

Patient Name: _____ DOB: _____ Age: _____ SSN: _____

Street Address: _____ City/State: _____ Zip: _____

Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____ Sex: M / F ___ Married ___ Single ___ Divorced ___ Widowed

Employer: _____ Occupation: _____ Address: _____ Phone: _____

(If Applicable) Spouse Name: _____ Employer: _____ Occupation: _____

Nearest Relative/Friend (not living with you): _____ Phone: (____) _____ - _____

Responsible Party: SELF OR Other: _____ Relationship: _____

(IF YOU ARE THE PARENT/GUARDIAN OF THE PATIENT PLEASE FILL OUT THE FOLOWING WITH YOUR INFORMATION)

PRIMARY INSURANCE COMPANY: _____ Address: _____

Insurance Phone: _____ Policy/Identification#: _____ Group Name & #: _____

Insured Name (if other than self): _____ DOB: _____ SSN: _____

SECONDARY INSURANCE COMPANY: _____ Address: _____

Insurance Phone: _____ Policy/Identification#: _____ Group Name & #: _____

Insured Name (if other than self): _____ DOB: _____ SSN: _____

PCP/Family Physician Name: _____ City/State: _____ Phone: (____) _____ - _____

How were you referred to this clinic?: _____ City/State: _____ Phone: (____) _____ - _____

Is this visit work related? Y / N Date of Injury: _____ Describe Injury: _____

★ Pharmacy: _____ City/State: _____ Phone#: _____

Information Required by State: Ethnic Background: Hispanic/Latino Not Hispanic/Latino

Race: American Indian/Eskimo Aleut Asian or Pacific Islander Black White

Other (Includes other responses not listed. Patients who consider themselves as multiracial or mixed should choose this category).

Patient Consent for Use and Disclosure of Protected Health Information

I give permission / I do not give permission for THE SWAMY CLINIC PA to leave messages regarding my medical care, which may include lab and pathology results on my:

___ Home Answering Machine ___ Cell Phone ___ Work Voicemail ___ Other: _____

With this consent THE SWAMY CLINIC may mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment options, such as appointments, reminder calls or cards and billings statements. By signing this form, I am consenting to allow The Swamy Clinic PA to use and disclose my Private Health Information to carry out treatment options. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, THE SWAMY CLINIC may decline to provide me treatment.

HIPPA CONSENT

The patient understands that:

1. Protected health information may be disclosed or used for treatment, payment or health care operations.
2. The practice has a Notice of Privacy Practices and that the patient has the right to ask for this notice.
3. The practice reserves the right to change the Notice of Privacy Practices at any time.
4. The patient has the right to restrict the uses of their information but the practice does not have to agree to those restrictions.
5. The patient may revoke this consent in writing at any time and all future disclosure will cease.
6. The practice may condition receipt of treatment upon execution of this consent.
7. Please indicate any person/s to whom you would like information released to:

Name/Relationship: _____

Name/Relationship: _____

Name/Relationship: _____

Name/Relationship: _____

This consent was signed by: _____

Printed name of patient/Legal Representative

Signature

Relationship (if other than patient)

Date

The Swamy Clinic

Patient: _____ Date: _____ Age: _____ Height: _____ Weight: _____

Reason for today's visit: _____

List current medications (include prescriptions, over the counter, vitamins, herbs and supplements)

List Allergies: _____

Do you take aspirin or blood thinner? Yes No Do you smoke? Yes No Do you drink alcohol? Yes No

Family History (please circle all that apply)

Skin Cancer: Basal cell carcinoma / Squamous cell carcinoma / Melanoma / Other _____
Psoriasis Asthma Eczema Other: _____

Past Medical History (Please circle all that apply to you personally)

- Multiple Sclerosis / Fibromyalgia / Chronic Fatigue
- Eczema / Psoriasis
- Ear / Nose / Throat / or Mouth Disease
- Stroke / TIA's / Seizures / Headaches
- Diabetes / Thyroid Disease
- Heart Disease / Heart Attack
- Mitral Valve Prolapse / Heart Murmur
- Pacemaker / Defibrillator
- Heart Valve Replacement
- Asthma / Tuberculosis
- Allergies / Hay Fever
- Lupus / Rheumatoid Arthritis / Other _____
- Artificial Joint Replacement _____
- Herpes / Cold Sores / Keloids / Hives _____
- Organ Transplantation _____
- Menstrual Irregularities _____
- Pregnant? Yes No Due Date: _____
- Depression / Bipolar / Anxiety / Other _____
- Cancer Type _____
- Radiation Therapy / Chemotherapy _____
- Bleeding Disorder / Anemia _____
- Hepatitis / AIDS's / HIV Positive _____
- High Blood Pressure _____

List any other diseases or conditions: _____

Have you been told to take oral antibiotics before dental or other procedures? Yes No

Past Surgeries: _____

Skin Cancer History: (Please circle all that apply)

Melanoma Basal Cell Carcinoma Squamous cell Carcinoma Other _____

Location of the skin cancer and date treated: _____

Do you use sunscreen Yes No Daily / Seldom / Never / only when I am outside

What pharmacy do you use? _____ City: _____ Phone: _____

PCP/Family Physician Name _____ City: _____ Phone: _____

Disclosure For Acceptance Of Credit And Debit Cards

The Swamy Clinic continues to welcome your payment using a Credit/Debit card (Visa, MasterCard, & Discover). **Effective July 20, 2010, a new policy concerning refunds when the payment is made with a Credit/Debit Card goes into effect.**

If you are due a refund from The Swamy Clinic for a payment you made with a Credit/Debit card, our office will deduct **3% of the total credit due** from your refund in order to cover processing cost of the initial Credit/Debit charge processed. **Refunds will automatically be credited to the Credit/Debit card that was used for the original charge.** If you do not wish to have a refund issued to the Credit/Debit card that was used for the original sale, please contact the business office and request that your refund is issued by check. Whether the refund is issued via Credit/Debit card or check from our office, you will still be assessed the 3% charge.

Effective January 1, 2011 Any Credit/Debit card transaction equal or great than \$1,000.00 will be assessed a convenience fee of 5% of the transaction.

The Swamy Clinic accepts Credit/Debit cards in accordance with the policies as listed above and is in no way obligated to accept payment in the form of Credit/Debit cards. The choice of using a Credit/Debit card is given to our patients/customers as a convenience in lieu of using alternative forms of payment. The Swamy Clinic does not mandate that any payment issued or due be made by Credit/Debit card. If you, the patient, does not wish to pay with your Credit/Debit card because of the policies that have been instated The Swamy Clinic accepts payments in the form of Cash, Personal/Business Checks, Cashiers Check and Money Orders.

Please sign below to acknowledge this policy. Signing this acknowledgement in no way authorizes The Swamy Clinic to process additional charges to your Credit/Debit card at any time.

Patient/Legal Guardian Signature

Date

The Swamy Clinic Witness

Date