HUNTSVILLE PEDIATRIC AND ADULT MEDICINE ASSOCIATES
PATIENT INFORMATION

Patient's Name _____ Sex __ Male __ Female **Date of Birth** _____
Address _____City/State_____ Zip Code_____
Home Phone _____ Cell Phone _____ E-mail address _____
Driver License # _____ Marital Status __ Single __ Married __ Widowed
Occupation _____ Employer's Name _____ Work Phone _____
Spouse's Name _____ Employer's Name _____ Work Phone _____
In case of emergency, notify_____ Relation to Patient_____ Phone _____
Your Pharmacy _____ Phone _____ Referred by _____

Complete the Following if the Patient is a <u>Minor or a College Student</u>
Responsible Party's Name _____ Relationship to Patient _____
Father's Name _____ Home Phone_____ Cell Phone_____
Date of Birth _____ **Driver License #** _____
Employer _____ Work Phone _____ OK to call ____ Yes ____ No
Mother's Name _____ Home Phone_____ Cell Phone_____
Date of Birth _____ **Driver License #** _____
Employer _____ Work Phone _____ OK to call ____ Yes ____ No
Hospital where child was born _____
Other Children (Names and Ages) _____
Is there anyone other than a parent authorized to seek treatment for your child? If so, please list below:
Name _____ Relationship to patient _____
Name _____ Relationship to patient _____

INSURANCE INFORMATION: (Please provide copy of <u>current</u> insurance card)
Insurance Name _____ Policyholder's Name _____ **D.O.B**. _____
Policy Number _____ Group #_____ Group Name _____
Medicare # _____ Medicaid # _____

<u>RELEASE OF INFORMATION</u>:
I authorize Huntsville Pediatric and Adult Medicine Associates to release any medical or other information necessary to process claims for services provided to me.

<u>ASSIGNMENT OF BENEFITS</u>:
I authorize payment of government or other medical benefits to Huntsville Pediatric and Adult Medicine Associates for any services provided to me.

<u>FINANCIAL POLICY</u>:
I acknowledge that I have read and/or been offered a copy of this office's Financial Policy.

<u>PRIVACY POLICY ACKNOWLEDGEMENT</u>:
I acknowledge that I have read and/or been offered a copy of this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

I have read and agree to the Release of Information, Assignment of Benefits, Financial Policy, and Privacy Policy Acknowledgement paragraphs as stated above.

_____ DATE _____
Patient or Responsible Party Signature

_____
Relationship to Patient If Not Parent or Legal Guardian

HUNTSVILLE PEDIATIC AND ADULT MEDICINE ASSOCIATES

ADULT PAST MEDICAL HISTORY

Patient Name: _____ D.O.B._____ Date: _____

SURGERY (TYPE AND DATE) HOSPITAL SURGEON

1. _____

2. _____

3. _____

4. _____

HOSPITALIZATIONS (TYPE AND DATE) HOSPITAL PHYSICIAN

1. _____

2. _____

3. _____

4. _____

GYNECOLOGIC HISTORY: Last Pap Smear _____ Last Mammogram _____
First day of last menstrual period _____

MEDICAL ILLNESSES:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

History of Blood Transfusions: _____ When: _____

IMMUNIZATIONS:

Last Tetanus Shot _____ Hepatitis B _____
Pneumovax _____ Flu Vaccine _____
Misc. _____

MEDICATIONS CURRENTLY TAKING (Prescription and Over The Counter)

Birth Control: _____
All Other: _____
_____

Patient Name: _____ D.O.B. _____

ALLERGIES: _____

_____

OTHER PHYSICIANS YOU USE **FOR WHAT PROBLEM(S)?**

1. _____

2. _____

3. _____

FAMILY HISTORY:

FAMILY MEMBER	**ACTIVE/DECEASED**	**ILLNESS/CAUSE OF DEATH**
MOTHER		
FATHER		
BROTHER(S)		
SISTER(S)		

HAVE ANY FAMILY MEMBERS HAD: (Circle all that apply and explain in space below)

HEART ATTACK	**OTHER HEART PROBLEMS**	**HYPERTENSION**
HIGH CHOLESTEROL	**STROKE**	**DIABETES**
CANCER	**TUBERCULOSIS**	**LUNG PROBLEMS**
BLOOD DISEASE (i.e. Sickle Cell or Leukemia)		**DEPRESSION**
SUICIDE	**SEIZURES**	**ALCOHOLISM**

Any other illnesses that run in the family?
EXPLANATION: _____

_____

_____

Patient Name: _____ D.O.B. _____

PLACE OF BIRTH: _____ MARITAL STATUS: _____

OTHER COUNTRIES OR STATES LIVED IN: _____

WHO LIVES AT HOME WITH YOU: _____

EDUCATION: _____ Years HIGH SCHOOL: _____ Years COLLEGE: _____Years

OCCUPATION: _____ SPOUSE'S OCCUPATION: _____

CHEMICAL EXPOSURES: _____

DO YOU SMOKE? _____ HOW MUCH DAILY? _____ FOR HOW LONG? _____

HOW MUCH ALCOHOL DO YOU DRINK? _____

DO YOU USE ANY OTHER TYPES OF DRUGS? _____

DO YOU EXERCISE REGULARLY? _____ IF YES, WHAT DO YOU DO? _____

DO YOU FOLLOW ANY PARTICULAR DIET? _____

DO YOU DRINK CAFFEINATED PRODUCTS? _____ HOW MANY PER DAY? _____

HOBBIES: _____

ANY CONCERNS: _____

_____

_____

_____

_____

_____

Huntsville Pediatric & Adult Medicine
ASSOCIATES

Acknowledgement of Financial Policy

- **I understand Huntsville Pediatric and Adult Medicine Associates (HPAM) will copy my insurance card and driver's license. I further understand it is my responsibility to notify HPAM in the event of insurance coverage change.**
- **I understand HPAM will obtain demographic information including mailing address, contact phone numbers, and email address. I further understand it is my responsibility to notify HPAM if any demographic information changes.**
- **I understand HPAM does not accept Worker's Comp.**
- **I understand payment for co-payments, deductibles, and percentages not covered by insurance carrier are due at the time services are rendered.**
- **I understand if I do not have insurance coverage I will be responsible for services rendered at the time of service.**
- **If I am a Medicare recipient, I understand I will be responsible for annual deductibles, 20% co-insurance, non-covered services, and any charges Medicare states I am responsible for.**
- **I understand a $30.00 service charge will be applied to all returned checks.**
- **I understand a $25.00 fee will be charged for missed appointments and for appointments cancelled less than 4 business hours prior to my appointment time.**
- **I understand I will receive a separate statement from the Radiologist that interprets all x-rays done at HPAM.**
- **I understand that a fee is charged for copies of medical records and is due prior to the release of records.**

For Insurance Billing:

I hereby authorize Huntsville Pediatric and Adult Medicine Associates (HPAM) to furnish my insurance company with all the information which the insurance company may request concerning my present illness or injury. I hereby assign Huntsville Pediatric and Adult Medicine Associates all money to which I am entitled for medical expenses related to the service reported. I understand I am financially responsible to Huntsville Pediatric and Adult Medicine Associates for charges not covered by this assignment.

Patient Name: _____ Patient DOB: _____

Responsible Party: _____ Printed Name

Patient/Responsible Party: _____ Signature

Date: _____

Huntsville Pediatric & Adult Medicine
ASSOCIATES

Patient Authorization to Release Protected Health Information

I, _____, give my authorization to release my protected information including results of my laboratory tests, x-ray, and/or other test results to the following designated representative(s).

_____ (Initial) Spouse Name _____

_____ (Initial) Child(ren) Name(s) _____

_____ (Initial) Other Name(s) _____

_____ (Initial) Parent(s) Name(s) _____

_____ (Initial) Authorize Huntsville Pediatric and Adult Medicine to call the following numbers and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care such as test results.

_____ (Initial) Home Number (as on file)

_____ (Initial) Cell Number (as on file)

_____ (Initial) Work Number (as on file)

_____ (Initial) Other Number(s): _____

_____ (Initial) Authorize Huntsville Pediatric and Adult Medicine to mail to the following address any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminder cards, unable to reach patient by phone letters, and statements as they are marked Personal and Confidential.

_____ (Initial) My home address as on file.

_____ (Initial) Other address: _____

_____

I understand that this release of information is considered valid until a new release of information is submitted or my child turns 18. The office will not disclose any information to any items above that do not have an initial beside it.

Patient or Legal Guardian Signature: _____

Patient Name: _____ Patient DOB: ____/____/_____ Age: _____

Date: ___/___/_____

****

Office Use Only:

____ This patient is a child and will be 18 as of _____/_____/_____ and will need a new release of information form.