

MIDWEST MEDICAL SPECIALISTS, P.A.
Patient History Form

NAME: _____ **AGE:** _____ **OCCUPATION:** _____

DATE: _____ **SEX:** M F **MARITAL STATUS:** S M W D

DATE OF BIRTH: _____ **HEIGHT:** _____ **WEIGHT:** _____

CHIEF COMPLAINT(Please list all symptoms)

- 1) _____ 2) _____
3) _____ 4) _____

OFFICE USE ONLY	
DATE	/ INITIAL

List ALL Medication Allergies: _____

List ALL Present Medications: _____

Are you presently taking aspirin? YES _____ NO _____ Do you have hearing loss? YES _____ NO _____

YOUR HOSPITALIZATIONS:	YEAR	HOSPITAL
ILLNESSES (kind) _____	_____	_____
_____	_____	_____
_____	_____	_____
SURGERY (kind) _____	_____	_____
_____	_____	_____
_____	_____	_____

<u>FAMILY HISTORY</u>	CAUSE OF DEATH	DO YOU HAVE A FAMILY HISTORY OF:	YES	NO
1) Your Father Alive _____ Dead _____	_____	1) Heart Disease	_____	_____
2) Your Mother Alive _____ Dead _____	_____	2) High Blood Pressure	_____	_____
3) Your Brothers Alive # _____ and Sisters Dead # _____	_____	3) Diabetes	_____	_____
4) Your Children Alive # _____ Dead # _____	_____	4) Stroke	_____	_____
		5) Cancer	_____	_____
		6) Thyroid Disease	_____	_____
		7) Other Disease	_____	_____
		Explain: _____		

Please list any serious diseases in children: _____

YOUR PERSONAL HABITS: DO YOU?	YES	NO	PLEASE EXPLAIN
Regularly exercise 3 or 4 times a week	_____	_____	_____
Wear auto seat belts (90% of time)	_____	_____	_____
Use ILLEGAL drugs	_____	_____	_____
Use Alcohol	_____	_____	_____
Were you ever a heavy drinker?	_____	_____	_____
Smoke	_____	_____	_____
If ever, when did you stop?	_____	_____	_____

PLEASE COMPLETE REVERSE SIDE

Review of systems: Please indicate any personal history below:

◆ CONSTITUTIONAL SYMPTOMS

Good general health lately YES NO
Recent weight change YES NO
Decreased appetite YES NO
Fever/night sweats YES NO
Fatigue/Weakness YES NO
Headaches YES NO

◆ EYES

Eye Disease or injury YES NO
Wear glasses/contact lenses YES NO
Blurred or double vision YES NO
Glaucoma/cataracts YES NO

◆ EARS/NOSE/THROAT

Hearing loss or ringing YES NO
Earaches or drainage YES NO
Chronic sinus problem YES NO
Nose bleeds YES NO
Mouth sores YES NO
Sore throat or voice change YES NO
Swollen glands in neck YES NO

◆ CARDIOVASCULAR

Heart trouble YES NO
Chest pain or angina pectoris YES NO
Palpitation YES NO
Shortness of breath with walking or lying flat YES NO
Swelling of feet, ankles or hands YES NO

◆ RESPIRATORY

Chronic or frequent coughs YES NO
Spitting up blood YES NO
Shortness of breath YES NO
Asthma or wheezing YES NO

◆ GASTROINTESTINAL

Loss of appetite YES NO
Change in bowel movements YES NO
Nausea or vomiting YES NO
Frequent diarrhea YES NO
Painful bowel movements or constipation YES NO
Rectal bleeding or blood in stools YES NO
Abdominal pain YES NO
Peptic ulcer (stomach or duodenal) YES NO

◆ GENITOURINARY

Frequent urination YES NO
Burning or painful urination YES NO
Awaken at night to urinate YES NO
Blood in urine YES NO
Change in force of stream when urinating YES NO
Incontinence or dribbling YES NO
Sores or discharge YES NO
Kidney stones YES NO
Sexual difficulty YES NO
Male-Testicle pain/lumps YES NO
Female-Pain with periods YES NO
Female-Irregular periods YES NO
Female-Vaginal discharge YES NO
Female-# of pregnancies
Female-# of miscarriages
Female-Date of last pap smear

◆ MUSCULOSKELETAL

joint pain YES NO
joint stiffness or swelling YES NO
Weakness of muscles or joints YES NO
Muscle pain or cramps YES NO
Back pain YES NO
Difficulty in walking YES NO

◆ INTEGUMENTARY (skin/breast)

Rash or itching YES NO
Change in skin color YES NO
Change in hair or nails YES NO
Varicose Veins YES NO
Breast pain YES NO
Breast lump YES NO
Breast discharge YES NO

◆ NEUROLOGICAL

Frequent or recurring headaches YES NO
Light headed or dizzy YES NO
Convulsions or seizures YES NO
Numbness or tingling sensations YES NO
Shakes YES NO
Paralysis YES NO
Stroke YES NO
Head injury YES NO

◆ PSYCHIATRIC

Memory loss or confusion YES NO
Nervousness YES NO
Depression YES NO
Insomnia YES NO

◆ ENDOCRINE

Glandular or hormone problem YES NO
Thyroid disease YES NO
Diabetes (insulin or non insulin-circle one) YES NO
Excessive thirst or urination YES NO
Heat or cold intolerance YES NO

◆ HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts YES NO
Bleeding or bruising tendency YES NO
Anemia YES NO
Blood clots YES NO
Blood transfusion YES NO
Enlarged glands YES NO

◆ ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reaction to:
Penicillin or other antibiotics YES NO
Morphine, Demerol, or other narcotics YES NO
Novocaine or other anesthetics YES NO
Aspirin or other pain remedies YES NO
Tetanus antitoxin or other serums YES NO
Iodine, merthiolate or other antiseptic YES NO
Other drugs/medications:
Known food allergies:
Environmental allergies:

REVIEWED BY _____

INSURANCE RELEASE OF INFORMATION AUTHORIZATION AND ASSIGNMENT

**I request that payment of authorized Medicare/ Other Insurance Company/carrier benefits be made on my behalf to Midwest Medical Specialists, P.A. for any services furnished to me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

**I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financial Administration or its intermediaries or carriers of the original, and request payment of medical insurance benefits to the party who accept assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)

**Please initial that you have read and understand the above information. _____

FINANCIAL POLICY

Midwest Medical Specialists is committed to providing you with the best possible care. If you have medical insurance we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

- 1) **CONTRACTED INSURANCE:** All contracted insurances are billed directly as a courtesy only. We are not a party in that contract. A remaining balances for non-covered benefits, deductibles, copays, and coinsurances are your responsibility. Payment for this is expected within 30 days from receipt of your statement.
- 2) **CO-PAYS:** All copays are expected at the time of services is rendered. Although our staff tries hard to predict your amount due, we cannot always determine what your insurance will hold you responsible for. You are responsible for your copay whether it is collected the time of your visit or not.
- 3) **REFERRALS:** If you have an HMO or PPO requiring a referral, you must have a completed referral form or referral number with you the time of your appointment. You are responsible for knowing whether your plan requires a referral. If you do not have this information at the time of the appointment you will be required to pay the entire fee in order to be seen.
- 4) **METHOD OF PAYMENT:** We accept cash, checks, money orders, Visa, or MasterCard.
- 5) **PAYMENT ARRANGEMENTS:** We understand that there may be times when financial difficulties come upon us without warning. Under special circumstances temporary payment arrangements may be made if approved in advance. Accounts on temporary payments plans are required to make payment each and every month. Missed payments could result in collections. Accounts on a payment plan must continue to pay at the time of services. Our goal is to help you from attaining a greater debt and to assist you by keeping your account at a manageable level.
- 6) **RETURNED CHECKS:** There will be a \$25.00 fee for all returned checks.
- 7) **DIVORCED, SEPARATED, OR BLENDED FAMILIES:** In order to keep our accounts clean and eliminate any embarrassing or uncomfortable situations for you, we have chosen NOT to become involved in any agreement, understanding, and/or court order regarding reimbursement from the absent parent. Payment is required at the time of service from the parent accompanying the patient. Reimbursement from the absent parent is your responsibility.
- 8) **NO SHOW/CANCELLATION POLICY:** There may be a fee for no-show appointments or cancellation of appointments without 24-hour notice.
- 9) **PAST DUE ACCOUNTS:** Accounts become past due 60 days after your insurance pays. We reserve the right to send your account to collection agency if the balance is not paid in full within 90 days.

**** If you are concerned about the cost of any procedure please make an inquiry in advance.**

I HEREBY ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND AND AGREE TO THE TERMS OF THIS ENTIRE DOCUMENT AND RELATING TO MY INSURANCE COVERAGE AND PAYMENT OF MY BELL.

PATIENT OR GUARDIAN'S

DATE