

LEWISVILLE FAMILY PHYSICIANS

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Name _____ Male / Female(Circle)

Address _____ City _____ State _____ Zip _____

DOB ____/____/____ SSN ____-____-____ Marital Status _____

Home Phone (____) _____-____ Work Phone (____) _____-____ Cell Phone (____) _____-____

Place of Employment _____

Emergency Contact

Name _____ Address _____ Relationship _____

Home# _____ Work# _____ Cell# _____

Lewisville Family Physicians values their patients and we will take reasonable steps to maintain the confidentiality of patient's health information. Protected health information refers to individually identifiable information (including demographic information) relating to a person's health, to the healthcare provider to a person or to payment for healthcare. In effort to serve our patients, we are asking that you review and sign below indicating your preference of how we should provide you with any medical information that you should need which could include test/lab results or appointment/referral information.

Please list any names and telephone numbers that we may leave or discuss information with about your health care which could also include test/ lab results or appointment/referral information:

Name	Relationship	Phone
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Please initial that you have received a copy of the Protected Health Information Sheet _____

INSURANCE INFORMATION

Insurance Company _____ Plan Name / Type _____

Employer _____ Group Number _____ Policy Number _____

Policy Holder Name _____ Relation to patient _____

SSN of Policy Holder _____ Policy Holder's DOB _____

Secondary Insurance

Insurance Company _____ Plan Name / Type _____

Policy Holder Name _____ Relation to patient _____

Co Address _____ City _____ State _____ Zip _____

Lewisville Family Physicians will gladly submit you bill to your insurance company as a courtesy to you, however if we haven't received a response from them within 30 days of the billed date this bill will become your responsibility. All co pays and co insurance are due at time of service.

Patient
Signature _____ Date _____

Responsible Party _____ Date _____

Patient Name: _____ Date: _____

Person filling out form, and relationship to patient: _____

Please list all Medications you take, **including vitamins and supplements:** (if you have a list, let us make a copy)

Medicine name and dose (mg)	Times per day	Reason for medicine	When did you start it?

Your preferred pharmacy: _____

Please list any **Medication ALLERGY** below:

ALLERGY	REACTION

Are you allergic to LATEX? YES NO (circle one)

Medical History

Do you have, or have you had, any of the following conditions? (circle YES or NO):

High Blood Pressure YES NO **Diabetes** YES NO **High Cholesterol** YES NO

Cancer YES NO if yes, please explain _____

Depression YES NO **Arthritis** YES NO **Chronic Pain** YES NO if yes, where? _____

Mental Health Condition YES NO please explain _____

Heart Problems YES NO if yes, please explain _____

Lung Problems YES NO if yes, please explain _____

Stomach/Intestinal Problems YES NO if yes, please explain _____

Any Other Medical Problem: if yes, please explain _____

Have you had **Chicken Pox, or the vaccine?** YES NO (Please state which) _____

When was your last **tetanus booster?** (if over age 11) _____

Have you ever had a **blood transfusion?** YES NO if yes, when and why? _____

Patient Name: _____

Have you had ANY **Surgery** of any type? If so, please list below

Check if you have had: Date (year)
 Appendectomy _____
 Hysterectomy _____
 Gall Bladder removed _____
 Tonsils removed _____

Other operations:

Date	Surgery	Reason	Comment

Any **Hospitalizations** other than those above? YES NO

If YES, please explain _____

Family History	Living, Yes/No	If living, Date of Birth	Any medical problems?	If deceased, at what age?	Cause of death?
Father					
Mother					
Sister					
Brother					
Other siblings					
Children					

Are there any other conditions that seem to run in the family? If so, please explain:

Heart problems? _____
 Cancer of any sort? _____
 Diabetes _____
 Other? _____

Do you see any other doctors on a regular basis (OB-GYN, Cardiologist, etc.)? If so, please list their name(s) and the reason for treatment, and initial if you give permission for us to send information:

_____ Init _____
 _____ Init _____
 _____ Init _____

More:

Patient Name: _____

Are you: Married Single Divorced Separated Widowed

Who lives with you at home? _____

Do you have a Living Will or Advanced Directive? Yes No

Do you smoke? YES NO If you smoke cigarettes, how many packs per day? ____ For how many years? ____

Are you interested in quitting? YES NO

Do you exercise? YES NO if yes, what form? _____ How many times per week? _____

Do you drink alcohol in any form? YES NO If yes, how much in one week? _____

Do you use, or have you used, recreational drugs? Yes No In the past: what? _____

If you currently use recreational drugs, what? _____ Any injected drug use? YES NO

Occupation? _____ Employer? _____

Are you exposed to hazardous chemicals at work? YES NO if yes, explain _____

For Children:

Attend daycare: YES NO

Up to date on immunizations? YES NO Please provide a copy of shot records, as soon as possible.

Any reactions to past shots? YES NO if yes, please explain _____

Ladies Only

Age when you first had your period? _____

Have you gone through menopause? YES NO If yes, at what age? _____

Did you take hormone replacement? YES NO if YES, for how long? _____

Are your periods regular? YES NO if no, please explain _____

When was your last Pap smear/ Well Woman Exam? _____

Have you ever had an abnormal Pap smear test? YES NO if "yes" please explain _____

If you are over 40, when was your last mammogram? _____ Was it normal? YES NO

if not, please explain _____

Any family member with breast cancer, or breast disease? _____

Do you use contraception? YES NO If YES, what form? _____

Obstetrical history:

Have you EVER been pregnant? YES NO if yes, how many times? _____

How many deliveries/births? _____ Any problems? _____

Do you have any concern for your safety at home?

PATIENT/GUARANTOR ASSIGNMENT OF BENEFITS
AND
ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I, _____ (patient or guarantor's name)

Full Address (if different from patient): _____

SSN: _____.

hereby agree to accept financial responsibility for the medical treatment provided to me, or to _____ (name of patient), by the physicians and other employees and agents of Lewisville Family Physicians (the "Practice"). I agree to cooperate fully with the employees and agents of the Practice in order for the Practice to obtain payment from any available third party sources, including insurance carriers, for the services provided by the Practice and hereby assign any benefits payable by such payor sources as a result of services rendered by the Practice's agents and employees to the Practice. I acknowledge that the Practice will file claims on my behalf with the applicable payor as a courtesy only and I hereby agree to be fully responsible for any balance of the Practice's charges not covered by any applicable payor source, to the extent permitted by applicable federal and state law. In the event that collection services are required, I agree to be responsible for the collection fees and a collection service charge..

Signed this _____ day of _____, 200__.
Day Month

Signature of Patient or Guarantor

Witness

Some useful information about insurance, our charges, and your bill:

The world of health insurance is complicated and confusing. Here are some explanations of a few important topics that apply to how much you pay for medical care.

What exactly is a "co-pay"?

If you have a co-payment (co-pay), this is set by your insurance company. Your insurance company pays us a set amount for a specific service, and the co-pay is subtracted from this amount. It is your portion of the total payment.

**Your co-pay is not an added payment for us.*

We are not allowed, by your insurance company's rules, to change or reduce the co-pay amount. If you co-pay increases, it means your insurance company has decreased how much they pay us by the same amount. We are required to collect the co-pay at the visit.

What is "co insurance"?

In some cases, instead of a co-pay, your insurance company states that you must pay a percentage of the charges. In this case, the amount will depend on the particular service.

Preventive Health services

Some insurance plans do not pay for preventive services, such as physicals, vaccinations, or blood tests such as cholesterol levels. It is the patient's responsibility to check if the services are covered. **If the services you want are not covered, you will be responsible for the charges.**

Deductibles

Some insurance companies, or employers, have included a "deductible" in your insurance coverage. A deductible is a set amount that your insurance company says that you have to pay first before they will start to pay for any services. Usually, this is a yearly arrangement which means it starts over every year. If you have not paid this amount yet, you are responsible for the full charge until you have.

We have no control over the amount of your deductible, or your charges. This is decided solely by your insurance company and your employer.

If you have questions regarding your bill, co-pay, or deductible please contact your insurance company, or your employer's Human Resources department. As I have outlined above, they tell us what your charges will be. We do not have any control over your bill.

This information does not apply to "self-pay", or those patients who do not have insurance. These charges are due in full on the day of the service.

Dr. Summer

Lewisville Family Physicians

Information for new patients to our practice:

1. Same-day Appointments.

We always reserve some space each day for “same-day” appointments, but please call as early as possible. We cannot guarantee that you will be seen that day if we are already full, but will make every effort possible. We **will** always see your children that same day as a rule.

2. Refills

Please ask your pharmacy to send us a refill request, and give us 24-48 hours to process it. We will usually get to it sooner, but give us a little time. If it is urgent, please call us first. We will not do refills after hours for any controlled medication (pain medication, etc.).

3. Physicals

Please call to make an appointment. There are often lab tests that we can do ahead of time so the results will be ready when you come for your exam.

4. If You Need to be Hospitalized:

I have arranged for Inpatient Physicians of Forsyth to care for our patients that need to be treated in the hospital at Forsyth Medical Center. I communicate closely with these doctors who practice exclusively in the hospital.

5. X-rays

Yes, we can do most regular X-rays here in the office.

6. After-Hours Needs

I have registered nurses who are available after office hours for medical advice. Just call the regular office number (336-945-2080) and you will automatically be connected to the answering service and then the nurse on duty. They will contact me if you need to speak to me directly. Of course, if it is an emergency, please call 911.

7. Payments due before seeing the doctor

We ask that you have your standard insurance co-pay ready when you check in, as required by your insurance company. If you have a deductible, we will check and will ask for that amount if you have not met it yet.

8. Missed appointments

We ask that you give us at least 24 hours notice if will not be able to keep a scheduled appointment. If you miss an appointment without notice, there will be a charge: usually \$30 for a routine appointment, and \$50 for a physical or procedure appointment.

9. Appointment Times

Your appointment time only guarantees that I have reserved time for you that day. It does not guarantee that you will be seen at that exact time. We do the best we can to be timely, but sometimes issues require more time than expected and you may have to wait. Just remember that it may be you that requires that extra time someday.

9. Phone calls

All of my time during the day is scheduled with patients in the office. As a general rule, I do not communicate with patients by phone due to time constraints. If you need my input about a medical issue, please schedule an office visit. If it is a simple question, my staff can help you, or will ask me and then get back to you,

Dr. Summer