FRANKLIN COUNTY
FCMC
MEDICAL CENTER

DR. PARKINSON NEW PATIENT FORM

Date:		PATIENT DEMOGRAPHICS		
Patient's Full Name:		Middle Initial:	Maiden Name:	Sex:
Preferred Name:	Date of Birth:	Age:	Social Security:	Marital Status:
Patient Address:		City:	State:	Zip Code:
Primary Care Provider:				
Employer:			Employer Phone #:	
Spouse's Name:		Spouse's Cell Phone #:	Spouse's SSN:	Spouse's Date of Birth:

RESPONSIBLE PARTY INFORMATION

(person signing this consent if the patient is a minor)

Responsible Party's Name:		Relationship to Patient:	Sex:	Date of Birth:
Address (if different from patient's):		City:	State:	Zip Code:
Primary Phone #:		Cell Phone #:	Email:	
SSN:	Employer's Name & Address:			Employer Phone #:
Signature of Patient or Responsible Party (If Patient is a Minor) Authorizing Medical Services:				

INSURANCE INFORMATION

Primary Insurance Name:	Insurance Effective Date:	Contract ID:	Group:
Insurance Address:	City:	State:	Zip Code:
Subscriber Name:	Sex:	Date of Birth:	Relation to Patient:
Subscriber Address (if different from Patient's):	City:	State:	Zip Code:

ALLERGY HISTORY

- ☐ None
- ☐ Acetaminophen
- ☐ Erythromycin
- ☐ Epinephrine
- ☐ Lidocaine
- ☐ NKDA (No Known Drug
- ☐ Allergies
- ☐ Latex
- ☐ Sulfa
- ☐ Penicillin
- ☐ Aspirin
- ☐ Others:_____

MEDICATION HISTORY

☐ I am not currently taking any medications.

List any medications, vitamins, minerals, and herbals you are currently taking.

NAME OF MEDICATION	DOSAGE	FREQUENCY

FAMILY HISTORY

Has any member of your family been diagnosed with any of the following conditions (including deceased family members)? Place an "X" under the correct family member with the condition, and indicate if the family member passed away due to that condition.

CONDITION	MOTHER	FATHER	SISTER	BROTHER
Arthritis				
Asthma				
Cancer				
Congestive Heart Failure				
COPD				
Coronary Artery Disease				
Crohn's Disease				
Depression				
Diabetes Type 1				
Diabetes Type 2				
High Cholesterol				
Hypertension				
Kidney Disease				
Osteoporosis				
Parkinson's Disease				
Thyroid Disease				
Other				

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SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Separate ☐ Divorced ☐ Widowed ☐ Child

Work/Student status: ☐ Employed ☐ Self-Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Full-time student ☐ Part-time student

Have you ever been exposed to hazardous chemicals? ☐ Yes ☐ No

If yes, when:_____ what:_____

Living situation: ☐ Alone ☐ Significant Other ☐ Home Healthcare ☐ Assisted Living Facility

Assistive devices: ☐ Oxygen ☐ Wheelchair ☐ Shower Chair ☐ CPAPC ☐ Wheeled Walker ☐ Bedside Commode ☐ Nebulizer ☐ Cane

Please describe your current tobacco use :

☐ Smoker, current status unknown ☐ Light tobacco smoker ☐ Heavy tobacco smoker
☐ Current every day smoker ☐ Former smoker ☐ Never smoker ☐ Unknown if ever smoked

Do you drink alcoholic beverages? ☐ Yes ☐ No

If yes, please indicate what type of beverage and how many servings per day:_____

Do you drink caffeinated beverages? ☐ Yes ☐ No

If yes, please indicate what type of beverage and how many servings per day:_____

Have you ever used an illicit drugs? ☐ Yes ☐ No

If yes, please indicate what type of beverage and how many servings per day:_____

PAST SURGICAL HISTORY

☐ None
☐ Angioplasty (stent)
☐ Appendectomy
☐ Back Surgery
☐ Breast Cancer
☐ Carotid
☐ Endarterectomy
☐ CABG (heart bypass)
☐ Cesarean Delivery
☐ Cholecystectomy
☐ Ear Tubes
☐ Hernia Repair
☐ Hemorrhoidectomy
☐ Hip Replacement
☐ Hysterectomy
☐ Incontinence
☐ Kidney Stone
☐ Neck Surgery
☐ Prostate
☐ Sinus Surgery
☐ Thyroidectomy
☐ Tonsillectomy

Others: _____

PAST MEDICAL HISTORY

☐ None
☐ Asthma
☐ Cancer
☐ Coronary Artery Disease
☐ Crohn's Disease
☐ High Blood Pressure
☐ Kidney Disease
☐ Type 1 Diabetes
☐ Type 2 Diabetes

Others: _____

INSURANCE

If you have insurance, please present your card to the receptionist. We **CANNOT** bill your insurance without a copy of the front and back of your insurance card.

If you do **NOT** have insurance, please request a "Sliding Fee Scale Form" from the receptionist in order to set-up a payment plan. **Payment is due at the time of service.**

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HIPPA

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I consent to the use of disclosure of my protected health information by Franklin County Medical Center for the purpose of diagnosing treatment to me, obtaining payment for my healthcare bills or to conduct health care operations. I understand that diagnosis of treatment of me by Franklin County Medical Center may be conditioned upon my consent as evidenced by my signature.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Franklin County Medical Center is not required to agree to the restrictions that I may request. However, if Franklin County Medical Center agrees to a restriction that I request, the restriction is binding on Franklin County Medical Center.

I have the right to revoke this consent, in writing, at any time. Except to the extent Franklin County Medical Center and Obstetrics has taken action in reliance upon this complaint. My "protected information" means health information, including demographic information collected from me and created or received by my physician, another healthcare provider, a health plan, my employer, or healthcare clearing house. This protected health information relates to my past, present and future physical or mental health or condition and identifies me, or there is reasonable basis to believe the information may identify me.

I understand I have the right to review Franklin County Medical Center Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices of Franklin County Medical Center has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills, or in the performance of health care operations of Franklin County Medical Center. The Notice of Privacy Practices for Franklin County Medical Center is also provided in the office of Health Information. This Notice of Privacy Practices also describes my rights and Franklin County Medical Center duties with respect to my protected health information.

Franklin County Medical Center reserves the right to change the privacy practices that are now described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____
Patient Name (Please Print)

_____
Signature of responsible party

_____
Date

Family members okay to receive Medical Info:

_____

_____

_____

_____

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CONSENT TO TREAT

I consent to and authorize Franklin County Medical Center to furnish me, and/or my dependents, with necessary medical care. This medical care may include radiology examination, laboratory testing and other diagnostic procedures as may be required.

RELEASE OF MEDICAL INFORMATION

I consent to and authorize Franklin County Medical Center to disclose all or part of my, or my dependents, medical records to my mutually agreed upon referring physicians.

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I consent to and authorize Franklin County Medical Center to furnish medical information to any third party who may be responsible for payment of all or part of any charges incurred in this office.

I authorize my insurance company, or any responsible third party, to pay benefits directly to Franklin County Medical Center.

FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for the payment of medical charges incurred by me or my dependents, behalf at the office of Franklin County Medical Center regardless of third party coverage. Should the account be referred to an attorney of collections agency for collections the undersigned shall pay reasonable attorney's fees and collection expenses. All delinquent accounts bear interest at the legal rate.

_____

PATIENT/GUARDIAN SIGNATURE DATE

MEDICARE/MEDICAID BENEFICIARIES (if applicable)

I request that payment of authorized Medicare/Medicaid benefits be made on my behalf to Franklin County Medical Center. I authorize the holder of my medical information to release to the Health Care Financing Administration and its agents any information required to determine those benefits.

_____

PATIENT/GUARDIAN SIGNATURE DATE