NEST FAMILY MEDICINE

Please fill out this form completely.

1. Patient Information

Last Name_____First Name_____Middle MI_____

Sex (M/F) _____Marital Status (Married/Single/Other)_____

DOB_____Drivers License #_____SSN_____

Home Address_____

City_____State_____Zip_____

Phone (Home)_____Phone (Work)_____Phone (Cell)_____

Email address_____

Employer Name_____

Work Address_____

City_____State_____Zip_____

2. Emergency Contact

Last Name_____First Name_____Middle MI ____

Relationship _____Phone_____Email_____

If you are visiting Nest Family Medicine for the first time, we would like to know how you heard about us:

□ Family □ Friend □ Insurance □ Print Ad □ Facebook □ Instagram □ Twitter □ Google Search

□ Referring Doctor (Name)_____ □ Other_____

3. Guarantor Information (who brings the minor)

Relationship with Primary Insured (Self/Spouse/Child/Other)_____

If you did not check Self, please fill out the following info about the responsible person

Last Name_____First Name_____Middle MI_____

Sex (M/F) _____Marital Status (Married/Single/Other)_____

DOB_____Drivers License #_____SSN_____

Home Address_____

City_____State_____Zip_____

Phone (Home)_____Phone (Work)_____Phone (Cell)_____

Email address_____

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4. Primary Insured Information

Insurance Company Name_____

Address_____

Phone_____Fax_____

Relationship with primary insured (circle one): Self | Spouse | Child | Other

If you did not check Self, please fill out the information about the primary insured person:

Last Name_____First Name_____Middle MI_____

Sex (M/F) _____Marital Status (Married/Single/Other)_____

DOB_____Drivers License #_____SSN_____

Home Address_____

City_____State_____Zip_____

Phone (Home)_____Phone (Work)_____Phone (Cell)_____

Email address_____

5. Pharmacy Information

Pharmacy Name_____ _____

Pharmacy Phone number _____

Pharmacy Address_____

City_____State_____Zip_____

NEST FAMILY MEDICINE

For Office use only: ☐ Complete Physical ☐ Other

Name_____DOB_____Age_____Date_____

Preferred Name_____

PAST MEDICAL HISTORY

Current Medications and Doses

Medication	Doses	Medication	Doses

What medication are you allergic to and what kind of reaction did you have? _____

_____

Do you take herbs or supplements? ☐ Yes ☐ No Which ones?_____

List all disease you have or have had in the past:

☐ High blood pressure ☐ Elevated Cholesterol ☐ Cancer ☐ Diabetes ☐ Thyroid disease ☐ Heart Disease

☐ Others_____

Hospital admissions/Surgeries/Procedures/Biopsies

Year	Description	Year	Description

FAMILY HISTORY

Father ☐ Living – Illness _____ Mother ☐ Living – Illness _____

☐ Deceased – Cause of death _____ ☐ Deceased – Cause of death_____

Age at death_____ Age at death_____

Has any parent, brother or sister had: (Please indicate which relative and approximate age at diagnosis)

A) ☐ Colon Cancer ☐ Ovarian Cancer ☐ Thyroid Cancer ☐ Heart Disease (before age 55 if male, or age 65 if female)
☐ Colon Polyps ☐ Prostrate Cancer ☐ Breast Cancer ☐ Osteoporosis (bone thinning) ☐ Melanoma

B) ☐ Stroke ☐ Diabetes ☐ Bleeding Disorders ☐ Alcoholism
☐ Glaucoma ☐ Kidney Disease ☐ Arthritis ☐ Depression

SOCIAL HISTORY

Occupation _____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partner ☐ # of Children_____

Alcohol _____ drinks per week

Have you ever had problem with alcohol use? ☐ Yes ☐ No

Have you ever felt you need to cut down on drinking? ☐ Yes ☐ No

Have people annoyed you by criticizing your drinking ☐ Yes ☐ No

Have you ever felt guilty about drinking ☐ Yes ☐ No

Have you ever felt you need a drink first thing in the morning to steady your nerves or to get rid of hangover? ☐ Yes ☐ No

Do you smoke? ☐ Yes how many packs a day? _____ for how many years?_____ ☐ No☐ Quit,When?_____

Do you chew tobacco or chew snuff? ☐ Yes how much? _____ for how many years?_____ ☐ No ☐ Quit,When?_____

Coffee/Tea: _____ cups per day Caffeinated Sodas _____ per day

Recreational drugs use? Substance abuse (injections or others): ☐ Yes ☐ No ☐ Past Which substance?_____

☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Transgender female ☐ Transgender male ☐ Other

What type of exercise do you do? _____ How often? _____

NEST FAMILY MEDICINE

Patient Consent Form

In April of 2003, new federal requirements regarding privacy of information for health care patients take effect. H.I.P.A.A., the Health Insurance Portability and Accountability Act require that all medical providers, insurance companies and others put in place controls to ensure that your personal medical information is safe. NEST FAMILY MEDICINE requests that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital and insurance company. By signing this form you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

Signature of Patient or Representative:_____Date:._____

Printed Name of Patient/Representative:_____ D.O.B._____

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents or others to call and request the results of test and procedures. Under the requirements for the H.I.P.A.A., we are not allowed to give this information to anyone without the patient's consent. If you wish to have your test results released to family members you must sign this form. Signing this form will only give consent to release laboratory and radiology results to the family members indicated below. This consent form will not allow NEST FAMILY MEDICINE Associates to release any other information to these family members.
You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. I authorize NEST FAMILY MEDICINE Associates to release my laboratory/radiology results and all medical related reports to the follow individuals:

1. Name_____
   Relation to Patient _____
2. Name_____
   Relation to Patient _____

Patient Name_____

Patient/Representative Signature_____

NEST FAMILY MEDICINE

Authorization to Leave Messages with Family Members or Answering Machine

From time to time it is necessary for representatives of NEST FAMILY MEDICINE to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss lab or procedure results, or to ask a patient to call NEST regarding an issue or concern. At no time will a representative of NEST discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient Name_____

Patient/Representative Signature_____

Consent to Photo

I hereby authorize NEST FAMILY MEDICINE to take digital photographs of me. I understand that the photograph is only be used for my personal medical record serving a purpose of identification.

Patient/Representative Signature:_____Date:_____

NEST FAMILY MEDICINE

Financial Policies and Responsibility

- Copayment is due at the time of the visit. If you do not have your co-payment, we will ask that you reschedule your appointment.
- If you have not met your deductible, you are expected to pay in full at the time of the visit.
- We charge the insurance carriers our "normal fees". We are paid their allowable amounts, and write off the difference between those two amounts as the discount. We do not write off amounts that have gone to the deductible, non- covered services, or co-payments.
- After your insurance company has paid their portion, if there is any amount not covered due to your deductible, non- covered services such as preventive care, etc., we will send you a bill for the amount due. We ask that you remit the owed amount upon receipt of the bill.
- It is ultimately the patient's responsibility to be aware of their plan's limitations and restrictions on covered services.
- If you need a referral to a specialist, we will ask that you see one of our physicians first. We need specific information and documentation in our files in order to obtain authorization for you to see another doctor, be hospitalized, or have certain procedures.
- Failure to keep the patient's account current may result in NEST FAMILY MEDICINE being unable to provide additional services except for emergencies.
- We reserve the right to charge you (not your insurance company) an office fee if you do not cancel your appointment within 24 hours of your appointment time, or if you no-show for your appointment.

_____ I hereby authorize NEST FAMILY MEDICINE to release any information concerning my condition and treatment or examination (including HIV, psychological records and all forms of communication) rendered to me, my child or person under my legal guardianship to the insurance carrier and/or healthcare provider(s) involved in my healthcare.

_____I authorize and request the insurance company to pay directly to NEST FAMILY MEDICINE for benefits otherwise payable to the patient.

_____I understand the insurance company may not pay the actual bill for services, and I agree to be responsible for payment of all services rendered for myself, my child or the person under my legal guardianship.

_____ Patient or his/her legal representative accepts full responsibility for payment of the physician's charge for all services furnished by the physician.

Signature below is acknowledgement that you have read our Patient Consent Form & Financial Policies:

Print Name_____ Date of Birth: _____

Signature_____ Date: _____

Please list any other individuals or family members that you authorize access to your medical information:

_____ _____

_____ _____