Doctor: Cynthia D Barry DO

Date:___________

PATIENT INFORMATION

Name:

Address:

City,State, Zip:

Phone: [ ]Home [ ]Work [ ]Other

Phone: [ ]Home [ ]Work [ ]Other

Phone: [ ]Home [ ]Work [ ]Other

Ethnicity: [ ]Hispanic or Latino [ ]Non Hispanic or Latino [ ]Other

Patient ID #:

Sex: [ ]M [ ]F

Date of Birth:

Age:

Social Security #:

Preferred Language:

Marital Status: [ ]Married [ ]Single [ ]Divorced

Email Address:

Referring Physician:

Primary Physician:

Race: [ ]American Indian or Alaska Native [ ]Asian [ ]Black or African American [ ]Native Hawaiian or Other Pacific Islander
[ ]White or Caucasian [ ]Other or Undetermined

PATIENT EMPLOYMENT INFORMATION

[ ]Employed [ ]Retired [ ]Unemployed [ ]Other

Employer's Name:

Employer's Phone:

Occupation:

EMERGENCY CONTACTS

Name	Relationship	Phone

RESPONSIBLE PARTY ***(If patient is under 18 years of age)***

Name:

Address:

City,State, Zip:

Employer:

Home Phone:

Work Phone:

SSN:

Date of Birth:

PRIMARY INSURANCE

Insurance Company Name:

ID #:

Group/Policy #:

Subscriber's Name:

Subscriber's Phone #:

Relationship to Patient:

Subscriber's Employer:

Subscriber's SS #:

Subscriber's Date of Birth:

SECONDARY INSURANCE

Insurance Company Name:

ID #:

Group/Policy #:

Subscriber's Name:

Subscriber's Phone #:

Relationship to Patient:

Subscriber's Employer:

Subscriber's SS #:

Subscriber's Date of Birth:

INSURANCE AUTHORIZATION AND ASSIGNMENT (Please read and sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor, and authorize him/her to furnish information regarding my illness to my insurance carrier. ***I understand that I am responsible for any amount not paid for by my insurance.***

PATIENT/GUARDIAN SIGNATURE　　　　DATE

I authorize the clinic to obtain medication history electronically from my pharmacy benefit administrator.

PATIENT/GUARDIAN SIGNATURE　　　　DATE

I HEREBY AUTHORIZE MY INSURANCE COMPANY TO MAKE PAYMENT DIRECTLY TO:
ACCREDITED FAMILY HEALTHCARE

I understand that I am financially responsible for any co-payments, deductibles, coinsurance, and all charges, which are not covered by my insurance at the time of service. I understand that verification of coverage is not a guarantee of benefits. Insurance benefit payment is determined by your insurance company when the claim is received. I understand I will be responsible for all portions not covered by insurance. Please be aware there is a $25.00 fee for a missed office visit or canceled office visit for which you do not give 24 hours notice. The doctor has allowed time for your visit, so if you need to cancel, please call 24 hours ahead to let us know. Please be aware there is a $35.00 returned check fee for any returned checks.

I understand that Accredited Family Healthcare does not accept liens. We are happy to file your insurance for you, however, please understand that you are responsible for all charges if it is determined that the insurance information you have provided is not correct and that it is your responsibility to notify our office if there are any changes in your insurance whatsoever. Due to the large amount of insurance plans and policies, it is impossible for the physicians and staff to know what services are/are not covered. It is the patient's responsibility to be aware of the services covered by the patient's plan and to be aware of what laboratory your insurance will permit your lab work to be processed at. Our lab of choice is **Sonora Quest/LAB Corp.** We use **Lab Corp** for any United Healthcare patients. If your insurance company requires that it be processed elsewhere, it is your responsibility to inform both the nurse and doctor of this fact.

I understand that delinquent accounts will be turned over to an attorney or collection agency without notice. I understand that an account will be considered delinquent if unpaid after 60 days of billing date. I understand that in the event my account is turned over for collection, I am responsible for all reasonable collections, court costs, etc. at the time the account is considered delinquent.

I hereby authorize Accredited Family Healthcare to release any medical or incidental information to my referring physician or any other physicians who have been or may become involved in my care; and the release and obtaining of any medical records including reports of a psychological or psychiatric nature, drug abuse, alcoholism, AIDS results, and pharmacy records. I also authorize the release of information that may be necessary in the processing of any insurance claims.

If you have not been seen in our office in the past 3 years your chart will automatically be made inactive.

Patient statements are sent via patient portal. **Initial ______**

EMAIL ____

Due to the HIPPA laws now in effect we must have detailed information as to whom we may release medical information. Please read and check the appropriate areas as you see fit. This release is valid until you notify us in writing otherwise.

To whom may we release your medical, financial, and billing information?

___Spouse______________________________ ___Other ________________________

___Sibling______________________________ ___Son or Daughter______________________

___Parent ________________________________

May we leave a message on your answering machine confirming an appointment or informing you that there are test results that you need to call us regarding? ___Yes ___No

Your signature indicates complete understanding and agreement to all information contained on this page. If you have questions, please feel free to discuss with the receptionist prior to signing below.

Signature of
Patient/Guardian____Date_______________________

Patient Name____DOB________________________

<u>ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE</u>

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

__________________________________ ________________________

Patient Name **Date of birth**

__________________________________ _______________________

Patient or legally authorized individual signature **Date**

__________________________________ __________________________

Printed Name **Relationship (parent, legal guardian, Personal representative, etc.)**

Patient Questionnaire Date: / / Date of Birth: / /

Name:______________________________ Ethnicity: ______________

Occupation/Employer:______________________________

Highest Level of Education: High School / Associates / College / Graduate

Reason For Visit: ______________________________

Hospitalizations:	If you have been in the hospital overnight - State the Year - Illness/Operation		
Year	Illness / Operation	Year	Illness / Operation

Past Medical & Family History — Please Check if You (Self) or any Blood Relative had any of the following. Space Below for more Details

	SELF	RELATION			SELF	RELATION
1. Recent Weight Loss				17. Kidney / Bladder Prob		
2. Migraine Headaches				18. Neurological		
3. Epilepsy / Convulsions				19. Arthritis		
4. Eye Disease				20. Osteoporosis		
5. Hearing Disorder				21. Cancer		
6. Recurring Nose Bleeds				Type		
-Sinus Throat Infection(s)				22. Bleeding Disorder		
7. Agnina - Chestpain				23. Blood Transfusion		
8. Heart Attack				24. Anemia		
9. High Blood Pressure				25. Diabetes		
10. Stroke				26. Thyroid		
11. High Cholesterol				27. Alcohol or Drug Use		
12. Heart Valve Disorder				28. Mental Ilness		
13. Lung Disease				29. Depression		
14. Stomach Ulcer				30. Psoriasis / Eczema		
15. Bowel Problems				31. Hairloss		
16. Liver Dis. / Hepatitis				31. Accident - Major		

List All Medications You Take

Medication	Dose	Times a Day

Do you now or ever Consumed

Cigarettes Y N Pks/Day _____

Alcohol Y N Drks/Wk _____

Coffee/Tea Y N Cups/Day_____

Street Drugs Y N

Type________________________

Last time you had a (Year)

______Flu Vaccine ______ Tetanus Shot

______Hep Vaccine ______ Pneumo Shot

______T.B. Test ______ Rectal Exam

______Stool Bld Test ______ Eye Exam

______Dental Exam

______Cholesterol Test(results) __________

Drug Allergies

Drug	Reaction

Date of Late Menst Period / /

Are you using Birth Control Y N

Number of Pregnancies ___________

Number of Births ___________

Number of Abortions ___________

Year of Last :			
_______ Pap	NORM	ABN	
_______ Mammogram	NORM	ABN	
_______ Bone DEXA	NORM	ABN	
_______ Colonoscopy	NORM	ABN	