

# 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 (\_\_\_\_) \_\_\_\_\_-\_\_\_\_

Email: \_\_\_\_\_ ( please initial here if you would like to be able to log into your own records\_\_\_\_)

Place of Employment \_\_\_\_\_

**Emergency Contact:** Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

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 \_\_\_\_\_

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**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 \_\_\_\_\_

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**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 \_\_\_\_\_

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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?

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## **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.

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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*