Patient Registration

PREVENTATIVE MEDICINE AND PRIMARY CARE

DR. HOOVER'S OFFICE

DR. RICK **HOOVER, DO** BILLY **DYCUS, FNP-C**

Patient Information:

Last Name: _____ First:_____ MI:_____ Suffix:_____ Preferred:_____

Address:_____

City, State, Zip: _____

Cell Phone: _____ Home Phone: _____ Work:_____

Birth Date: _____ Soc Sec #:_____ Race: _____

Sex: □ Male □ Female Marital Status: □ Married □ Single □ Other

E-mail Address _____

May we leave messages regarding Appointments, Billing, and or Medical Care? □ YES □ NO

Phone numbers we may use to leave messages: □ Cell □ Home □ Work

Emergency Contact: _____ Phone: _____ Relationship:_____

Responsible Party: (If over 18 skip to Insurance Section)

Relationship to Patient: _____ Soc Sec #: _____

First Name: _____ Last Name: _____ Birth Date: _____

Address (if different from above):_____
_____

City, State, Zip: _____

Home Phone: _____ Cell:_____

Please provide a copy of all Insurance Cards and a Driver's License / Photo ID

Primary Insurance Information:

Insurance Company Name: _____ ID#_____

Employer: _____ Group #: _____

Policy Holder Name: _____ Policy Holder Birth Date: _____

Policy Holder Soc. Sec. #: _____

Secondary Insurance Information: ☐ Check Box if no secondary coverage

Insurance Company Name: _____ ID#_____

Employer: _____ Group #: _____

Policy Holder Name: _____ Policy Holder Birth Date: _____

Policy Holder Soc. Sec. #: _____

Patient Authorizations

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Optional Authorization to Release Medical Information to Others:

☐ I authorize Preventative Medicine and Primary Care to discuss or disclose information checked below regarding any matters relating to my appointments, insurance, billing information, test results and/or medical care to the persons listed below. Listed persons also have my permission to pick up prescriptions on my behalf:

1.) Name: _____ Relationship: _____ Phone:_____

□ Appointments □ Billing □Medical Care/Lab Results □ Leave Message □ Rx Pick Up

2.) Name: _____ Relationship: _____ Phone:_____

□ Appointments □ Billing □Medical Care/Lab Results □ Leave Message □ Rx Pick Up

☐ I do not authorize the release of my information

Authorization for Prescriptions

☐ I authorize Preventative Medicine and Primary Care to send my prescriptions via electric prescription transmission, or e-prescribing to the pharmacy(s) listed below. I understand it is my responsibility to update the office of any changes prior to or at the time of prescription refill. I am also aware that some prescriptions some prescriptions cannot be called in or e-prescribed to my pharmacy.

Pharmacy: _____ Phone Number: _____

Location: _____

Mail Order: _____ Phone Number: _____

Consent for Treatment, Release of Information, Authorization & Insurance Authorization

☐ I consent to treatment necessary to the care which has been discussed and directed by the provider.

☐ I authorize the release of all medical records to specialists and/or consulting physicians if applicable to my care and condition. I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, it intermediaries, its carriers, or any other insurance carrier any information needed for this or any other related claim to be processed. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to me or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any party who may be responsible for paying for my treatment.

☐ I further authorize and request that insurance payments be directed to Preventative Medicine and Primary Care

☐ I understand a copy of the practice's Patient Privacy Information may be obtained at any time from Preventative Medicine and Primary Care

Policy & Procedures

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☐ **Appointments (Check Box to Indicate Understanding)**

We encourage you to schedule appointments for preventative health visits, physicals, chronic medical conditions, prescription renewals well in advance. We do not take walk-in visits. If you need acute care or a sick visit, call the office and every effort will be made to work you in with a provider within 24 hrs.

If you need to cancel your appointment we ask that you give at least a 24 hr notice. Failure to do so may result in a $35 "no show fee". Three (3) "No Show" appointments within 1 calendar year will result in your patient status being terminated and you will no longer be able to schedule appointments with our clinic.

New and Annual Wellness Visit patients are required to check in 15 minutes prior to their appointment time in order to complete paperwork.

A 15 minute grace period after your appointment time will be given. After that time your appointment will need to be rescheduled.

*Please note No-Show charges are not billable to insurance and must be paid before further scheduling.

☐ **Financial Responsibility Statement (Check Box to Indicate Understanding)**

Preventative Medicine and Primary Care accepts limited health plans and files insurance claims as a courtesy to our patients. Co-pays are due at time of service. Any money not payable by your insurance company is the patient's responsibility in accordance with your plan.

Various forms and/or letters are sometimes needed to assist with your health care needs. We ask that you please allow 7 to 10 days for completion. If our office fills out paperwork, it will be a $15 charge.

☐ **Medication & Refill Guidelines (Check Box to Indicate Understanding)**

If you have refills left on your prescription you MUST request a refill through your pharmacy.

All other request can be made by calling the office. Same day refills are not available. We require 2 business days to process and fill refill request.

We do not refill narcotic or order antibiotics over the phone. We also do not routinely order narcotic pain Medicine. You may be required to obtain these through Pain Management.

I have read, fully understand and agree to the above **medication refill guidelines, financial responsibility statement, consent for treatment** and **release of medical information & insurance authorization**. I also certify that all of the information, provided is complete and accurate.

Signature: _____ Date:_____

Medical History

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Past Medical History:

Allergies	Y	N	Glaucoma	Y	N
Anemia	Y	N	Heart murmur	Y	N
Anxiety	Y	N	HIV/AIDS	Y	N
Arthritis	Y	N	Hyperlipidemia	Y	N
Asthma	Y	N	Hypertension	Y	N
Blood transfusion	Y	N	Kidney disease	Y	N
Cancer	Y	N	Meningitis	Y	N
Cataracts	Y	N	Myocardial Infarction	Y	N
CHF	Y	N	Nerve/muscle disease	Y	N
Clotting disorder	Y	N	Osteoporosis	Y	N
COPD	Y	N	Seizures	Y	N
Coronary artery disease	Y	N	Sickle cell anemia	Y	N
Depression	Y	N	Stroke	Y	N
Diabetes	Y	N	Substance abuse	Y	N
Emphysema	Y	N	Thyroid	Y	N
GERD	Y	N	Tuberculosis	Y	N
			Ulcers	Y	N

Other Medical History:_____

Past Surgical History:

			Fracture surgery	Y	N
Appendectomy	Y	N	Hernia repair	Y	N
Brain surgery	Y	N	Hysterectomy	Y	N
Breast surgery	Y	N	Joint replacement	Y	N
CABG	Y	N	Prostate surgery	Y	N
Cholecystectomy	Y	N	Small intestine surgery	Y	N
Colon surgery	Y	N	Spine surgery	Y	N
Cosmetic surgery	Y	N	Tonsillectomy	Y	N
C-section	Y	N	Tubal ligation	Y	N
Eye surgery	Y	N	Valve replacement	Y	N
			Vasectomy	Y	N

Other Surgical History:_____

	Alcohol Abuse	Arthritis	Asthma	Birth Defects	Cancer	COPD	Depression	Diabetes	Drug Abuse	Early Death	Hearing Loss	Heart Disease	Hyperlipidemia	Hypertension	Kidney disease	Learning disabilities	Mental Illness	Mental retardation	Miscarriages	Stroke	Vision loss
Mom																					
Dad																					
Sis																					
Bro																					
Daughter																					
Son																					
Maternal Aunt																					
Maternal Uncle																					
Paternal Aunt																					
Paternal Uncle																					
M Grand Mother																					
M Grand Father																					
P Grand Mother																					
P Grand Father																					

☐ Adopted ☐ Family History Unknown

Other Family History: _____

Social History	**Please Circle all that apply**	
Marital	Single Married Widow Divorce	Number of children:
Occupational	Employed: FT PT Self	Occupation:
	Retired Disabled Homemaker	
	Student Not Employed	
Tobacco	Yes – Packs per day: Smokeless	Never Smoked
	Former – Quit Date:	
Alcohol	Yes – Drinks per week: Type:	No
Drug Use	Yes – Type:	No
Sexually Active	Yes Partner(s): Male Female	No
	Birth Control Method:	

Current Medications, Vitamins, and Herbal Supplements

Drug Name Ex: Tylenol	Strength Ex: 500mg	Dose Ex: 2 tablets	Frequency Ex. Twice Daily	Prescribed By Ex: Dr. Example

Allergies: Please list allergen, including non-medication allergens and reaction

Drug Name	Reaction

Medical Care Team: Please list your other medical providers

Cardiologist		Dermatologist	
Pulmonologist		Oncologist	
Ear, Nose, Throat (ENT)		Neurologist	
Ophthalmologist (Eyes)		Rheumatologist	
Gastroenterologist (GI)		Urologist	
Orthopedist		Nephrologist	

Other: _____

Disease Prevention and Health Maintenance – Please list the most recent dates.

Vaccines	Month/Year	Test	Month/Year	Test	Month/Year
Flu		Mammogram		Eye Exam	
Pneumonia		Pap Smear		Heart Cath	
Tetanus		Colonoscopy		Endoscopy EGD	
Hepatitis B		Bone Density		Heart Stress Test	
Shingles		EKG		Ab Aneurysm screen	
Gardisil		Chest x-ray		HIV Test	