physicians, specialty physicians, chiropractors, pharmacies, herbalists and therapists. IF YOU USE OXYGEN PLEASE PROVIDE THE NAME OF SUPPLIER

Former Primary Care Physician(s)	**Specialty**
Other Patient Care Team members	**Specialty**
Pharmacy: Local	**Mail order**

Medications:

Name	**Dose**	**Directions**

Medication Allergies:

Medication	Reaction

Your History: Please check the appropriate box for the conditions as they apply to you:

Medical History

Condition	yes	no	Comments		Condition	yes	no	Comments		Condition	Yes	No	Comments
Allergies					Depression					Heart Attack (Myocardial infarction)			
Anemia					Diabetes					Nerve/muscle disease			
Anxiety					Emphysema					Osteoporosis			
Arthritis					Reflux, Heartburn (GERD)					Seizures			
Asthma					Glaucoma					Sickle cell anemia			
Blood transfusion					Heart murmur					Stroke			
Cancer					HIV/AIDS					Substance abuse			
Cataracts					High Blood Pressure (Hypertension)					Thyroid disease			
Heart Failure (CHF)					Kidney disease					Tuberculosis			
Clotting disorder					Meningitis					Ulcers			
Chronic obstructive lung disease (COPD)					Hyperlipidemia (High Cholesterol)								

Other Medical History / Injuries:

Surgical History: Female

Number of Pregnancies_____ Number of live births_____

Surgery	Yes	No	Date:		Surgery	Yes	No	Date:		Surgery	Yes	No	Date:
Appendectomy					Cosmetic surgery					Joint replacement			
Brain surgery					C-Section					Small intestine surgery			
Breast Surgery					Eye surgery					Spine surgery			
Gall Bladder Surgery (Cholecystectomy)					Fracture surgery					Tubal Ligation			
Colon surgery					Hernia repair					Heart Valve Replacement			

Surgical History: Male

Surgery	Yes	No	Date:		Surgery	Yes	No	Date:		Surgery	Yes	No	Date:
Appendectomy					Cosmetic surgery					Prostate surgery			
Brain surgery					Eye surgery					Small intestine surgery			
Heart Bypass					Fracture surgery					Spine surgery			
Gall Bladder Surgery (Cholecystectomy)					Hernia repair					Heart Valve Replacement			
Colon surgery					Joint replacement					Vasectomy			

Other surgical history:

Family History: Please check the appropriate box of the conditions that apply to your blood relatives:

Relation	**Alive**	**Deceased**	Alcohol abuse	Arthritis	Asthma	Cancer	Type of Cancer	Chronic Obstructive	Depression	Diabetes	Drug Abuse	Early Death	Reason of Early Death	Heart Disease	High Cholesterol	Hypertension	Kidney Disease	Mental illness	Stroke	Vision loss
Mother																				
Father																				
Maternal Grandmother																				
Maternal Grandfather																				
Paternal Grandmother																				
Paternal Grandfather																				
Sister																				
Brother																				
Daughter																				
Son																				
Other Family:																				

Family history comments:

Social History:

Sexually Active
____Yes_____No____Not currently
Have you been tested for HIV / STDs
____Yes_____No If Yes date of last screening_____
Caffeine Use
____Yes_____No
If Yes:_____number of drinks per day
Alcohol Use
____Yes_____No
If Yes:_____number of drinks per week
Recreational Drug Use
____Yes_____No
If Yes:_____number of times used per week
If Yes: list type(s) of recreational drugs used _____

Tobacco Use
____Yes_____No _____Never Smoked?

Complete appropriate responses below:

_____Current Every day Smoker? _____Number of packs per day _____Number of Years
_____Current Smoker?(not daily) _____Number of packs per week_____Number of Years
_____Former Smoker? _____Quit date
_____Passive Smoker?

Are you ready to Quit?_____Yes_____No

BEHAVIORAL RISK FACTORS

PHYSICAL ACTIVITY

How often do you typically exercise? (Check one)
____Regularly
____Infrequently
____I am currently not exercising

Date of last :
Physical Exam_____Lab tests_____Colonoscopy_____Bone Density Screening_____
Tetanus Vaccination_____Pneumonia Vaccination_____Shingles Vaccination_____
If Female date of last:
Mammogram_____
Pap Smear_____
Have you ever had an abnormal Pap smear No Yes If yes date:_____

Do you take any vitamins or supplements?
_____
_____
_____

Do you have an Advance Directive, Living Will or Power of Attorney for Health Care (POA), in the case that an injury or illness causes you to be unable to make healthcare decisions?
____Yes
____No

Would you like further information regarding Advance Directives?
____Yes
____No

_____ _____
Patient signature **Date**

If completed by someone other than the patient:

_____ _____ _____
Print Name **Signature** **Date**

_____
Relationship to patient

Sage Family Health Center

Debra K. Higginbotham MD

PATIENT REGISTRATION

Name_____Date_____
Last First MI

Address_____
Street City State Zip Code

Phone w/area code_____Work Phone_____Cell Phone_____

Social Security Number_____–_____–_____Date of Birth_____Email _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Ethnicity: ☐ American Indian ☐ Hawaiian or Other Pacific Island ☐ African American ☐ Caucasian ☐ Asian
☐ Other ☐ Declined Are you of Hispanic or Latin Origin: Yes No

Primary Language: ☐ English ☐ Spanish ☐ Other

Employer_____Occupation_____

Who should we contact in an emergency?_____Phone Number _____

Insurance

Sage Medical Center will bill your primary and secondary insurance only

Primary Insurance_____ Policy #_____

Secondary Insurance_____Policy #_____

Insurance Subscriber (Policy holder) Information

Ins. subscriber name_____Phone Number _____
Last First MI

Sex: Male ☐ Female ☐ Social Security Number_____–_____–_____Relationship to Patient_____

Date of Birth_____Employer _____

Sage Family Center is committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about of fees or your financial responsibility.

A $25.00 - $50 missed visit fee depending on the type of appointment will be charged for Missed appointments that have not been canceled at least Twenty four hours prior to scheduled appointment time.

Patients must complete all Information Forms prior to seeing the physician.

Co-Payments – By law, we must collect your carrier designated co-pay at the time of service. Please be prepared to pay that co-pay at each visit...
Self-Pay – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.
Account Balances – You are responsible for timely payment of your account. Sage Medical Center reserves the right to reschedule or deny any future appointments on delinquent accounts.

WE ACCEPT CASH, CHECKS, MASTERCARD, DISCOVER AND VISA

I understand it is my responsibility to inform Sage Medical Center of ANY changes to my insurance coverage. New Id cards, numbers or new insurance provider. IF NOT PROVIDED I UNDERSTAND I WILL BE FULLY RESPONSIBLE FOR ALL FEES INCURRED.

_____ _____

Responsible Party Signature Date

INFORMED CONSENT FOR TREATMENT

Name_____ Date of Birth _____

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CONSENT FOR TREATMENT:
I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions the physician.

_____ _____
Signature Date

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

Signature of Patient or Legal Representative Witness

Date Notice Effective Date or Version

____Accepted_____Denied

Signature_____

Date: _____

I verify that my insurance should be billed in the following order.
I understand if this information is incorrect I will be responsible for all costs.
I understand Sage Medical Center will bill only my primary and secondary insurance.

Primary insurance:_____

Secondary insurance_____

Signature_____Date_____