ONCALL HEALTH AND AESTHETIC CARE NEW PATIENT PACKET

Name_____

Address _____City_____State_____Zip_____

DOB_____ SS#_____ Home Phone_____ Cell Phone _____

Married_____ Divorced _____ Single _____ Widowed_____ Minor_____

INSURANCE

Primary Insurance _____

ID# _____ Group #_____

Secondary Insurance _____

ID# _____ Group #_____

***Please bring current insurance cards with you to every visit.**

IN CASE OF EMERGENCY

Name_____

Relationship to Patient _____

Home Phone _____ Cell Phone _____

PLEASE INITIAL EACH SECTION TO ACKNOWLEDGE AGREEMENT

I hereby consent to examination and/or treatment as recommended by professional staff of this office. _____

I understand Timothy Maynard or another provider employed by OnCall Health will now be considered as my PCP. I will not be seeing another physician as primary care. I understand that I can still see all my specialty physicians. _____

I accept responsibility for all payment, charges and fees for professional services for the patient named at the beginning of the paperwork. I understand the non-payment of my account balance may result in the use of collection/legal action in an attempt for this office to obtain payment for services rendered. I understand that if my account falls into bad debt collection status, a debt collector has permission to call my home phone or cell phone in attempt to collect. _____

I authorize any insurance benefits that are reimbursable for services to be paid directly to this office. This office will bill your insurance company on your behalf for charges incurred; however, you are responsible for the full amount of your account (except for certain government insurance plans). _____

I consent to the release and disclosure of all or any part of medical records to applicable professional or private review organizations and to my insurance company. _____

I authorize ONCALL HEALTH AND AESTHETIC CARE to deliver telephone calls to be used as a next appointment reminder. _____

I have received a copy of this office's Privacy Notes. _____

I understand that the Practitioners do not prescribe Narcotic medications. _____

I understand that if any controlled prescriptions are written for me, I will need to provide a urine sample or cheek swab for a drug screen at least every three months. I also understand that I may be subject to a pill count randomly. I understand that if I am called in to do a random urine drug screen, I will be given 24 hours to come into the office. _____

I understand that if my urine drug screen comes back for controlled, narcotic or recreational drugs not prescribed to me, I will no longer be prescribed controlled medications and have the possibility of being terminated as a patient. _____

I authorize any care plan, medication lists, lab findings, etc. to be shared with my house representative and the house coordinator. _____

Termination of services may occur if it is determined that the patient is uncooperative with treatment, fails to keep scheduled appointments, abuse of medications, nonpayment of account, fails to show up for a urine drug screen/pill count, harasses or is disrespectful to office staff. _____

_____

Signature of Patient Date

Printed name of Patient

Signature of Guardian or Power of Attorney Date

Printed name of Guardian or Power of Attorney

Medical Information

Allergies

_____

_____

_____

Medication Names, Dosage and Quantity

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Surgical History

_____

_____

_____

Habits (yes or no)

Do you smoke? _____ How many packs a day? _____

Do you chew? _____ How often? _____

Do you drink alcohol? _____ How often? _____

Do you take any recreational drugs? _____ How often? _____

Circle if you have been diagnosed with or are currently experiencing:

High blood pressure

Diabetes

Cancer

Asthma

Heart Disease

CHF

AFIB

Chest Pain

Palpitations

Lightheadedness

COPD

Persistent Cough

Bronchitis

Pneumonia

Abdominal Discomfort

Acid Reflux

Constipation

Diarrhea

Nausea

Vomiting

Ulcers

Blood in Stool

Change in Bowel Habits

Hemorrhoids

Unexplained Weigh Gain/Loss

Frequent/Difficulty Urinating

Gallbladder Disease

Liver Disease

Kidney Disease

Kidney Stones

Thyroid Disease

Migraines

Gout

Head or Neck Pain

Back Pain

Arthritis

Skin Disease

Anemia

Blood Disease

Alcohol or Drug Abuse

Other:_____

_____

_____

Family Medical History (illnesses no names)

Mother: _____

Father: _____

Siblings: _____

Referrals

Are you being seen anywhere else for anything? If so by whom, where, and for what?

_____

_____

_____

Vaccines (circle)

Hep B:	Yes	No	Date/Location: _____
Hep A:	Yes	No	Date/Location: _____
Shingles:	Yes	No	Date/Location: _____
Flu:	Yes	No	Date/Location: _____
Pneumonia:	Yes	No	Date/Location: _____

Other: _____

Procedures (circle)

Colonoscopy:	Yes or No	Date/Location/Doctor: _____
Mammogram:	Yes or No	Date/Location/Doctor: _____
Bone Density Scan:	Yes or No	Date/Location/Doctor: _____
Last Gynecological Visit:		Date/Location/Doctor: _____

Other: _____

Transportation Stable? (circle)

Yes No

Do you feel safe at home? (circle)

Yes No Other: _____