Drs. Lawaczeck,McKinnon, Feagin, Carter, Gee and Dahl, P.C

Patient Name_____ Goes By:_____
FIRST MIDDLE LAST

Mailing Address_____

City_____State_____ Zip Code_____

Daytime Phone:_____ Cell Phone:_____

Date of Birth_____ Age _____ Gender: ☐ M ☐ F Social Security Number_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Employed ☐ Student ☐ Retired

Employer/Parent's Employer_____Occupation_____

Work Phone_____

Spouse name (Parent name if minor)_____Spouse/Parent Work Phone_____

Emergency Contact : _____ Phone number:_____

Relationship_____ **Primary Care doctor:**_____

Primary Insurance Company		
ID#	Group #	**Effective Date**
Subscriber Name		**Relationship to Patient**
Social Security Number	**Date of Birth**	Employer

Secondary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		**Relationship to Patient**
Social Security Number	Date of Birth	Employer

Tertiary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		**Relationship to Patient**
Social Security Number	Date of Birth	Employer

TODAY'S DATE:_____

INTERIM MEDICAL HISTORY

(office use only:) Date of **last visit:**_____

Name_____ Date_____

List all Prescriptions and Over the Counter medications you are taking: (Including Eye Drops)

If you have a list, please give to receptionist to copy in lieu of filling out form: ☐ Attached list

_____ _____

_____ _____

Do you have any ***drug* allergies**? ____NO If YES, list the medication allergy:

_____

Have you had any **major illnesses** or **injuries** since your last visit?

_____

Have you had any **surgeries** since your last visit?

_____

Review of Systems (ROS):	**Circle any conditions that currently apply to you or check none. NONE**	
EYES:	Burning , Itching, excessive tearing, discharge, redness, eye injury/trauma, sudden loss or change in vision, swelling of lid or growth	
CONSTITUTIONAL:	Fever, weight loss, weight gain , fatigue, headaches	
EARS, NOSE, THROAT:	Deafness, dry mouth, sinus infection , other	
CARDIOVASCULAR:	High B/P, heart attack, chest pain, congestive heart failure, high cholesterol, irregular heartbeat, chest pain, low B/P , pace maker	
RESPIRATORY:	Bronchitis, Chronic obstructive pulmonary disease, emphysema, tuberculosis, asthma	
GASTROINTESTINAL:	Hepatitis, Jaundice	
GENITOURINARY:	Bladder or kidney problems	
INTEGUMENTARY:	Dermatitis	
MUSCULOSKELETAL:	Arthritis	
NEUROLOGICAL:	Multiple sclerosis, stroke,	
PSYCHIATRIC:	Anxiety, depression,	
ENDOCRINE:	Diabetes, hypothyroid, hyperthyroid	
HEMATOLOGY:	Infection, Prostate	
ALLERGIC/IMMUNOLOGIC:	Allergies, hay fever	

FAMILY

Any changes to family medical status (mother, father, sibling, grandparent)? _____YES _____NO

If YES, describe_____

SOCIAL

Marital Status (married, divorced, single, widowed)_____

Do you drive? _____YES _____NO

Do you have visual difficulty when driving? _____YES _____NO

Do you have problems with night vision? _____YES _____NO

Do you drink alcohol? _____YES _____NO If YES: occasional 1 per day 2-3 / day 4+ / day

Do you smoke? _____YES _____NO If YES: occasional ½ pack/day 1 pack/day 1+ pack

AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION:

Name: _____ **Date of Birth:** _____

May we leave messages/detailed medical information on voicemail at either of these phone numbers?

□ Yes □ No Day Phone: _____ □ Yes □ No Cell Phone: _____

May we contact you at your place of employment? □ Yes □ No If so, may we leave a message? □ Yes □ No

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general information, surgical and billing)? □ Yes □ No If yes, please provide:

Name: _____ Relationship: _____ Phone: _____
Is this person your Power of Attorney for medical purposes? □ Yes □ No

Name: _____ Relationship: _____ Phone: _____
Is this person your Power of Attorney for medical purposes? □ Yes □No

--If no one is listed above, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices. ***This authorization remains in effect until revoked.***—

I hereby authorize Drs. Feagin, Carter, Gee and Dahl and/or administrative and clinical staff of to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions.

A copy of this policy will be provided to me **upon request**. I have reviewed/understand the 2003 Notice of HIPAA Privacy Policy.

Patient Signature: _____ Date: _____

- **Insurance:**

I certify that I (or my dependent) have insurance medical coverage and agree to have insurance payments made directly to Drs. Lawaczeck, McKinnon, Feagin, Carter & Gee, and P.C. and to be applied to my account for services rendered. All Copayments, Co-Insurance, self-pay visits, deductible and or non-covered services must be paid at the time service is rendered. (We do not accept Vision Plans) For patients covered by Medicare the patient will be responsible for 20% of the Medicare allowable charges plus any deductibles, coinsurance and uncovered charges that apply.

- **Referrals:**

You are responsible for obtaining a referral if one is required by your insurance carrier. (A few that require referrals: BCBS, Medicare Complete, Cigna Healthsprings, United Healthcare with PCP referrals on front of card). If we are participating providers with your carrier, we will file your claim for your office visit or surgery and allow 45days for payment in full. Should payment not be received within 45days, the balance due will become the obligation of the guarantor on the account and must be paid within 30days.

- **Agreement to Pay:**

As consideration for the Physician's rendering services to the patient, the patient or person responsible for the account agrees to pay all charges for services at the completion of such services. In the event the account is not paid in full within 45days, the Physician, may, at his/her discretion, place the unpaid account with an attorney for collection. The patient or person responsible for the account agrees to pay all costs of collection, including reasonable attorney's fees and agrees to pay the legal rate of interest on the account until paid in full and hereby waives all rights of exemption under the Constitution and laws of the State of Alabama. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. I am aware there may be additional collection and/or attorney's fees if my account is referred for collection.

_____ _____
Patient's signature **Today's date**

- **Consent to Treat:**

I hereby consent to the treatment for myself or the above listed patient

_____ _____
Patient's signature **Today's date**