Welch Family Medicine

2601 Thomas Dr. Panama City Beach, FL 32408

PH: 850-588-5835 Fax: 850-588-5837

INTAKE FORM

LAST NAME: _____ **FIRST NAME:** _____ **MI:** _____

DATE OF BIRTH: _____ **SEX:** M F **SOCIAL SECURITY #** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

PHONE: _____ **CELL:** _____ **WORK:** _____

MARITAL STATUS: S M D W **SPOUSE'S NAME:** _____

EMERGENCY CONTACT: _____

PHONE: _____ **RELATIONSHIP:** _____

Thank you for the opportunity of letting us help you maintain your health. Our non-medical communication is done by electronic mailing. This includes all billing invoices as well. If you agree to this, please provide us with an email.

I, _____**, agree to receive non-medical communication at the following email address** _____.

Patient Signature: _____ **Date:** _____

WELCH FAMILY MEDICINE

PRIVACY NOTICE

THE FOLLOWING NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY.

- Your confidential information may be released to other healthcare professionals within the office/hospital for the purpose of providing you with quality healthcare.
- Your confidential information may be released to your insurance provider for the purpose of the office receiving payment for providing you with needed healthcare services.
- Your confidential healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime, or domestic violence.
- Your confidential healthcare information may be released to other healthcare providers in the event you need emergency care.
- Your confidential healthcare information may be released to a public healthcare organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication).
- Your confidential healthcare information may not be released for any other purpose than that which is identified in this notice.
- Your confidential healthcare information may be released only after receiving written authorization from you. You may revoke your permission to release confidential healthcare information at any time.
- You may be contacted by the office to remind you of any appointments, healthcare treatment options, or other health services that may be of interest to you.
- You have the right to receive confidential communication about your health status.
- You have the right to review and photocopy any/all portions of your healthcare information, a fee of $1.00 per page will be charged.
- You have the right to make changes to your healthcare information.
- You have the right to know who has accessed your confidential healthcare information and for what purpose.
- You have the right to possess a copy of this privacy notice upon request. This copy can be in the form of an electronic transmission or on paper.
- The office is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information and will provide the patients with a list of duties or practices that protect confidential healthcare information.
- The office will abide by the terms of this notice. The office reserves the right to make changes to this notice within 60 days of making the changes.
- You have the right to complain to the office/hospital if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please notify us as soon as possible. All complaints will be investigated. No personal issue will be raised for filing a complaint.

For further information about this privacy notice, please contact:

Leo Welch, MD

Matthew Welch, MD

Patient Signature: _____ Date: _____

By signing, I am confirming that I have received and understand this information.

This notice will be effective as of your date of service.

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

OUR FINANCIAL POLICY

We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment.

Full payment is due at the time of service unless other arrangements have been made in advance.

YOUR INSURANCE

We have made prior arrangements with many insurers and other health plans. We will bill those plans with which we have an agreement and will collect any required co-payment at the time of service. Your co-payment must be collected at the time of service according to your agreement with your insurance carrier. In the event your health plan determines a service to be "not covered", you will be responsible for payment of that service upon receipt of a statement or an explanation of benefits from your insurance carrier.

PATIENTS WHO ARE MINORS

The adult accompanying patients who are children is responsible for payment of all services rendered on that date of service, unless prior arrangements have been made.

OTHER FINANCIAL SERVICES

In many cases the physician orders an X-ray or lab test. In the event that these tests are sent out to be interpreted by a specialist, you will receive a separate bill from that facility or specialist.

I have read the above financial policy and I agree to pay all bills on the date of service or as otherwise agreed.

Signature of Responsible Party _____ **Date** _____

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Request Information From: _____

Address: _____

Phone: _____ Fax: _____

Reason For Release: Continued Medical Care

Please Check:

_____ I hereby request the above named individual or practice to release all medical data and information marked below to Welch Family Medicine.

MEDICAL DATA/INFORMATION

_____ Name, Address, Phone Number

_____ Social Security Number

_____ Date of Service

_____ Diagnosis

_____ Findings of Physical Exam

_____ Laboratory Data

_____ Reports of Diagnostic Tests

_____ Listing of Medications

_____ Listing of Treatments

_____ Information From Physician Consults

_____ Ancillary Personal Notes; Nursing, Social Services, Pharmacy, Psychiatric Services

Patient Name (please print): _____ DOB: _____

Date of Service Requested: _____

Signature of Patient: _____ Date: _____

Signature of Witness: _____ Date: _____

New Patient Medical Information

Circle any past medical problems:

Neurological: Tremors Headache Other (please list): _____

Psychiatric: Depression Anxiety Other (please list): _____

Respiratory: Asthma COPD Seasonal Allergies Other (please list): _____

Cardiovascular: Hypertension High Cholesterol Heart Problems Other (please list): _____

GI: Reflux Colitis Liver Gallbladder Pancreatic Other (please list): _____

GU: Kidney Stones Prostate Urine Infection Other (please list): _____

Skeletal/Muscular: Back Pain Neck Pain Muscle Cramps Other (please list): _____

Endocrine: Diabetes (HIGH / LOW)Thyroid (HIGH / LOW)Testosterone Other (please list):_____

Skin: Eczema Acne Other (please list): _____

Additional Med Hx (please list): _____

Past Surgical History (please list): _____

Social History

Who do you live with: _____

Your Occupation: _____

Do you use (please **circle**): Tobacco (yes / no) If yes; how much: _____ per day, (Dip or Chew)

Do you use (please **circle**): Alcohol (yes / no) If yes; how much: _____

Do you use (please **circle**): Recreation Drugs (yes / no)

Family History

Mother: (Living / Deceased) List any medical history: _____

Father: (Living / Deceased) List any medical history: _____

Siblings: (Living / Deceased) List any medical history: _____

Drug/Food Allergies: List

_____

_____

New Patient Medical Information

Patient Name: _____

List of Current Medications:

1. _____
   Dosage: _____ **How Often:** _____
2. _____
   Dosage: _____ **How Often:** _____
3. _____
   Dosage: _____ **How Often:** _____
4. _____
   Dosage: _____ **How Often:** _____
5. _____
   Dosage: _____ **How Often:** _____
6. _____
   Dosage: _____ **How Often:** _____

Release of Information to the Following Family/Friends:

Name: _____

a: If minor: Permission to bring child in: Yes No

1. Name above has access to the following: (please circle all the apply)
   Medical Records Schedule Balance/Payments Insurance

Name: _____

a: If minor: Permission to bring child in: Yes No

1. Name above has access to the following: (please circle all the apply)
   Medical Records Schedule Balance/Payments Insurance

Name: _____

a: If minor: Permission to bring child in: Yes No

1. Name above has access to the following: (please circle all the apply)
   Medical Records Schedule Balance/Payments Insurance

How did you hear about our office: _____

Patient/Guardian Signature: _____ **Date:** _____