3190 Irvine Road
Richmond, KY 40475

PH: 859-369-0070
Fax: 859-369-0073

New Patient Intake: Date: ____________________

First Name: ____________________ MI: _____ Last Name: ____________________
DOB: ____________________ SSN: ____________________
Street Address: ____________________
City: ____________________ State: ____________________ Zip:____________________
Cell Phone: ____________________ Home Phone: ____________________ Work Phone:____________________
Email: ____________________

Please list all other medical providers that you see: ____________________
____
____

Allergies: ____________________
____

Emergency Contact:
Name: ____________________ Relation: ____________________ Phone: ____________________

Guarantor Name (Person financially responsible): ____________________
Guarantor SSN: ____________________ Phone:____________________

Insurance:

Primary Insurance Company:____________________
Policy Number: ____________________ Group Number: ____________________
Subscriber Name: ____________________ SSN: ____________________

Secondary Insurance Company:____________________
Policy Number: ____________________ Group Number: ____________________
Subscriber Name: ____________________ SSN: ____________________

Tertiary Insurance Company:____________________
Policy Number: ____________________ Group Number: ____________________
Subscriber Name: ____________________ SSN: ____________________

Past Medical History:

	Yes	No		Yes	No		Yes	No
Acid Reflux			Depression			HIV/AIDS		
Anxiety			Diabetes			Migraines		
Asthma			High Blood Pressure			Peripheral Artery Dis		
Bipolar Disorder			High Cholesterol			Rheumatoid Disease		
Blood Clot (DVT/PE)			Enlarged Prostate			Seizure Disorder		
Cancer			Heart Attack			Stroke		
Chronic Pain			Heart Valve Problem			Seasonal Allergies		
COPD			Hepatitis			Substance Abuse/Alcoholism		
Coronary Artery Disease			Hemophilia (Free Bleeder)			Thyroid Problem		
Crohn's Dis/Ulcerative Colitis			Kidney Disease			Tuberculosis		

Surgical History:

	Year		Year
Appendix Removed		Heart Bypass	
Back Surgery		Hernia Repair (Type)	
Bladder Surgery		Hysterectomy: Partial or Complete	
Cataract		Orthopedic Surgery	
C Section		Tonsils Removed	
Ear Tubes		Tubal Ligation	
Heart Catheterization		Vasectomy	
Gallbladder Removal		Other	

Family History:

	None	Mother	Father	Sister	Brother	Other
Cancer Type:____________________						
High Cholesterol						
Diabetes Mellitus						
Heart Disease						
Hypertension						
Mental Illness						
Stroke						
Substance Abuse/Alcoholism						
Other (specify):						

Social History:

☐Married ☐Single ☐Widow ☐Divorced

Do you have children? ☐Yes ☐No # of children: ____ Do you have custody? ☐Yes ☐No

Occupation:____ ☐Disabled ☐Retired

Tobacco Use: ☐None ☐Quit (date)_________ ☐Still use: ☐Cigarettes ☐Chew ☐Cigars ☐Vape

Amount of tobacco you use(d) each day. ☐1/2 pack/can ☐1 pack/can ☐2 packs/cans ☐more

Alcohol Use: (A drink is 1 shot of liquor, 1 glass of wine, or 1 bottle/can of beer.) ☐None

☐Less than 1 drink/month ☐1-15 drinks/month ☐4-14 drinks/week ☐more than 2 drinks/day

Drug Use: ☐Yes ☐No ☐Quit (date)__________ If yes, what do you use?_________________

HIV/AIDS Screening: ☐Yes ☐No If yes, where and when?____________________________

Health Maintenance:

Do you wear seatbelts? ☐Always ☐Sometimes ☐Never

Have you seen a dentist in the past year? ☐Yes ☐No

Date of your last colonoscopy:_____________Date of your last pneumonia shot:_____________

Date of your last tetanus shot:_____________Date of your last shingles shot:________________

Date of your last flu shot:_________________Date of your last eye exam:_________________

Women ONLY:

Date of your last mammogram:_______________Date of your last pap smear:________________

Number of pregnancies?____________________

Current Medications:

▢None

Name of Medication	Strength (mg)	How Often	Reason for taking

Drug Allergies:

▢None

Name	Reaction

Preventive Care:

☐None

GME	
Colonoscopy	
Mammogram	
Prostate Exam/PSA	
PAP	
DEXA Scan	
LD Chest CT	
AAA Screen	
Hep C Screen	
Eye Exam	
Other	
Vaccines	
Flu	
Pneumonia	
Shingles	
Td/Tdap	
Hep A	
Other	

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Confidential Communications

In order to protect your privacy, we ask that you complete this form so we know the ways in which we may communicate with you regarding your health information. Please mark as many of the communication options below you feel comfortable with so we have multiple ways to reach you regarding important matters concerning your health care.

Patient Name:_______________________________________DOB:___________________

I prefer to receive my appointment reminders in the following method: ▢Text ▢Phone call

I authorize Family Clinic, its providers and employees, to do the following:

	Yes	No
Leave a message on my phone regarding appointment reminders/scheduling.		
Send me a letter in the mail regarding appointment reminders, test results and /or scheduling needs.		
Leave my test results in a message at my home/cell number.		
Send my appointment reminders in a text message.		

I authorize Family Clinic to discuss my healthcare as indicated with the following individuals:

Name:	Name:	Name:
Relationship:	Relationship:	Relationship:
Phone:	Phone:	Phone:

	Yes	No		Yes	No		Yes	No
Appointment reminders			*Appointment reminders*			*Appointment reminders*		
Test results			*Test results*			*Test results*		
Billing Information			*Billing Information*			*Billing Information*		

I understand that I have the right to change or cancel this request at any time by notifying Family Clinic. I also understand that the changes or cancellation will not affect action taken based on this request prior to the change or cancellation.

____

Signature of Patient/Representative and Date | Printed Name of Patient/Representative

____

Relationship to Patient | Witness Signature and Date

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Assignments and Authorizations

Patient Name:_______________________________________DOB:___________________

On behalf of myself or other patient named above;

Consent to Treat:

I hereby give my permission to Family Clinic for the evaluation and treatment of the presented medical condition. I am requesting that health care services be provided to me (or the patient named above) at Family Clinic. I voluntarily consent to all treatment and healthcare services that the caregivers at Family Clinic consider to be necessary for me (or the patient named above). I am aware that the practice of medicine is not an exact science; no guarantees have been made to me about the results of treatments, examinations, or services. Pain medication isn't given unless prescribed by the physician after being evaluated.

____

Financial Responsibility:

Subject to applicable law and the terms and conditions of any applicable contract between Family Clinic and a third-party payer, and in consideration of all health care services rendered or to be rendered to me (or the above-named patient), I agree to be financially responsible and obligated to pay Family Clinic for any balance not paid under the “Assignment of Benefits” paragraph below. Subject to applicable law, and in consideration of all health care services rendered or to be rendered to me (or the above named patient), I agree to be financially responsible and obligated to pay Family Clinic for the patient balances due.

____

Consent to Retrieve Medical Information:

As a patient of Family Clinic, I authorize Family Clinic to retrieve and use my medication history from SureScripts, an electronic prescription network. This is an electronic way for Family Clinic to access patient prescription benefit information and patient medication history. Family Clinic can only retrieve medication history from offices that support SureScripts. Utilizing this method is the best way to obtain the most up to date information so that your healthcare provider can deliver the best care to you.

____

Assignment of Benefit:

In consideration of all health care services rendered or to be rendered to me (or the above named patient), I hereby assign to Family Clinic all rights, title, and interest in and to any third-party benefits due from any and all insurance policies and/or responsible third-party payers of an amount not exceeding Family Clinic's regular and customary charges for the health care services rendered. I authorize such payments from applicable insurance carriers, third party payers, and other third-parties. I consent to any request for review or appeal by Family Clinic to challenge a determination of benefits made by a third-party payer. Except as required by law, I assume responsibility for determining in advance whether the services provided are covered by insurance or other third-party payer. I understand that my current insurance must be on file with Family Clinic for my insurance to be billed and as such I will be expected to present my insurance card at each visit to verify my insurance coverage. If I do not provide Family Clinic with insurance information, I will be considered a self-pay patient and obligated to pay all fees associated with the services rendered.

____

Notice of Privacy Practice

I have received a copy of the Family Clinic Notice of Privacy Practices. The Notice of Privacy Practices explains how Family Clinic may use and disclose confidential health information that identifies me (or the above named patient). I consent to let Family Clinic use and disclose health information about me (or the above named patient) as described in the Notice of Privacy Practices. In doing so I consent to the release of my (or the above named patient's) health information and financial account information to all third-party payers and/or their agents that are identified by Family Clinic, its billing agents, collection agents, attorneys, consultants, and/or other agents that represent Family Clinic or provide assistance to Family Clinic for the purposes of securing payment from all parties who are potentially liable for payment for my (or the above named patient's) health care. I can revoke my consent in writing at any time except to the extent that Family Clinic has already relied on my consent. I consent to receive text messages and/or telephone calls or other communications using live, artificial or prerecorded voices, automatic telephone dialing systems, or any other computer-aided technologies from Family Clinic and its affiliates, clinical providers, and business associates, along with any billing services, collection agencies, agents, or other third parties who may act on their behalf. Such text messages and/or telephone calls may be related to any purpose, including those related to my account and/or the care rendered.

____

____

Patient/Legal Guardian Signature Relationship to Patient

____

Witness Signature Date

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Release of Protected Health Information

Patient Name:______________________________________DOB:__________________

I request that my protected health information (PHI) be ▢ disclosed to ▢ obtained from
Recipient Name:____
Street Address:__________________________City:___________________State:_________Zip:____________
E-mail Address:____Phone:__________________________
Fax (healthcare provider only): ____

I authorize the following PHI to be released from my medical record(s):
____All records covering the period of healthcare from ______________________to________________________
____Only Family Clinic records
____Records regarding treatment of specific illness, condition, or injury
____Other (please specify)____

Purpose for requesting information: ▢Legal ▢Insurance ▢Personal ▢Continuation of Care
▢ Other (please specify):____

By signing this authorization form, I confirm I have been made aware of the rights and conditions listed below:

____
Patient or Authorized Representative Signature Date

____
Print Name Relationship to Patient (if other than self)

____
Witness Signature (Verified by) Witness Signature Date

Rights and Conditions:

- I am authorizing Family Clinic to disclose/obtain certain protected health information (PHI) about me to the party or parties listed above.
- I have the right to change or cancel this authorization at any time by notifying Family Clinic.
- I understand that unless otherwise revoked, this authorization will expire 1 year from the date signed.
- I understand that information used or disclosed based on this authorization may be subject to additional disclosure by the recipient named above and may not be protected by federal laws and regulations regarding the privacy of the medical PHI. I understand that I have the right to inspect and copy the information to be disclosed.