Heritage Family Medicine
P. O. Box 617 / 12205 County Line Road, Suite B
Madison, AL 35758

Date ___________________

Patient Information

Patient's Name ____
Last Name First Name Middle Name Name you go by

Street ____

City, State_________________________ Zip ____________ Home Phone ____________________Cell Phone ____________________
Include area code Include area code

Sex_______ Birth Date ___________________ Age ____ SSN ___________________ Driver's Lic. # ______________ Marital Status ______________
mm/dd/yyyy

Patient's Employer ______________________________ Occupation ________________________ Work Phone ___________________________
Include area code

Spouse's Name ____
Last Name First Name Middle Name Name goes by

Spouse's Employer ___________________________Occupation ________________________Work Phone ___________________________
Include area code

Emergency Contact

Contact's Name _____________________________________ Relationship _______________________ Phone __________________________
Include area code

Referred By/ Email Address

Referred By ____

Email Address: ____________________________ May we add you to our email list? ___yes ___no

Insurance Information

Insurance #1____

Group # ________________________ Contract # ___________________________ Co-pay _________________________

Name of Insured ____ Relationship to Patient ______________________

Sex _______ Birth Date _________________ SSN ____
mm/dd/yyyy

Insurance #2 ____

Group # ____________________________ Contract # ______________________ Co-pay _________________________

Name of Insured ____ Relationship to Patient ______________________

Sex _______ Birth Date _________________ SSN ____
mm/dd/yyyy

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Medical History - Confidential

Circle any medical symptoms you are currently having.

General
Chills
Depression
Dizziness
Fainting
Fever
Forgetfulness
Headache
Loss of sleep
Loss of weight
Nervousness
Numbness / Tingling
Sweats

Gastrointestinal
Appetite changes
Bloating/gas
Excessive thirst
Constipation
Diarrhea
Hemorrhoids
Vomiting
Vomiting blood
Stomach pain
Indigestion
Nausea
Rectal bleeding

Ear, Nose, Throat
Visual disturbances
Hay fever
Hoarseness
Difficulty swallowing
Sore throat
Ear pain or discharge
Allergies
Ringing in Ears
Loss of hearing
Sneezing/Runny nose
Nose bleeds
Congestion

Men Only
Breast lump
Erectile difficulties
Lump in testicles
Penile discharge
Sore on penis
Other_________

Women Only
Abnormal pap smear
Bleeding between periods
Breast Lump
Extreme menstrual pain
Hot flashes
Nipple discharge
Painful intercourse
Vaginal discharge
Other________________
Date of last period_________
Date of last pap _________
Date of last mammo_____
Are you pregnant?_________
Number of Children?______

Muscle/Joint/Bone
Pain, weakness, numbness in:

Arms	Hips
Back	Legs
Feet	Neck
Hands	Shoulders

Cardiovascular
Chest pain
High blood pressure
Irregular heart beat
Low blood pressure
Poor Circulation
Rapid heart beat
Swelling in ankles
Varicose veins

Skin
Bruises easily
Hives
Itching
Change in moles
Rash
Scars
Sore that won't heal
Boil / Abscess - location _________

Genito-Urinary
Blood in urine
Frequent urination
Lack of bladder control
Painful urination

Chronic Conditions *Circle any previous or chronic conditions you currently have or have had.*

Asthma	Chemical Dependency	High Blood Pressure	Prostate Problem
Alcoholism	Chest Pain	High Cholesterol	Psychiatric Care
Allergies	Chicken Pox	HIV positive	Reflux (GERD)
Anemia	Chronic Pain	Kidney disease	Spinal Bifida
Appendicitis	Diabetes	Liver disease	Stroke
Arthritis	Emphysema / COPD	Migraine headaches	Suicide Attempt
Anorexia / Bulimia	Epilepsy	Miscarriage	Thyroid problems
Benign Tumors	Glaucoma	Mononucleosis	Tonsillitis
Bleeding disorders	Goiter	Multiple Sclerosis	Tuberculosis
Breast Lump	Gout	Neurological Problems	Tobacco addiction
Bronchitis	Heart Attack	Organ Transplants	Ulcers
Cancer	Heart disease	Osteoporosis	Vaginal infections
Cataracts	Hepatitis	Pacemaker	Venereal Disease (STD)
Cerebral Palsy	Hernia	Polio	Other _____________________

Current Medications and dosages: ____

____

____

Drug or Food Allergies (please specify) ____

____

Preferred Pharmacy ____________________________ Phone__________________________

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Family History

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				
Grandparents				

Circle if your blood relatives had any of the following:

Disease	Relationship to you
Allergies/Hay fever	
Arthritis / Gout	
Asthma	
Cancer (type) ________	
Diabetes	
Heart Attack	
Heart Disease	
High Blood Pressure	
High Cholesterol	
Kidney Disease	
Stroke	
Tuberculosis	
Other	

Hospitalizations & Surgeries

Hospital	Date	Reason for Hospitalization

Pregnancies

Year	Sex	Complications/Vaginal/C-Sect.

Have you ever had a blood transfusion? Yes No

If yes please give approximate dates. ______________________

Serious illness or injuries	Date	Outcome

Habits	How often used
Alcohol	
Tobacco	
Caffeine	
Street Drugs	
Other	

Occupational *Circle if your work includes to you any of the following.*

Stress **Hazardous Substances** **Heavy Lifting** **Other**

Occupation____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if myself or my child ever has a change in health.

____ ___________

Signature of Patient, Parent, Guardian or Personal Representative Date

____ ___________

Please print name of Patient, Parent, Guardian or Personal Representative Date

I understand that my insurance is filed as a courtesy and that I am responsible for payment of all services rendered. I authorize this office to release to the Social Security Administration or its intermediaries or other insurance carriers any information needed to secure payment. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the physician. This authorization is valid for any claim / billing for services rendered. I agree to be responsible for all attorney and/or collection fees in the event such costs are incurred in the collection of the debt. The total balance is due at the time services are rendered with allowance for insurance coverage approval and verification.

____ ___________

Signature of Patient / Guardian Date

HERITAGE FAMILY MEDICINE INFORMATION AND POLICIES

In order to make your transition to our practice as simple as possible we have policies that you will need to read and sign. We look forward to serving you as our patient.

Heritage Family Medicine Providers:

- **Dr. Dawn Mancuso**
- **Dr. Cindy McAdams**
- **Dr. Ashley Burchfield**
- **Shelley Whitney, C.R.N.P**

Office hours are from 8:00 a.m. – 4:30 p.m. Monday thru Friday with lunch from 12:00 – 1:00 pm. We provide on-call services after hours for emergencies only. In the event of an emergency call our office number and our answering service will contact the Provider on call.

PRESCRIPTION REQUESTS REQUIRE 24-48 HOUR NOTICE. Any routine medication refills will be called in during regular office hours only so that we can have your medical record available.

After hour's prescription requests: Prescriptions will be called in at the discretion of the physician. **NO NARCOTICS OR CONTROLLED SUBSTANCES WILL BE CALLED IN PERIOD. A call in medications will be subject to a $25.00 fee.**

We prefer good quality preventive medicine to emergency only care. This is better medical care for you and your family. Please make an effort to establish with your caregiver a standard routine for medical care appropriate for your age and medical history. We are familiar with up-to-date standards for good health care for our patients.

Your insurance will be filed for you as a courtesy. Please be familiar with the terms and policies of your insurance plan. If you have a deductible, which has not been met, or your insurance deems your visit as a non-covered service you will be responsible for the balance. **The terms of your insurance policy are between you and your insurance company.** All co-payments are due prior to service. No exceptions. Any credit on your account will be applied to future visits. Collection fees will be charged if your account is in arrears.

There will be a $25.00 charge on all returned checks. Only cash or money orders will be accepted when picking up a bad check. No exceptions. If you miss an appointment without notifying the office staff at least one hour prior to your appointment, a $25.00 fee will be charged to your account. If you arrive more than 20 minutes late for your appointment, you may be asked to reschedule in order to be fair to the other patients who arrive on time. In the same regard, we make our best effort to see our patients at the time of their appointment, but in the event of an unforeseen medical situation, please understand that if we are running behind, you will received your Providers best care as soon as possible. We appreciate your patience.

All patients will need to bring their current drivers license or photo ID and an updated insurance card. If you do not bring your updated insurance card, you will be expected to pay in full. Your insurance company depends on accurate information. Incorrect information can result in the denial of your claim and incorrect contact information can result to use of a credit agency to locate you. In the case of divorced parents, the primary care giver will be responsible for any co-payments or balances not covered by insurance unless legal documentation is provided showing otherwise.

Having read the above, I agree to abide by the policies set by **HERITAGE FAMILY MEDICINE.** I realize that all charges incurred by me and my dependents are my financial responsibility and all court fees, attorney fees, or other fees necessary to collect any past due balances are my responsibility. Failure to follow these policies could result in my immediate dismissal as a patient. I confirm that the information that I have provided is true and correct. I have signed these policies of my own free will and in my right mind.

Patient Signature____ **Date:** __________________________

YOUR RIGHT TO PRIVACY

We at **HERITAGE FAMILY MEDICINE** respect your right to privacy. Therefore, our Providers and staff will only access and use your Protected Health Information *(PHI)* for treatment, payment, and healthcare operations such as:

1. To provide your care here in our office
2. To collect payment from your insurance company.
3. To assist your pharmacy in filling your prescriptions.
4. Your records will be sent to any physician that we refer you to. It is important that your care be coordinated with all of your doctors.
5. When a minor reaches the age of fourteen, we can no longer discuss the child's private medical information with a parent without the child present or a written consent from the child. The exception is as follows: if a child seeks medical treatment and wishes to use the parent's insurance policy, it is the policy holder's right to know what their insurance company has been billed for. If the child does not wish for the policy holder to be given that information, they must pay cash up front for that visit.

All other releases of your personal information will only be with your permission and authorized by a signature from you. **THIS INCLUDES YOUR IMMEDIATE FAMILY UNLESS OTHERWISE DESIGNATED BELOW.** In the event of an emergency, we will contact your designated emergency contact.

You have the right to review or request copies of your records at any time. We request a 48 hours notice to allow us to accommodate you.

I give permission for personal information to be left on my answering machine at the following number ________________________________.

I authorize the staff of **HERITAGE FAMILY MEDICINE** to discuss my care with the following persons:

____ Relation ________________________________

____ Relation ________________________________

I understand and consent to the use of my protected health information for the above purposes.

Signature ____ Date: __________________

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Messages left for our office will be returned **within one to two business days**.

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