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 _____

PEDIATRIC PATIENT HISTORY (0-18 years)

Please complete to the best of your ability to assist our staff in providing the best possible care for you and/or your family members.

LAST NAME _____ FIRST NAME _____ MI _____

DATE OF BIRTH _____ PRIMARY LANGUAGE _____ MALE/FEMALE _____

CHILD'S MEDICAL HISTORY (indicate any significant medical problems along with the date of onset)

Y or N (date of onset)	Medical Problem	Y or N (date of onset)	Medical Problem
	Allergies/Hay Fever		Seizures
	Blood Transfusion		Recurrent Ear Infections
	Premature Birth		MRSA/VRE
	R.S.V.		HIV/AIDS
	Lung Problems		Eczema/Rash
	Hepatitis/Liver problems		Dental Concerns
	Heart Defect/Disease		Sexually Transmitted Disease
	Other:		Other:

MEDICATIONS (if you need more space for medications please ask for another form)

Name of Medication	Dosage	How many times per day	Date Started	Prescribed By

ALLERGIES (circle and explain type of reaction below): Medication Household Products, Animals, Environment

_____

_____

_____

BIRTH HISTORY ADOPTION ☐Y or N☐

Child's Birth Weight		Length of Pregnancy	
Complications with Pregnancy or Birth	☐Y or N☐		

PAST SURGICAL AND HOSPITALIZATION HISTORY (any surgeries or hospitalizations along with dates)

Date	Surgery/Hospital Stay	Date	Surgery/Hospital Stay

FAMILY MEDICAL HISTORY-Indicate family member. For extended family, note whether on mother's side (M) or father's side (F).

Medical Problem	Relative (M or F)	Age at onset or death	Medical Problem	Relative (M or F)	Age at onset or death	Medical Problem	Relative (M or F)	Age at onset or death
Alcohol/Drug			Diabetes			Mental illness		
Allergies			Stomach/ intestine			Migraine headaches		
Alzheimer/ Dementia			Bladder/Kidney			Lung problem		
Anesthesia problems			Heart			Stroke		
Arthritis			High Blood Pressure			Thyroid		
Asthma			Cholesterol			Cancer		
Blood disease			Other			Other		

NOTES _____

_____

_____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Tobacco use

- ☐ None in household
- ☐ Quit: packs/day_____ years smoked:_____ quit date:_____ type of tobacco:_____
- ☐ Current smoker: packs/day_____; start date:_____ type of tobacco:_____
- ☐ Second-hand smoke (who in home smokes) _____

Alcohol use (each drink contains 0.5 oz alcohol): (answer for children over 12 years of age)

- ☐ No
- ☐ Yes: Drink(s) per week:_____ Type of alcohol _____

Substance Abuse

- ☐ Yes Type _____ Amount_____ How often_____
- ☐ No

Nutrition and Activity

- ☐ Caffeine (coffee, tea, soda):☐yes /☐no, if yes, how much per day:_____
- ☐ Diet: ☐good /☐fair /☐bad /☐vegetarian /☐vegan
- ☐ Exercise: types:_____ min per day: _____; times per week:_____

Social and Special needs

- ☐ Do you feel safe at home:☐yes ☐no
- ☐ Do you have communication needs that affect your medical care:☐yes /☐no ; if yes explain:_____

Health Care Maintenance (please enter dates: also write N for "normal" or AN for "abnormal"):

Last Physical_____ Last Dental Exam_____ Last eye exam (Dr) _____

Immunizations Up-To-Date _____

Form completed by _____ Date _____

REV. 11/28/11

POQUOSON FAMILY MEDICINE & CHIROPRACTIC CLINIC

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. Copays are due at check in.

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 of $50.00 for missed appointments. Repeated cancellations may result in discharge from the practice. If you need to be seen the same day please contact PFM for "same day" availability accommodations.

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

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

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: _____

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