POQUOSON FAMILY MEDICINE 868-7709

PATIENT ADMITTANCE FORM

File#:_____

Full Name: _____Date:_____

Address: _____City: _____State: _____Zip:_____

Phone (home):_____Work:_____Cell:_____

DOB: _____Age: _____Sex:_____ Marital Status: _____Spouse's Name: _____

Email:_____

SS#: _____ Occupation: _____

Employer: _____Employer Address: _____

Emergency Contact: Name: _____ Relationship _____

Phone: _____ Address: _____

Insurance Information:

Insurance Co: _____ Phone: _____

Agent: _____ Policy: _____ Group: _____

Insured's Name: _____ Insured DOB: _____

Insured SS#:_____

Minor Consent:

I being the parent, guardian or custodian of the minor being _____Age:_____, do herby authorize, request and direct this office, its doctors and staff to perform examinations, diagnostic X-rays, laboratory tests and any treatment that in their judgment is deemed advisable or is requested while said minor child is under care of this office's doctors and staff until legal age. All charges for services and care given to said minor child will be charges directly to me and I will be personally responsible for payment of them.

Parent, Guardian or Custodian Signature _____ Date _____

POQUOSON FAMILY MEDICINE 868-7709

Patient Name:_____

Date: _____

Health History Questionnaire

File:_____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Personal Health History:

Previous or referring doctor: _____

Occupation:_____ List Hobbies:_____

Marital Status: _____ Who lives with you (include pets):_____

Childhood illness: ☐ Measles ☐ Mumps ☐Rubella ☐Chickenpox ☐Rheumatic Fever ☐ Polio

Immunizations and dates: ☐ Tetanus or TdaP:_____ ☐ Hepatitis A and/or B:_____

☐ Influenza:_____ ☐ Pneumonia:_____ ☐ Chickenpox or Varicella Vaccine ☐ MMR *Measles, Mumps, Rubella*:_____

List any medical problems that other doctors have diagnosed (ie. Lung disease, asthma, high blood pressure, diabetes, cancer, high cholesterol, heart disease, thyroid or kidney disease):

_____

_____

_____

Surgeries:

Year: _____Reason_____Hospital_____

Year: _____ Reason _____Hospital _____

Year: _____ Reason _____Hospital_____

Other hospitalizations:

Year: Reason: Hospital:

_____

_____

List your prescribed drugs: (include birth control) and over-the-counter drugs, such as vitamins, herbs, aspirin, calcium and inhalers.

Name the Drug: Strength: Frequency Taken:

_____

_____

_____

_____

_____

_____

_____

Allergies to medications:

Name the Drug: Reaction you had:

_____

_____

_____

Health Habits and Personal Safety

All questions contained in this questionnaire are optional and will be kept strictly confidential

Exercise:

☐ Sedentary (no exercise)
☐Mild exercise
☐Occasional vigorous exercise (less than 4x 30min week)
☐ Regular vigorous exercise (recreation 4x/week for 30 min)

Eating Habits:

Are you dieting? ☐ Yes ☐ No
# of meals you eat in an average day: _____
Rank salt intake: ☐ Hi ☐ Med ☐ Low
Rank fat intake: ☐ Hi ☐ Med ☐ Low

Caffeine: ☐ None ☐ Coffee ☐ Tea ☐Cola
# of cups/cans per day?_____

Alcohol:

Do you drink alcohol? ☐ No ☐ Yes
How many drinks per week? _____
Are other concerned about the amount you drink? ☐ No ☐ Yes
Have you ever experienced blackouts? ☐ No ☐ Yes
Are you prone to "binge" drinking? ☐No ☐ Yes

Tobacco:

Do you use tobacco? ☐ No ☐ Yes If YES, are you interested in stopping? ☐ No ☐ Yes
# of Years_____ If you have **QUIT**, what year_____
Cigarettes- Pks./Day:_____ Chew-#/day:_____ Pipe-#/day:_____ Cigars-#/day:_____

Drugs:

Do you currently use recreational or street drugs? ☐ No ☐ Yes
Have you ever given yourself street drugs with a needle? ☐ No ☐ Yes

Sex:

Are you sexually active? ☐ No ☐ Yes
If yes, are you trying for a pregnancy? ☐No ☐ Yes
If not trying for a pregnancy list contraceptive or barrier method use:_____
Any discomfort with intercourse? ☐No ☐ Yes
Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors or this illness intravenous drug use and unprotected sexual intercourse. Would you like to be screened for this and other sexually transmitted infections?
☐ No ☐ Yes

Personal Safety:

Do you always wear a seatbelt? ☐ No ☐ Yes
Do you have frequent falls? ☐ No ☐ Yes
Do you have vision or hearing loss? ☐ No ☐ Yes
Do you have an Advance Directive or Living Will? ☐ No ☐ Yes
Do you have a gun in your home? ☐ No ☐ Yes If yes, secured? ☐ No ☐ Yes
Physical and/or mental abuse has also become major public health issue in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? ☐No ☐ Yes

MENTAL HEALTH HISTORY

Is stress a major problem for you?	☐ No	☐ Yes
In the past month, have you had little interest or pleasure in doing things, or felt down, depressed or hopeless?	☐ No	☐ Yes
Do you panic when stressed?	☐ No	☐ Yes
Do you have problems with eating or your appetite?	☐No	☐ Yes
Do you cry frequently?	☐ No	☐ Yes
Have you ever attempted suicide?	☐ No	☐ Yes
Have you ever seriously thought about hurting yourself?	☐ No	☐ Yes
Do you have trouble sleeping?	☐ No	☐ Yes
Have you ever been to a counselor?	☐ No	☐ Yes

FAMILY HEALTH HISTORY

		AGE:	Significant Health Problems:
Father:		_____	_____
			_____
Mother:		_____	_____
			_____
Siblings:	☐ M ☐ F	_____	_____
	☐ M ☐F	_____	_____
	☐ M ☐ F	_____	_____

List Relatives Significant Health Problems Below:

Grandmother :_____
(maternal) _____
Grandfather :_____
(maternal) _____
Grandmother :_____
(paternal) _____
Grandfather : _____
(paternal) _____

CHILDREN: Age: Health Problems:

☐ M ☐ F _____
☐ M ☐ F _____
☐ M ☐ F _____
☐ M ☐ F _____

ANY OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain:

☐ Skin	☐ Chest/Heart	☐ Head/Neck	☐ Back
☐ Ears	☐Nose	☐Throat	☐ Lungs
☐ Intestinal	☐ Bladder	☐ Bowel	☐ Circulation

Recent Changes in: ☐Weight ☐ Energy level ☐ Ability to sleep ☐ Other pain/discomfort:

WOMEN ONLY:

Age at onset menstruation:_____ Date of last menstruation: _____ Period every _____ days.

Heavy periods, irregularity, spotting, pain, or discharge? ☐ No ☐ Yes

Number of pregnancies _____ Number of live births_____

Are you pregnant? ☐ No ☐ Yes or are you breastfeeding? ☐ No ☐ Yes

Have you had a D&C? ☐ No ☐ Yes

Hysterectomy? ☐ No ☐ Yes

Cesarean? ☐ No ☐ Yes

Any urinary tract, bladder, or kidney infections within the last year? ☐ No ☐ Yes

Any blood in your urine? ☐ No ☐ Yes

Any problem with control of urination? ☐ No ☐ Yes

Any hot flashes or sweating at night? ☐ No ☐ Yes

Do you have menstrual tension, pain, bloating, irritability or other symptoms at or around time of period? ☐ No ☐ Yes

Experienced any recent breast tenderness, lumps or nipple discharge? ☐ No ☐ Yes

Date of last pap and rectal exam? _____ Date of last mammogram?_____

MEN ONLY:

Do you usually get up to urinate during the night? ☐ No ☐ Yes If Yes, # of times: _____

Do you feel pain or burning with urination? ☐ No ☐ Yes

Any blood in your urine? ☐ No ☐ Yes

Has the force of your urination decreased? ☐ No ☐ Yes

Have you had any kidney, bladder or prostate infections within the last 12 months? ☐ No ☐ Yes

Do you have any problems emptying your bladder completely? ☐ No ☐ Yes

Any difficulty with erection or ejaculation? ☐ No ☐ Yes

Any testicle pain or swelling? ☐ No ☐ Yes

Date of last prostate and rectal exam? _____

POQUOSON FAMILY MEDICINE & CHIROPRACTIC CLINIC (PFM)

PATIENT RESPONSIBILITY & FINANCIAL AGREEMENT

1.FINANCIAL RESPONSIBILITY: I assign any benefits to PFM that I may have for reimbursement for my medical treatment received by PFM which I may be entitled to from any insurance coverage, worker's compensation benefits, disability benefits, and all settlements, judgments and verdicts against any liable third party. If I fail to pay my outstanding PFM balance, I understand PFM will have a lien against any such settlement, judgment or verdict equal to the full amount of any unpaid PFM bill. I further direct any attorney handling or disbursing such proceeds to withhold and promptly pay PFM the full amount of any outstanding balance owed by me, the Patient, to PFM for medical services rendered. I also understand and agree to pay a $30 fee incurred for any returned checks.

2. ALL PAYMENTS DUE AT TIME OF SERVICE: While PFM as a courtesy to patients will bill most insurance companies; PFM is under no obligation do so. If your insurance company fails to pay all or part of your bill, you are responsible for all charges. By signing this agreement, I agree to accept full responsibility of all PFM charges. Full payment is required at the time of service unless other arrangements are made. If any PFM bill is not paid in full at the time of the service, PFM reserves the right to charge interest at a rate of 12% from the time of delinquency on any outstanding balance. In addition to interest, I agree to pay both any reasonable collection agency and/or attorney fees associated with recovering any outstanding balance.

3. DISCLOSURE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS: I authorize PFM to share my medical information and medical records to my insurance company and third party payers. I also assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

4. PATIENT/FAMILY CONDUCT: While in the office of PFM, I agree to be respectful and courteous to the PFM Staff, all medical providers and other patients. I realize the importance of honoring my scheduled appointments and agree to provide adequate notice (at least 24 hours) for rescheduling appointments. Failure to keep appointments or rescheduling without adequate notice may result in consequences including a charge for the missed appointment. Repeated cancellations may result in discharge from the practice.If you need to be seen the same day please contact PFM for "same day" accommodations.

PFM will accept "walk-in" patients provided that:

a) they are an existing patient with current and updated medical records on file
b) the "walk-in" process does not conflict with current scheduled appointments
c) the Patient acknowledges there may be additional waiting time involved to incorporate their treatment within an existing schedule

5. PFM IS NOT RESPONSIBLE FOR LOSS OF PERSONAL ITEMS: PFM will not be responsible for any loss, theft or damage to any personal property of the Patient (including money, jewelry, documents, clothing, spectacles, dentures, prosthetic devices or other personal articles).

6. PATIENT CARE: PFM provides medicinal and holistic approaches to healing. All medications (OTC and Rx) will be monitored regularly and will require previous medical records (if available) to obtain prescription(s). Please note that pain management cases will be referred to the appropriate pain management facility. Please allow 72 hours for all prescription refills. For accurate records and treatment purposes, it is the Patient's responsibility to provide PFM physicians with the most updated/current medicines taken by the Patient. PFM does not administer immunizations; however, immunizations for ages 5 and up are available at the Health Department or local pharmacies. PFM **DOES** offer medical services for homebound patients; PFM physicians are available for house calls. Please note this may require additional preauthorization as required by your insurance carrier. During afterhours care it is the Patient's responsibility to contact 911 or attend an ER/Urgent Care facility. Please note that PFM will require the release of medical records to coordinate aftercare. PFM medical services include and are not limited to the following: Routine Family Care (includes physical, school and sports exams), Women's Health (includes PAP smears), Diabetes Care, High Cholesterol, Hypertension, Depression, Anxiety, Adolescent Care, Health Promotions (includes exercise, healthy eating and weight loss), Chiropractic Care, Physical Therapy.

EACH PARTY TO THIS AGREEMENT ACKNOWLEDGES THAT THEY HAVE READ AND FULLY UNDERSTAND THE MEANING AND CONSEQUENCES OF EACH AND EVERY TERM AND PROVISION OF THIS AGREEMENT.

Print Patient's Name	Date of Birth	Date & Time
Patient or Responsible Party Signature		Relationship to Patient

POQUOSON FAMILY MEDICINE 868-7709

POQUOSON CHIROPRACTIC CLINIC 868-7709

NOTICE OF PRIVACY PRACTICES:

I am aware of and/or have received PFM's Notice of Privacy Practices pamphlet. Upon receiving an inquiry as to the presence of condition of the Patient, PFM may (unless otherwise requested by the Patient, next of kin, or physician) release at its discretion: the name, address, age, sex, general nature of injuries, and/or the general condition of the Patient. I understand that a separate written consent is required for me and/or the person(s) listed below to receive copies of my **written** medical records.

However, **I hereby give permission** to my physician & office personnel to verbally discuss any and all of my medical condition(s) with the following person(s).

_____ _____

Print Individual Name & Phone # Print Individual Name & Phone #

_____ _____

Print Individual Name & Phone # Print Individual Name & Phone #

I DO NOT GRANT PERMISSION to my physician & office personnel to verbally discuss any and all of my medical condition(s) with the following person(s).

_____ _____

Print Individual Name & Phone # Print Individual Name & Phone #

HIPPA and Office Policy:

I have read and understand the above information and have been offered a copy from the treating provider.

_____ Date: _____

(Patient Signature)

FOR OFFICE USE ONLY:

☐Patient Unavailable for Signature If Patient unable to sign, Give Reason_____

☐Patient does not want to receive a copy of this document.☐Patientrequested and was provided a copy of this document.

☐No Responsible Person Available Staff Member Initials: _____ Date: _____

POQUOSON FAMILY MEDICINE 868-7709

Dr. Theresa Ledger, DO
Dr. Carol Steiner, MD

Authorization for Release of Records

Date: _____

To: _____

(If multiple physicians involved please leave blank)

Address: _____

_____

I Herby authorize and request you to release the following:

- ☐ Records
- ☐ X-Rays

Patient: _____

DOB: _____ SS#: _____

Signature: _____

Witness: _____

Relationship: _____

Date: _____

370-A Wythe Creek Road, Poquoson VA, 23662
Phone: (757) 868-7709 Fax: (757) 868-7603