Patient Information

Please Provide ID and Insurance Card if Applicable for copy to Office

Last Name:______________________________First Name:___________________MI:_____________
Previous Name:____
Date of Birth: ____/___/_____ Gender:_____________ SSN:_____________________________
Mailing Address: ____
City/State/ Zip Code:____
Cell Phone: ____________________________________Home Phone: _________________________

Can we leave you a detailed Message on your Voicemail *Yes or No*

Occupation: _____________________________________Employer:_________________________
Marital Status: _______________________________Spouses Name/ Number: _______________
Emergency Contact- Name/ Phone Number:______________________Realtionship:_____________
Email:____________________________________ Pharmacy & Location: _______________________

RESPONSIBLE PARTY

If the patient is a minor, the parent or guardian bringing the patient will be listed as the guarantor

Last Name: ____________________________________ First Name: _____________________________
Date of Birth: ___/___/____ Phone Number: __________________SSN: ________________________
Address of Person Responsible: ____
City/State/ Zip Code: ____

INSURANCE

Company Name:____
ID Number: ____ Group Number: ______________________
Subscriber/ Employee Name: ______________________________ Relationship to Patient: ______________
Date of Birth: ____/_____/_______ SSN: _______________________ Gender:_____________
Secondary Insurance (if applicable) ____

The information that I have provided is complete and true to the best of my ability,

Printed Name: ____

Signature Name: ___________________________________ Date: __________

Thank you for choosing Active Family Healthcare, The following information is provided for your conveniences as well as the convenience of your office.

PLEASE INITIAL THE FOLLOWING YOU HAVE READ

_______Late Policy

We make every effort to remain on schedule. In order to do this we ask the patients to be ***15-20 minutes*** *early for their appointments. Patients that arrive more than 10 minutes after their scheduled time will be cancelled and rescheduled: dependent on the discretion of the provider's schedule.*

_______No Show or Cancelation

Established patients will be charged a $50 "No-Show" Fee if the office has not been notified at least 12 hours before cancelation of appointment.

______Prescription Refills

Please notify your pharmacy one week prior to being out of medicine and ask them to send a request electronically. We require a 48-72 hours notice for prescription refills to be processed. If you are requesting to refill a narcotic prescription a urine sample may be needed as well as an appointment.

______Insurance/ Co-Pays/ Deductibles

It is the patient's responsibility to provide Active Family Healthcare with the correct insurance information. It is crucial that you know/ understand the contract you've signed with your insurance provider. Our staff will interpret insurance information to the best of their ability to provide you with the most accurate information regarding your copay and deductible. Your copay or payment towards your deductible is required upon date of service.

_____Past Due Accounts

If you have a past due balance on your account you will be expected to pay the full balance or a minimum of $50 toward the balance before you are seen. This does not include your copay or deductible amount for that day's appointment. All delinquent accounts beyond 120 days will be forwarded to collection service for legal action.

_____Emergencies/ After Hours

If you have a life-threatening emergency, call 911 or go to the nearest emergency room immediately. If you feel this is or an urgent matter that is not life threatening and can not wait till the next business day, you can call our On-call provider at 208-651-5101

_____Billing

Please direct all Billing questions to our Billing Company Pacific Medical Revenue, 1-855-621-8250

_____Office Etiquette

When at the office please silence your cell phone, no unattended children and NO guns/knives in our office.

Financial Agreement/ Release of Information/ Office Policies

I request that payment of authorized Medicare or other insurance benefits be made to Active Family Healthcare for any services furnished to myself by Active Family Healthcare.

I authorize Active Family Healthcare to furnish all requested medical information of the persons or entity names above if requested by my insurance company in order to process my claim. I acknowledge that I have reviewed Active Family Healthcare's policy and procedures. I understand that regardless of my insurance status, I am solely responsible for payment of any professional services rendered to me, or on my behalf whether or not paid by my insurance company. I acknowledge I have received and read a copy of the AFH office policies.

SIGNATURE ____ **DATE**____________

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of AFH notice of Privacy Practices. I further acknowledge that a copy of the current notice will be made available to me upon request.

SIGNATURE ____ **DATE**____________

Authorization for AFH to Utilize Information as described in Privacy Notice

Please indicate by signature below that you are authorizing us to use private patient information as indicated in our Notice of Privacy Practices. This is not a change in how we have historically used your information. New laws require us to disclose how we use this information.

SIGNATURE ____ **DATE**____________

Patient's Consent for AFH to share protected Health Information with whom is Listed

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____

____

SIGNATURE ____ **DATE**____________

Patient's History Information Sheet

Name: ______________________ **Gender:** __________ **DOB:** ____/____/____

Allergies: ______________________

List of ALL MEDICATIONS you take, including over the counter (OTC) medication and Vitamins.
Included specific doses and when taken. If you don't know please call your pharmacist to confirm

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Personal Medical History (Please circle all that apply)

ADHD
Alcoholism
Allergies, Seasonal
Anemia
Anxiety
Arrhythmia (irregular heart beat)
Arthritis
Asthma
Bipolar
Bladder Problems
Bleeding Problems
Cancer: __________
Headaches
Crohn's Disease

COPD/Emphysema
Dementia
Depression
Diabetes: 1 or 2
Diverticulitis
DVT (Blood Clot)
GERD (Acid Reflux)
Glaucoma
Heart Disease
Hiatal Hernia
High Blood Pressure
Kidney Stones
Kidney Disease

High Cholesterol
HIV
Hepatitis
Irritable Bowel Syndrome
Lupus
Liver Disease
Macular Degeneration
Neuropathy
Osteopenia/ Osteoporosis
Parkinson's Disease
Peripheral Vascular Disease
Peptic Ulcer
Psoriasis
Pulmonary Embolism (PE)

Rheumatoid Arthritis
Seizure Disorder
Sleep Apnea
Stroke
Thyroid Disorder
Ulcerative Colitis

Last Menstrual Period Date: ______________ Normal Abnormal

Colonoscopy Date: ______________ Normal Abnormal

Mammogram Date: ______________ Normal Abnormal

Dexa (Bone Density)Date: ______________ Normal Abnormal

PAP Date: ______________ Normal Abnormal

Other Medical Problems not listed above: ______________________

Surgical History: Please list ALL prior surgeries and approximate Dates performed.

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SOCIAL/ CULTURAL HISTORY: EDUCATION LEVEL: GED/ HIGH SCHOOL VOCATIONAL COLLEGE

Are there any VISION problems that affect your communication? YES NO

Are there any HEARING problems that affect your communication? YES NO

Are there any limitations to understand or following instructions (either written or verbal)? YES NO

Current Living Situation (Check ALL that apply):

Single Family Household
Shelter
Multi-generational Household
Skilled Nursing Facility
Homeless
Other: __________

Smoking/ Tobacco Use: YES NO

If Yes, How often? ______________________ Number of Years: ______________

Alcohol Use: YES NO Drinks/ Week: ______________

Recreational Drug Use: YES NO Type: ______________________

Are you Sexually Active? YES NO

Are there any personal problems or concerns at home, work, or school you would like to discuss? YES NO

Are there any financial issues that directly impact your ability to manage your health? YES NO

Are there any cultural or religious concerns you have related to our delivery of care? YES NO

How often do you get the social and emotional support you need?

ALWAYS USUALLY SOMETIMES RARELY NEVER

Comments(Please feel free to comment on any "YES" above)

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FAMILY HISTORY

FATHER LIVING AGE__________ DECEASED AGE__________

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: __________	Diabetes: 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/ Emphysema	DVT(blood clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: ____

MOTHER LIVING AGE__________ DECEASED AGE__________

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: __________	Diabetes: 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/ Emphysema	DVT(blood clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: ____

Siblings History:

____

____

List other Medical Providers you see on a Regular basis

(Cardiologist, Mental Health, Kidney Doctor, Dental, ect.)

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Patients Signature: ______________________________

Print Name:______________________________ **DATE:** ______________