Patient Information

Referring Provider_____How did you hear about us?_____

First Name_____Middle_____Last_____
Address_____

Suffix_____Date of Birth_____Social Security_____-____-_____Gender: M / F

Primary Phone #_____Work Phone #_____E-mail_____

Emergency Contact Name:_____Phone Number:_____

Emergency Contact Relationship_____

Marital Status: Single Married Divorced Separated Widow Civil Union Domestic Partner

Race: American Indian or Alaska Native Asian Black or African American White
Native Hawaiian or other Pacific Islander Declined to specify

Ethnicity: Hispanic or Latino Not Hispanic or Latino Declined to Specify

Preferred Language: English Spanish Declined to Specify

Preferred Contact Method: No Preference Email Phone Postal Patient Portal

Appt. Notification Contact Method: No Preference Email Phone Postal Patient Portal

Employer:_____Occupation_____
Employment Status: Full-time Part-time

Pharmacy _____Address _____

Guarantor ID: (Responsible for Bill)_____
Patient's Relationship to Guarantor:_____
Guarantor Name:_____Date of Birth_____
Guarantor Social Security_____-____-_____Guarantor Employer_____
Guarantor Primary Phone_____Work Phone:_____
Guarantor Employer_____
Insurance or Self-Pay
Primary Insurance Name_____PolicyNumber_____
Group Number_____
Patient's Relationship to Insured: (Self, Dependent, Spouse) Insured Date of Birth_____
Secondary Insurance Name and Policy Number_____
Tertiary Insurance Name and Policy Number_____

Name _____ Gender _____ Age _____

Date of Appointment: _____

Reason for Visit

What brings you to the office today?

How is your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any other concerns you would like to address?

Current Medications

What medications are you currently taking?

Name	Dosage	Frequency

Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates (Sleeping Pills) ☐ Aspirin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

Name	Reaction

Past Medical History

☐ Alcoholism ☐ Back Problems ☐ Ear Problems
☐ Allergies ☐ Bleeding Disorder ☐ Eating Disorder
☐ Anemia ☐ Blood Disease ☐ Epilepsy
☐ Anxiety Disorder ☐ Blood Transfusion ☐ Glaucoma
☐ Arthritis ☐ Cancer ☐ Gout
☐ Asthma ☐ Diabetes ☐ Heart Disease
☐ AIDS / HIV ☐ Depression ☐ Heart Problems
☐ Hepatitis - A, B, or C ☐ Measles ☐ Skin Disorder
☐ High Blood Pressure ☐ Migraines ☐ Stomach Ulcer
☐ High Cholesterol ☐ Osteoporosis ☐ Substance Abuse
☐ Joint Disorder ☐ Pneumonia ☐ Thyroid Disorder
☐ Kidney Disorder ☐ Polio ☐ Tuberculosis
☐ Liver Disorder ☐ Rheumatic Fever ☐ Venereal Disease
☐ Lung Disease ☐ Stroke

Hospitalizations & Surgeries

Reason	Date

Women Only:

# of Pregnancies	# of Miscarraiges	# of Abortions	# of Living

Last Pap Smear	Last Mammogram	Birth Control Method

Family History

Has anyone in your family ever had any of the following conditions?

☐ Alcoholism ☐ Cancer ☐ Joint Disorder
☐ Allergies ☐ Depression ☐ Kidney Disease
☐ Alzheimer's ☐ Diabetes ☐ Liver Disorder
☐ Anemia ☐ Epilepsy ☐ Lung Disease
☐ Anxiety ☐ Genetic Disorder ☐ Migraines
☐ Arthritis ☐ Glaucoma ☐ Psychiatric Disorders
☐ Asthma ☐ Heart Disease ☐ Osteoporosis
☐ AIDS/HIV ☐ Hepatitis ☐ Stroke
☐ Bleeding Disorder ☐ High Cholesterol ☐ Substance Abuse
☐ Blood Disorder ☐ High Blood Pressure ☐ Thyroid Disorder

Details:

Lifestyle Factors

Are you sexually active?

☐ Yes ☐ No # of partners in past year _____

Do you wish to be checked for STDs?

☐ Yes ☐ No

Has anyone in your home ever physically or verbally hurt you?

☐ Yes ☐ No

Have you ever smoked?

☐ Yes ☐ No # of years _____ # packs/day _____

Do you smoke now?

☐ Yes ☐ No # packs/day _____

Do you use recreational drugs?

☐ Yes ☐ No types? _____ # times/week _____

How much alcohol do you drink per week?

drinks/week _____

How much caffeine do you drink per day?

drinks/day _____

How often do you exercise?

times/week _____

Elizabeth Dewey, MD PLLC Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Please read it, ask us any questions you may have, and sign in the space provided.

1.**Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment and deductible at each visit.

3**. Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. Most insurances have time filing restrictions. If a claim is not received within 30 days it can be rendered ineligible for payment and you will be responsible for the balance.

4**. Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and the insurance company.

5**. Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

6**. Missed appointments.** Our policy is to charge $25 for missed appointments not canceled within 24 hours of appointment time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

7. **Forms.** There is a $25 fee for completing FMLA, sick leave, AFLAC, and disability insurance forms that will be collected prior to form completion.

8. **Preventive or Wellness Visits** Please know that if any "established" or "acute" health conditions are addressed during this time, as per insurance requirements, you may be assessed a separate charge for services related to the established or acute condition. This may result in a copay, coinsurance and/or deductible.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.
Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**

Elizabeth Dewey, MD

HIPAA

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent in writing, signed by you. However, such a revocation shall not affect any disclosures already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- **Protected health information may be disclosed or used for treatment, payment, or health care operations.**
- **The Practice has a Notice of Privacy Practices and the patient has been given the opportunity to review this Notice.**
- **The patient has the right to restrict the uses of their information, but the Practice does not have to agree to the restrictions.**
- **The patient may revoke this Consent in writing at any time and all future disclosures will then cease.**
- **The Practice may condition receipt of treatment upon the execution of this Consent.**
- **The patient acknowledges that he/she has been offered a copy of the practice's Notice.**

The Consent was signed by: _____

Printed Name – Patient or Representative

Relationship to patient: _____

Witness: _____ **Date** _____

Printed Name – Practice Representative

AUTHORIZATION TO OBTAIN INFORMATION

Patient Name: Date of Birth:

I hereby authorize Elizabeth Dewey, MD, at 3150 N. Elm St., Suite 200, Greensboro NC 27408. fax 336-450-1560.

to obtain my medical records

_____ entire record _____ immunizations _____ imaging studies

from the following

Dr. Name or Practice Name:

Phone #:

Address:

The records are required for the specific purpose of continuity of care.

I understand that my authorization will remain effective from the date of my signature until 90 days, and that the information will be handled confidentially in compliance with all applicable federal laws.

I understand that I may see the information that is to be sent, and that I may revoke the authorization at any time by written, dated communication. I have read and understand the nature of this release.

_____

Signature of Patient or Designated Representative Date

Authorization for Release of Information – Compound Release

Name_____Date of birth_____
The practice of Elizabeth Dewey MD is authorized to release protected health information about the above-named patient in the following manner and/or to selected persons.

Check each person/entity approved to receive information.	Check type of information that can be given to person/entity on the left in the same section.
☐ Voice Mail	▫ Results of lab tests/x-rays ▫ Other_____
☐ Other person (s) (provide name and phone number)	▫ Financial ▫ Medical
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	▫ Financial ▫ Medical ▫ Appointment reminders ▫ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	▫ Appointment reminder ▫ Other: _____
☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	

Patient Rights:

- I have the right to revoke this authorization at any time by contacting our office.
  I may inspect or copy the protected health information to be disclosed as described in this document.
  Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
  Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

Date _____

Signature_____

*Description of Personal Representative's Authority (attach necessary documentation)

Revised June 2019