COMMUNITY MEDICAL ASSOCIATES

Patient Information (Please Print) DATE:_____________

____

(Last) (First) (Middle)

Date of Birth: _______________________ Social Security #___________________

Race: ___________, Gender: Male_________ Female___________

Ethnicity: Other/Hispanic: ____________ Non Latino/Hispanic: _________________

Marital Status: Single:_____, Married: _____, Divorced: ______, Widowed: _____ .

Preferred Language:____

Preferred method of contact: Phone:_______, E-mail:______, Other: ____________

E-mail address:____

Home Address:____

(Street) (City) (State) (Zip Code)

Mailing Address: (if different from above)

____

(Street) (City) (State) (Zip Code)

Primary Phone No: __________________Work Phone:________________ Cell Phone:_____________

Emergency Contact Name: ____

Emergency Contact Phone #: ____

Relationship to Emergency Contact: ____

Employment Information:

Employment Status: Full time _____ Part time ______ Retired ______ Disabled ______

Full Time Student ______ Part Time Student _______

Retirement Date: ____

Occupation: ____

Employer Name: ____

Employer Address: ____

(Street) (City) (State) (Zip Code)

Employer Phone No:____

Guarantor Information (Responsible for payment): ***Patients' 18 years and older will be made their own guarantor unless otherwise noted.

Guarantor Name: ____

Relationship to Patient:____

Date of Birth: _________________ Social Security #: _______________________________

Guarantor Address:____

(Street) (City) (State) (Zip Code)

Guarantor Primary Phone #: ____

Guarantor Employer: ____

Guarantor Work Phone #:____

Insurance Information:

Primary Insurance

Name of Primary Insurance Company:____

Policy #: ____________________ Group #:____

Insured's Name:____________________________ Date of Birth: ____________________

Social Security #:____

Patient's Relationship to Insured: _______Self, _______Spouse, _______Child.

Secondary Insurance

Name of Secondary Insurance Company:____

Policy #: ____________________ Group #:____

Insured's Name:____________________________ Date of Birth: ____________________

Social Security #:____

Patient's Relationship to Insured: _______Self, _______Spouse, _______Child.

Tertiary Insurance

Name of Tertiary Insurance Company:____

Policy #: ____________________ Group #:____

Insured's Name:____________________________ Date of Birth: ____________________

Social Security #:____

Patient's Relationship to Insured: _______Self, _______Spouse, _______Child.

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Community Medical Associates

Treatment and Financial Policies

Thank you for choosing Community Medical Associates for your healthcare needs. We are sincerely committed to providing you with the best possible care. Your understanding of our financial policy is a necessary part of our treatment program. We have outlined the most common financial/insurance issues for your convenience. If you need further information, please ask to speak with the Clinic Office Manager or Community Medical Associates Practice Manager at 706-678-5982.

Consent for Treatment: The undersigned hereby authorizes the Hospital Authority of Wilkes County d.b.a. Community Medical Associates to furnish the necessary treatments, surgical procedures, lab procedures, drugs, and supplies as may be ordered by the provider for the named patient. Behavioral Health Services are available and are included within the primary care services offered at the clinic. Behavioral health symptoms or diagnostic information will be available to your primary care provider and used in the overall medical and behavioral health treatment.

Insurance: You must provide your insurance card each visit at check in. Your medical insurance coverage is a contract between you and your insurance company. If you are not sure whether or not your insurance will pay for a particular service, you should check with your insurance company prior to having the service provided. If you have out-of-network insurance, we will send a claim to them for you but you will be required to pay in full at the time of service. Co-pays must be paid at check in. If you are not prepared to pay your co-pay at the time of your visit, we reserve the right to reschedule your appointment at our earliest convenience. It is considered insurance fraud for us to see you without you paying the co-payment. Additionally, your insurance requires us to collect. If you do not have insurance, payment in full is expected at the time of service. We accept cash, checks, and credit cards.

Billing: We file your insurance for you as a courtesy. Anything not covered by your insurance is your responsibility. You will receive a bill from us for any balance unpaid by your insurance company. The balance is due upon receipt of the bill. If you need to set up payment arrangements, it is very important that you call us promptly to arrange this. Balances are considered past due 28 days after you receive your first bill and are transferred to our in-house collections department at this point. If we send three statements with no response from you, we reserve the right to cancel any appointments you have scheduled and we may obtain the services of an outside collection agency to collect your balance. In this case, any fees we occur will be added to your balance, upon Community Medical Associates discretion.

Lab Services: If your insurance company requires your lab work to go to a specific lab, it is your responsibility to inform our staff. If you do not tell us where to send your lab work, it will be sent to the lab of the clinics choice. Any cost associated with lab work sent to an out of network lab will be the responsibility of the patient.

Missed appointments: Community Medical Associates reserves the right to charge a fee of $25.00 for missed appointments that you have not provided notification to our office 24 hours in advance. Multiple missed appointments can lead to termination of a patient from our practice upon physician discretion.

Forms/Paperwork: Forms and paperwork, including but not limited to disability and FMLA, will be filled out for you for a $15.00 charge for the first 2 forms. Any additional forms will be $10.00 each. Payment is due at the time of the request. Paperwork is completed as time permits and you will be notified when it is complete.

I have read and understand the financial policy of the practice and I agree to be bound by its terms.

______________________________ Signature of Patient or Responsible Party

______________________________ Date

______________________________ Please Print the Name of the Patient

______________________________ Date of Birth

Community Medical Associates

Azalea Patient Portal

Please initial to indicate selection:

_______ I would like to connect with my doctor using the Azalea Patient Portal. I understand that I will have access to certain medical information and be able to send messages to my doctor and set appointments. I understand that it is my responsibility to notify Community Medical Associates if I change my email address.

Email: ______________________________ Phone: ________________________________

*** The office staff will enter the email above. Once the email is entered, you will receive an invitation via the email above to join Azalea Healthcare and will be given access to your Azalea medical record. Your user name will be the email above. Please maintain all username and password in a secure location.

***I understand that it is my responsibility to notify Community Medical Associates if I change my email address.

_______ I would like to decline the ability to connect with my doctor using the Azalea Patient Portal. I understand that I can join the portal at any time in the future.

Patient Name: ______________________________________

Signature: ____ Date: ________________________

Relationship to patient: ______________________________

MR#: ___________________

COMMUNITY MEDICAL ASSOCIATES

MEDICAL HEALTH HISTORY FORM

PATIENT NAME: ____________________

DOB: ____________________

PLEASE COMPLETE ALL PAGES OF THIS FORM

PHARMACY INFORMATION

Pharmacy Name:	Address:	Phone #:

CURRENT MEDICATIONS

PLEASE LIST ALL PRESCRIBED/OVER THE COUNTER MEDICATIONS, VITAMINS, DIETARY SUPPLEMENTS, ETC. THAT YOU ARE CURRENTLY TAKING.

Name of Drug/Strength	Dosage (# of pills)	Taken How Often	Reason

ALLERGIES

DO YOU HAVE ANY ALLERGIES TO THE FOLLOWING? CHECK IN BOX IF YES, AND PLEASE LIST REACTION.

	ALLERGY	REACTION
[ ]	PENICILLIN	
[ ]	AMOXICILLIN	
[ ]	SULFA	
[ ]	ASPIRIN	
Other		
Other		
Other		
Other		

	ALLERGY	REACTION
[ ]	LATEX	
[ ]	ERYTHROMYCIN	
[ ]	EPINEPHRINE	
[ ]	CODEINE	
Other		
Other		
Other		
Other		

PERSONAL MEDICAL HISTORY

DO YOU HAVE NOW (CURRENT) OR HAVE YOU HAD (PAST) ANY OF THE FOLLOWING CONDITIONS OR TREATMENTS? [ ] NONE

CONDITION/TREATMENT	CURRENT	PAST
AIDS		
ALCOHOL/DRUG ABUSE		
ALLERGIES		
ANEMIA		
ANXIETY		
ARTHRITIS		
ASTHMA		
BLOOD DISEASE		
BLOOD CLOTS		
CANCER: LIST TYPE		
CHEMOTHERAPY		
COUGH, PERSISTENT		
COUGH UP BLOOD		
CHRONIC PAIN: LOCATION		
DEPRESSION		
DIABETES		

CONDITION/TREATMENT	CURRENT	PAST
HEART PROBLEMS		
HEMOPHILIA		
HEPATITIS		
HIGH BLOOD PRESSURE		
HIGH CHOLESTEROL		
HIV		
INCONTINENCE		
KIDNEY DISEASE/FAILURE		
KIDNEY STONES		
LIVER DISEASE		
MEMORY DIFFICULTIES		
PSYCHIATRIC CARE		
RADIATION TREATMENT		
SHORTNESS OF BREATH		
STOMACH ULCER		
STROKE		
SWELLING: FEET OR ANKLES		

PERSONAL MEDICAL HISTORY (CONTINUED)

DO YOU HAVE NOW (CURRENT) OR HAVE YOU HAD (PAST) ANY OF THE FOLLOWING CONDITIONS OR TREATMENTS? [ ] NONE

CONDITION/TREATMENT	CURRENT	PAST
DIZZINESS/FAINTING		
EPILEPSY/SEIZURES		
FAINTING		
FALLS, FRACTURED HIP, ETC.		
GLAUCOMA		
HEADACHES/MIGRAINES		
HEART MURMUR		

CONDITION/TREATMENT	CURRENT	PAST
THYROID PROBLEMS		
TONSILLITIS		
TUBERCULOSIS		
VENEREAL DISEASE		
OTHER: PLEASE LIST		

HEALTH MAINTENANCE SCREENING TESTS

LIPID (CHOLESTEROL) DATE: ABNORMAL? [ ] YES [ ] NO

COLONOSCOPY DATE: POLYP? [ ] YES [ ] NO

WOMEN ONLY:

MAMMOGRAM DATE: ABNORMAL? [ ] YES [ ] NO

PAP SMEAR DATE: ABNORMAL? [ ] YES [ ] NO

FAMILY HISTORY

PLEASE INDICATE IF A FAMILY MEMBER HAS/OR HAS HAD ANY OF THE FOLLOWING AND PLEASE LIST RELATIONSHIP (Ex. Mother, Father, etc.)

	CONDITION/ILLNESS	RELATIVE
[ ]	ALCOHOL/DRUG ABUSE	
[ ]	BLEEDING DISORDER	
[ ]	CANCER: LIST TYPE	
[ ]		
[ ]		
[ ]		
[ ]	DIABETES	
[ ]	HEART ATTACK	
[ ]	HEART DISEASE	

	CONDITION/ILLNESS	RELATIVE
[ ]	HIGH CHOLESTEROL	
[ ]	HIGH BLOOD PRESSURE	
[ ]	KIDNEY DISEASE	
[ ]	LIVER DISEASE	
[ ]	MENTAL ILLNESS	
Other		
Other		
Other		
Other		

SURGICAL HISTORY

PLEASE CHECK OFF ANY PROCEDURE OR SURGERIES. LIST ANY ABNORMAL FINDING OR COMPLICATIONS. [ ] NONE

PROCEDURE	YEAR	COMMENTS:
[ ] APPENDECTOMY		
[ ] BACK SURGERY		
[ ] BIOPSY (LOCATION)		
[ ] CARDIAC STENTS		
[ ] CAESAREAN SECTION		
[ ] EGD		
[ ] GALLBLADDER		
[ ] HIP SURGERY		

PROCEDURE	YEAR	COMMENTS:
[ ] HYSTERECTOMY		
[ ] KNEE SURGERY		
[ ] VASECTOMY		
[ ] PACEMAKER		
[ ] PROSTATE		
[ ] HEART SURGERY		
[ ] OTHER:		
[ ] OTHER:		

OTHER ILLNESSES, HOSPITALIZATIONS, OR OPERATIONS (NOT LISTED PREVIOUSLY)

YEAR	PLACE	ILLNESS, INJURY, OPERATION	DOCTOR

OTHER PHYSICIANS INVOLVED IN YOUR CARE

DOCTOR'S NAME	ADDRESS	PHONE #:

SOCIAL HISTORY

CURRENT WORK STATUS: [ ] FULL TIME [ ] PART-TIME [ ] RETIRED [ ] DISABLED [ ] UNEMPLOYED [ ] STUDENT

OCCUPATION OF PROFESSION (OF PATIENT): ______________________________

DO YOU EXERCISE REGULARLY? [ ] YES [ ] NO

WHAT KIND OF EXERCISE? ______________________________

HOW LONG? ______________ HOW OFTEN? ______________

CURRENT SMOKER? [ ] YES [ ] NO PACKS/DAY: ______________ # OF YEARS: __________

FORMER SMOKER? [ ] YES [ ] NO PACKS/DAY: ______________ # OF YEARS STOPPED: __________

DO YOU DIP/CHEW ? [ ] DIP [ ] CHEW AGE STARTED ________ NUMBER OF PACKS/POUCHES PER DAY__________

DO YOU VAPE [ ] YES [ ] NO AGE STARTED ________ HOW MANY TIMES PER DAY__________

DO YOU DRINK ALCOHOL? [ ] YES [ ] NO # OF DRINKS/WEEK: ________ [ ] BEER [ ] WINE [ ] LIQOUR

HAVE YOU EVER USED OR ARE YOU CURRENTLY USING ANY ILLICIT DRUGS? [ ] YES [ ] NO

HOW WOULD YOU DESCRIBE YOUR HEALTH? [ ] GOOD [ ] FAIR [ ] POOR

HAVE YOU COMPLETED AN ADVANCE DIRECTIVE FOR HEALTHCARE (ADHC), LIVING WILL, OR POLST (PHYSICIAN ORDERS OF LIFE SUSTAINING THERAPY?

(CIRCLE ABOVE ALL THAT APPLY) [ ] YES [ ] NO

SIGNATURE OF PATIENT/ GUARDIAN: ______________________________ DATE: ________

SIGNATURE OF PRACTITIONER REVIEWING HEALTH HISTORY: ______________________________ DATE: ________