Islands Family Medical Center

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Tel: 912.897.6832 & **Fax**: 912.897.7151

"New Patient Form"

PATIENT INFORMATION – PLEASE PRINT

TODAY'S DATE : _____

LAST NAME	FIRST NAME	M.I.	HOME PHONE	CELL PHONE

EMAIL ADDRESS	STREET ADDRESS	STATE	ZIP

D.O.B	SSN	SEX	MARITAL STATUS
		☐ M ☐ F	☐ S ☐ M ☐ W ☐ DIV ☐ SEP

EMPLOYER NAME	OCCUPATION	IF STUDENT – STATUS
		☐ FULL TIME ☐ PART TIME

IF PATIENT IS A CHILD, PARENT/GUARDIAN'S NAME	PARENT/GUARDIAN'S SSN	PARENT/GUARDIAN'S DATE OF BIRTH

PARENT/GUARDIAN'S ADDRESS (IF DIFFERENT THAN PATIENT'S ADDRESS)	PHONE
	( )

SPOUSE / RESPONSIBLE PARTY

LAST NAME	FIRST NAME	M.I.	HOME PHONE	CELL PHONE

STREET ADDRESS	CITY	D.O.B	SSN

EMPLOYER NAME	ADDRESS	OCCUPATION

INSURANCE INFORMATION – PRIMARY INSURANCE

INSURED'S NAME:	NAME OF INSURANCE	**Note**: It is patient's responsibility to make sure that Dr. Maria Jauhar is added to his/her network. Dr. Maria Jauhar's should be added as your PCP under your selected plan with your insurance. Also, it is patient's responsibility to intimate us immediately if his/her insurance has expired or not valid otherwise it will be charged as Self-Pay.
I.D. NUMBER	GROUP NAME	

PHARMACY PREFERENCE

NAME OF PHARMACY	ADDRESS & PHONE NUMBER

EMERGENCY CONTACT – NOT LIVING WITH YOU

NAME	RELATIONSHIP	HOME PHONE	CELL PHONE

STREET ADDRESS	CITY	STATE	ZIP

HOW DID YOU LEARN OF OUR PRACTICE?

☐ YELLOW PAGES ☐ INTERNET ☐ FRIEND _____ NAME ☐ HOSPITAL REFERRAL _____ NAME ☐ IN CO._____ NAME

BEST WAY TO CONTACT YOU: (CHECK ONE) ☐ HOME ☐ CELL ☐ EMAIL

May we leave a message on your answering machine or voicemail concerning lab or test results? I (the patient) understand that answering machines and voicemails are not secure lines. ☐ YES ☐ NO

I understand that Maria Jauhar, MD may send letters, postcards or leave voice messages for appointment reminders and mail billing statement to the Guarantor on my account. I certify that I am the patient (or authorized representative) and that the information given by me to the Provider in applying for payment under Medicare and/or Medicaid programs, insurance plans or other protection is correct and complete. I understand, acknowledge and agree to the terms set forth above.

_____ **NAME OF PATIENT**

_____ **DATE**

_____ **SIGNATURE OF PATIENT (OR RESPONSIBLE PARTY IF MINOR)**

Islands Family Medical Center

OUR FINANCIAL POLICIES

Thank you, for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bills is considered part of your treatment. The following is a statement of our Financial Policies which we require you to read prior to any treatment.

IN NETWORK INSURANCE: Regarding Insurance Plans where we are a participating provider, all co-payments and deductible are due at the time services are rendered. In addition, if your plan is an HMO plan our office must be listed as your primary care provider on your insurance card. In the event your insurance coverage changes, please notify us prior to being Seen or you will be responsible for payment of services denied by your insurance plan.

OUT OF NETWORK INSURANCE: Your insurance policy is a contract between you and your insurance company. We are not party to that contract. As a service to our patients, we may accept assignment of insurance benefits after your second visit. We will file insurance claims for you; however, we do require 20% coinsurance and deductibles to be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us accurate information. We will assist your insurance company with additional information they may need in order to process a payment. If we are having difficulties with your insurance company, we may call you and ask that you, as the customer of the company, contact the company to request payment. We will file claims to secondary insurance, if the information is provided to us.

MEDICARE: We accept Medicare assignment. We will file claims for secondary insurance for you, if accurate information is provided. You will be responsible for annual deductibles, co-payments and non-covered procedures if they are not covered by Medicare and secondary insurance. If you do not have secondary insurance you are expected to pay 20% coinsurance and deductibles at the time services are rendered. We do not file any claims to tertiary insurance; this will be your responsibility. Annual exams are preventive visits are not paid for by all insurance carriers. (Medicare only covers a portion of this exam.) I understand I am responsible for payment, if the exam or portion of the exam is not covered by my insurance. Annual exams do not typically include problems I may be having- as problem visits may require longer time. The office may reschedule another visit to address these concerns.

ANY UNPAID INSURANCE CLAIMS OVER 60 DAYS OLD WILL BE PATIENT RESPONSIBILITY: Our practice is committed to providing the best treatment to our patients and we charge what is usual and customary for our area. You are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.

COLLECTION SERVICE FEES: Any past due balances turned to collections agency are subject to a collection agency fee.

SELF-PAYING PATIENTS: All fees for services will be collected at time services are rendered. No credit will be extended; however, emergency credit may be extended on a case-by-case basis after services are rendered. Sometimes an advance payment will be collected for certain diagnostics or procedures.

FULL PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED: WE ACCEPT Cash, Checks (with verification), VISA, MASTER CARD, and AMERICAN EXPRESS.

RETURNED CHECKS: Additional charges are applied to my account for any returned checks used to pay on my account, for certified letters sent to me for collection on my account and collection agency fees. I may also be charged for not paying my co-pay and/or co-insurance or patient responsibility including deductible at time of service, for educational materials, and payment agreements which extend beyond 12 months, and for other administrative expenses not covered by my insurance plan.

ASSIGNMENT OF BENEFITS: I hereby authorize and assign all payments and/or insurance benefits for medical services and/or surgical procedures rendered to patient, directly to Maria Jauhar, MD. I hereby authorize Maria Jauhar, MD to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by my insurance plan.

CANCEL POLICY: We request that you please give our office 24-hour notice in the event that you need to reschedule your appointment with the physician. This allows other patients to be scheduled into that appointment. If a patient misses an appointment without contacting our office, this is considered a no-show, no call. A fee of $45.00 will be charged to you for a missed appointment. This fee will not be billed to your insurance carrier. If you are more than 15 minutes late to a scheduled appointment, the appointment will be cancelled unless we have been notified by phone, and the schedule allows for you to be seen. If you accumulate 3 missed appointments, you may not be rescheduled for future appointments and will be asked to leave the practice.

Thank you, for understanding our Financial Policy

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. Please let us know if you have any questions or concerns.

NAME OF PATIENT _____ **DATE** _____

SIGNATURE OF PATIENT (OR RESPONSIBLE PARTY IF MINOR) _____

CONSENT TO USE/DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATION

I the patient (or authorized representative consent Maria Jauhar, MD to the use or disclosure of my individually identifiable "protected health information: for the purpose of treatment, payment or healthcare operations as the terms are defined under federal HIPAA privacy rules.

My "protected healthcare information" means health information collected from me or my representative and created or received by my health care provider, another healthcare provider, insurance carrier, my employer or a healthcare clearinghouse. The protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have the right to revoke this Consent. Such revocation must be submitted to Maria Jauhar, MD in writing. The revocation shall be effective except to the extent that Maria Jauhar, MD has already taken action in reliance on the Consent.

I have received or have been allowed to view a copy of Maria Jauhar, MD's "Notice of Privacy Practices" as required by **HIPAA**.

I authorize discussion of my general medical condition and diagnosis (including treatment, payment and healthcare option with (if no one, leave blank):

NAME (PRINT) _____ **RELATIONSHIP** _____ **DATE** _____

ADDRESS & CELL PHONE: _____

Islands Family Medical Center

NAME: _____

DATE OF BIRTH: _____ **SSN:** _____

Patient History

FAMILY/SOCIAL HISTORY	FATHER	MOTHER	SIBLINGS	CHILDREN
Heart Disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐

	FATHER	MOTHER	SIBLINGS	CHILDREN
Migraine	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐
Asthma I COPD	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Osteoporosis I Arthritis	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
Alcoholism I Liver Disease	☐	☐	☐	☐

FATHER	☐	☐	_____
MOTHER	☐	☐	_____
SIBLINGS	☐	☐	_____
CHILDREN	☐	☐	_____

Alcohol _____ oz. per week Coffee I Tea _____ cups per day
Smoking ___ cig I day ___ #years year quit _____
Exercise _____
Street Drugs _____

HOSPITAL ADMISSIONS Not including pregnancies	YEAR	ILLNESS OR OPERATION	ALLERGIES	

LIST ALL MEDICATIONS YOU ARE NOW TAKING

VACCINE	YEAR	TEST / EXAM	YEAR
Tetanus I Td		Rectal/Stool	
Influenza (FLU)		Cholesterol	
Pneumonia		Eye	
Hepatitis		Colonoscopy	
Tuberculosis		PSA	

MEDICAL HISTORY (√)FOR CURRENT PROBLEMS ONLY

CONSTITUTIONAL:
- ☐ Fainting spell I dizzy spell
- ☐ Fainting I weakness I weight gain I weight loss
- ☐ Migraines I headache (frequent)

ENT:
- ☐ Decreased hearing I ear infections (recurrent)
- ☐ Ringing in rears I spinning sensation
- ☐ Nose bleeds (recurrent) I chronic sinus I tonsillitis
- ☐ Sore throat (frequent) I hoarseness I allergies I hay fever

CARDIOVASCULAR:
- ☐ Chest pain I palpitations I heart throbbing I CAD
- ☐ Arrhythmia
- ☐ Atrial fibrillation I irregular pulse, high blood pressure
- ☐ Lipid I cholesterol
- ☐ Leg pain I Ankle swelling
- ☐ Varicose vein I Phlebitis I blood clots or pulmonary embolism

GENITOURINARY:
- ☐ Urination - painful, frequent, burning, urgency
- ☐ Loss of urine control I stress incontinence - leakage with exercise or movement
- ☐ Overactive bladder - overnight > twice and more than eight times in 24 hours
- ☐ Blood in urine I kidney stones I frequent urinary infections
- ☐ Prostate problems (men only)
- ☐ History of Syphilis, Gonorrhea, Chlamydia

SKIN:
- ☐ Change in skin color I rashes I hives
- ☐ Psoriasis I eczema I acne
- ☐ Change in moles I nails I hair

ENDOCRINE:
- ☐ Diabetes
- ☐ Thyroid disease or goiter
- ☐ Hair loss: Progressive I Recent

ENDOCRINE:
- ☐ History of seizure I stroke
- ☐ History of head injury I concussion I fall Difficult or slurred speech I difficulty walking Numbness or tingling sensations I tremors or shaking

FEMALES:
- ☐ Number of pregnancies _____, abortions _____, miscarriages _____, births _____,
- ☐ Menstrual history; started at age _____, stopped at age _____, regular _____, irregular _____, days of flow _____, length of cycle _____, pains or cramps _____
- ☐ First day of period _____
- ☐ Last pap smear date _____ normal _____, abnormal _____
- ☐ Last mammogram date _____ normal _____, abnormal _____
- ☐ Birth control method _____
- ☐ Do monthly self-breast exam?
- ☐ Vaginal discharge I itching I dryness I bleeding after intercourse
- ☐ Menopausal symptoms _____

EYES:
- ☐ Blurred vision I double vision
- ☐ Cataract I Glaucoma
- ☐ Glasses I Contacts

RESPIRATORY:
- ☐ Frequent cold or cough I asthma I wheezing I emphysema (COPD)
- ☐ Shortness of breath (on exertion or at rest)
- ☐ Pneumonia I chronic bronchitis

GASTROINTESTINAL:
- ☐ Loss of appetite I difficulty swallowing
- ☐ Heartburn I peptic ulcer
- ☐ Frequent nausea I vomiting I diarrhea I constipation I belching I abdominal pain I bloody stool I rectal bleeding or pain
- ☐ Gall bladder problems I jaundice I hepatitis I diverticulosis I Crohn's disease
- ☐ Hemorrhoids I hernia I use laxatives regularly

BLOOD:
- ☐ Anemia I bruise easily I history of blood transfusion
- ☐ Sickle cell disease I hemophilia or bleeding disorder
- ☐ Cancer I History of chemotherapy or radiation

MUSCLES AND BONES:
- ☐ Joint pain I stiffness in joint I muscle weakness
- ☐ Back pain I neck pain I foot pain
- ☐ Gout I osteoporosis

BREAST:
- ☐ Swelling or redness or pain
- ☐ Lumps in breast I breast cancer
- ☐ Nipple discharge, changes or retraction

PSYCHIATRIC:
- ☐ Depression I anxiety I nervousness I agitation I moodiness
- ☐ Sleep problems
- ☐ Memory loss or forgetfulness
- ☐ Suicidal ideations I phobia I feeling of worthlessness

INFECTIONS:
- ☐ Chicken pox I polio I measles I mumps I German measles I tuberculosis I herpres

PROBLEM 1: _____

PROBLEM 2: _____