BAY MEDICAL FAMILY PRACTICE, P.C.

PATIENT INFORMATION

DATE: _____

PATIENT NAME _____ SS# _____ DOB ___/___/_____

ADDRESS _____ CITY/STATE/ZIP _____

MARITAL STATUS _____ SEX _____ EMAIL _____

HOME PHONE # _____ WORK PHONE # _____

PATIENT'S EMPLOYER _____ **CELL PHONE #** _____

_____ **YOUR CELL CARRIER:** _____

PHARMACY NAME _____ CITY _____ PHONE _____

RACE (OPTIONAL): ___WHITE ___BLACK/AFRICAN AMERICAN ___HISPANIC ___NATIVE AMERICAN ___ASIAN ___OTHER_____

PREFERRED LANGUAGE (OPTIONAL): _____ ENGLISH _____ SPANISH _____ OTHER _____

ETHNICITY (OPTIONAL): _____ CAUCASIAN _____ HISPANIC _____ NOT HISPANIC _____ BLACK/AFRICAN AMERICAN _____ OTHER_____

SPOUSE INFORMATION

NAME OF SPOUSE _____ SS# _____ DOB ___/___/_____

SPOUSE'S EMPLOYER _____ WORK PHONE # _____

RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY'S NAME (IF DIFFERENT THAN PATIENT) _____

RELATIONSHIP TO PATIENT _____ SS# _____ DOB ___/___/_____

ADDRESS _____ CITY/STATE/ZIP _____

HOME PHONE # _____ WORK PHONE # _____

RESPONSIBLE PARTY'S EMPLOYER _____ CELL PHONE # _____

From time to time, our doctors or staff may need to reach a patient (or the parents or guardian of a patient) directly concerning an appointment, test results, or medical information. It is at the patient's (or parent's or guardian's) discretion when and with whom we share this information. This is due to HIPAA (Health Insurance Portability and Accountability Act of 1996). I consent for this practice to use or disclose information about the patient for the purposes of treatment, payment and health care operations to whomever I have listed below:

____ Myself only ____ Leave Voice Message ____ Those listed below

1. **Name** _____ **Relationship** _____ **Phone** _____
2. **Name** _____ **Relationship** _____ **Phone** _____
3. **Name** _____ **Relationship** _____ **Phone** _____

EMERGENCY CONTACT

Name _____ **Relationship** _____ **Phone** _____

Patient Signature _____ **Date** _____

OFFICE USE ONLY: Entered by _____

**** OVER ****

ver 4/2023

Guarantee of Payment

I, the undersigned, hereby agree to pay all amounts and charges incurred by me and/or members of my family for services rendered by the physicians of Bay Medical. I understand that failure to make payment is basis for legal action, and I agree to pay all costs of collection including 30% collection fee on the balance due as well as any court costs incurred. I waive my right of exemption under law of the State of Alabama and any other state. For private pay patients: I agree to pay in full at the time of service.

For patients with insurance: I agree that it is my responsibility to know and understand the provisions and limitations stated in any insurance policy including providers covered by my contract. I accept full responsibility for all charges not covered by any insurance. I understand that insurance is a contract between my insurance company and me. This office is not a party to that contract. The filing of insurance is a courtesy which is extended to me, and all charges are my responsibility.

Assignment of Claims against Third Parties

In consideration of care rendered to me by physicians, I hereby assign to the physicians rendering services all claims that I may have against third parties who may be liable for any of my medical expenses, to the extent necessary to cover by expenses for physicians care and services. Any funds received by me in connection with such claims against third parties, or settlement of such claims shall be paid to the said physicians to cover my expenses. I hereby authorize payment directly to said physicians or their authorized billing agent of any of the above mentioned funds which are otherwise payable to me, but not to exceed the regular reasonable charges for this service.

Medicare Benefits to Physicians

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf for any services furnished to me by physicians. I authorize any holder of medical or other information about me to be released in order to process claims and request payment of my benefits to the physician rendering service.

Medicaid Authorization and Assignment

I authorize any holder of medical information about me to release information needed for this or a related Medicaid claim to the Alabama Medicaid Agency and I authorize the further release of any such information to any other parties who may be liable for any of my medical expenses. I hereby assign to the Alabama Medicaid Agency all claims against third parties who may be liable to any of my medical expenses to the extent that such expenses are paid by Medicaid; I also assign all rights whether or not a portion of any such settlement is designated as being for medical expenses. Any such funds received by me shall be paid to the Alabama Medicaid Agency. I permit a copy of the Authorization and Assignment to be used in place of the original.

Privacy Practices Acknowledgement

I hereby acknowledge that Bay Medical Family Practice has provided me with a notice of its privacy practices, as is required by the Federal Health Insurance Portability and Accountability Act (HIPAA). I understand that Bay Medical Family Practice will, upon request, provide me with a copy of the notice of privacy practice.

- By signing below, I am authorizing this physician and practice's staff to treat me for my medical condition.
- I authorize the release of my medical information to treating or referring physicians and to insurance companies or other pertinent parties to process payments.
- I authorize and request payment of medical benefits directly to my physician.
- I agree this authorization will cover all medical services rendered until such authorization is revoked by me in writing.
- I authorize the use of a fax in order to submit medical information to pertinent parties.
- I agree that a photocopy of this form may be used in lieu of the original.
- I understand that I am financially responsible for any balance that is not covered by my insurance carrier after 60 days.

_____ _____

Patient's Name **Signature of Patient** **Date**

_____ _____

Signature of Responsible Party/Guarantor **Date** **Witness** **Date**

**** PLEASE SIGN FORM ****

Bay Medical Family Practice, P.C.
Medical History

Patient Name:_____Date of Birth:_____Date:_____

This form is a tool to help us better serve our patients and make sure that we are taking care of your medical needs. If there is information that you need to share with us that is not listed, please hand write it in.

Past Medical History

Do you have a history of any of the following? If your conditions are not listed, please list under other.

ADD	Yes	No
Abnormal Heart Rhythm	Yes	No
Alcoholism	Yes	No
Alzheimers	Yes	No
Anemia/B12 Deficiency	Yes	No
Anxiety	Yes	No
Arthritis	Yes	No
Asthma	Yes	No
Atrial Fibrillation	Yes	No
Congestive Heart Failure	Yes	No
Cancer. If yes, what type?	Yes	No
Coronary Artery Disease	Yes	No
Degenerative Disc Disease	Yes	No
Dementia	Yes	No
Depression	Yes	No
Diabetes: Type I or II	Yes	No
Gallbladder Problems	Yes	No
Gout	Yes	No
Heart Attack	Yes	No
High Cholesterol	Yes	No
Hypertension	Yes	No
Stroke	Yes	No
Hepatitis	Yes	No
Insomnia	Yes	No
Kidney Disease	Yes	No
Liver Failure	Yes	No
Lupus	Yes	No
Migraines	Yes	No
Thyroid Problems	Yes	No
None or Other		

Please list medication allergies:

Maintenance Care

Date of last Mammogram:
Date of last Prostate Exam:
Date of last Colon Cancer Screening:
Date of last Pelvic/Pap Exam:
Date of last Bone Density Exam:

Family History

Is your Mother still living?	Yes	No
Is your Father still living?	Yes	No

Does your Mother or Father have a history of any of the following? Please ✓:	Mother	Father
Cancer		
Dementia		
Diabetes		
Heart Disease		
High Blood Pressure		
Mental Disorder		
Kidney Disease		
Migraine		

Social History

Do you have a living will?	Yes	No
Do you drink alcohol?	Yes	No
Are you a smoker?	Yes	No

What is your marital status? Circle one

Married Widowed Divorced Single

What is your employment status? Circle one

Employed On Disability Retired Unemployed

Past Surgical History: (Include Year)

Bay Medical Family Practice, P.C.

REVIEW OF SYSTEMS

PATIENT NAME:_____ DATE OF BIRTH:_____ DATE:_____

Please check all that apply to today's visit.

	GENERAL		GASTROINTESTINAL		GYNECOLOGIC
	Fever		Abdominal Pain		Abnormal Uterine or Vaginal Bleeding
	Chills		Black-Tarry Appearing Stools		Vaginal Discharge
	Sweats		Blood in Stool		Vaginal Pain
	Fatigue		Bowel Incontinence		Excessive Pain with Periods
	Weakness		Bowel Movement Changes		Irregular or Skipped Periods
	Appetite Changes		Constipation		Pain with Sex
	Weight Changes		Blood in Vomit		Hot Flashes
	HEENT		Heartburn / Indigestion / Reflux		**MUSCULOSKELETAL**
	Chewing/Swallowing Problems		Nausea		Back Problems
	Dizzy Spells		Vomiting		Swelling
	Headaches		**GENITOURINARY MALE**		Joint Pain
	Head Injury		Blood in Urine		Joint Stiffness
	Hoarseness		Painful Urination		Joint Swelling
	Mouth Sores		Urinary Frequency		Muscle Spasm
	Nasal Congestion		Urinary Urgency		Muscle Weakness
	Nosebleeds		Leakage of Urine or Incontinence		Pain
	Sore Throat		Waking Up to Urinate		**SKIN**
	Swelling		Decreased Force of Urinary Flow		Bruising
	EARS		Erectile Dysfunction		Hives
	Ringing in Ears		Flank Pain		Itching
	Discharge from Ears		Penile Bleeding		Lesions
	Ear Pain		Penile Discharge		Rashes
	Hearing Loss		Prostate Problems		**NEUROLOGY**
	EYES		Testicle Lumps		Focal Neurological Change
	Eye Pain		Testicle Pain		Headaches
	Vision Changes		**GENITOURINARY FEMALE**		Motor Deficits
	Eye Redness		Blood in Urine		Sensory Deficits
	Eye Discharge		Painful Urination		Numbness
	Watery Eyes		Urinary Frequency		Seizures
	RESPIRATORY		Urinary Urgency		Tingling
	Cough		Leakage of Urine or Incontinence		Weakness
	Shortness of Breath		Waking Up to Urinate		**PSYCHIATRIC**
	Shortness of Breath w/exertion		Decreased Force of Urinary Flow		Anxiety
	Wheezing		Flank Pain		Depression
	Snoring				Trouble Sleeping
	CARDIAC				Auditory Hallucinations
	Chest Pain or Pressure				Visual Hallucinations
	Fainting / Passing Out				Homicidal Ideations
	Shortness of Breath w/lying down				Suicidal Ideations
	Abnormal or Irregular Heart Beats				**HEMATOLOGY/LYMPH**
	Swelling of Limbs				Bleeding Problems
					Enlarged Lymph Nodes
					Easy Bruising
					Frequent Infections