Patient Name: ____ Date: _____/_______/______

Date of Birth: ______/_______/_______Occupation: ______________________________

Primary Phone: (__________)_________-___________ Mobile Work Home

Secondary Phone: (__________)_________-__________ Mobile Work Home

Email: ___________________________________ Guardian (if Minor): ___________________________

Address: ____

City, State, Zip: ____

May we leave medical information on your voicemail? Yes No

Emergency Contact: ______________________________ Relationship: ________________

Emergency Contact Phone Number: (__________)_________-___________

In the event we cannot reach you, can we leave medical information with your emergency contact? Yes No

Please Read and Initial Each Statement

I authorize payment of my medical insurance benefits to Weston Family Medicine, LLC. I understand that it is my responsibility to be aware of my insurance coverage, including but not limited to, the healthcare provider's participation in my particular plan and that I am financially responsible for any balance *not covered* by my health carrier. ________________

I authorize Weston Family Medicine, LLC to release any medical information that might be necessary for my medical care or in processing my medical claims. ________________

I am aware that often times the healthcare provider will request an office visit to discuss abnormal results. Otherwise a message from the healthcare provider will be relayed by the medical office staff. If I have any questions, regarding that message, an office visit with the healthcare provider is recommended. ________________

No referrals will be issued without 7 business days notice. My healthcare provider must examine me and determine that a referral is necessary. ________________

If I miss an appointment, or cancel without 24 hours notice, it will be my responsibility to rescheduled the appointment and pay the **$25.00 NO SHOW FEE**. ________________

Should my account default to collections, I will assume all costs pertaining to, but not limited to, court costs, interests, and legal fees. ________________

I am aware that during an office visit my medications are prescribed in an amount equal to the amount I will need until my next office visit. My healthcare providers ask that I bring all of my medications, or an updated list of medications and dosages, to my appointments as it is crucial to proper medical treatment. ________________

If after an appointment, my symptoms worsen or do not improve, it is my responsibility to make an appointment to return to the office or go to the Emergency Room. Failure to follow instructions can result in health or serious injury. ________________

I am aware that my healthcare provider will make only 3 attempt to reach me with important test results. It is my responsibility for updating all of my contact and insurance information for better communication with the office of Weston Family Medicine. ________________

By signing my initials and a smiley face, I acknowledge that I have read and agree to the above. ______________

____ ______/_________/________

Patient Signature (Parent or Guardian) **Date**

Date: ____/________/________ Referred By: ______________________________

Patient Name: ______________________________ Occupation: ______________________________

Medical Problems: ____

____

Allergies: ______________________________ Reaction: ______________________________

______________________________ ______________________________

Current Medication: ______________________________ Reason Taken: ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Surgeries: ____

Exercise (Type and Frequency): ____

Current Smoker? Y N If yes, how may packs daily? ____________ For how many years? ____________

Former Smoker? Y N How many packs daily? ________ How many years? _______ Year quit _______

Alcohol: How many drinks per **WEEK**? __________ Caffeine: How may cups per **DAY**? __________

Marital Status: Single Married Divorced Widowed

Last Tetanus Shot: ______________________________ Last Pneumonia Shot: ______________________________

Last Eye Exam: ______________________________ Last Colonoscopy: ______________________________

Shingles Vaccine: Y N Last Skin Exam: ______________________________

Last Mammogram: ______________________________ Last Pap Smear: ______________________________

Last Menstrual Cycle: ______________________________ # of Pregnancies: ______________________________

# of Children: ______________________________ # of Siblings: ______________________________

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Does your family have a history of…?

Disease	Details	Relationship to Patient	Age Diagnosed
Cancer			
Diabetes			
Depression			
Heart Disease			
High Cholesterol			
Hypertension			
Other (please specify)			

Although it is our policy to recommend yearly physicals for screening and health maintenance, please be aware that some insurance companies do not cover preventative lab, counseling or office exams. In this case you will be responsible for charges incurred. This office cannot be sure what your insurance plan covers.

A comprehensive physical exam, as covered by insurances, includes only screening and preventive health. Your other health issues and new medical problems MUST be addressed at a separate office visit.

I acknowledge the information and accept financial responsibility for any non-covered services rendered.

If you have ANY concerns beyond the scope of a well-care visit, then additional charges will be incurred for those services. Alternatively you can book another visit to address these concerns.

____   _______/_________/__________

Printed Name   Date

____

Signature

Please write in problems which have bothered you since your last physical with us, so that you and your provider can establish a separate visit to address these concerns. Chronic problems which have already been addressed, here or elsewhere, need not be indicated.

General: change in weight, appetite, fever, fatigue

Ear, Nose, Throat: hearing loss, dizziness, earache, sore throat, nose bleeds

Heart, Lungs: chest pain, shortness of breath, swelling, palpitations, wheezing, cough

Gastrointestinal: change in bowel habits or consistency, abdominal pain, nausea, heartburn, blood in stools

Genitourinary: pain during urination, genital sores, difficulty urinating, irregular discharge

Musculoskeletal: joint pain, muscle pain, stiffness

Skin: rash, lumps, new or changing moles

Neurological: frequent headaches, numbness, weakness

Psychological: depression, anxiety, panic, irritability

Other:

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Definition of a Physical

Commercial insurance companies and Medicare have defined a physical, or well-care visit, as a visit for preventative care. These recommendations apply to healthy people without disease or physical symptoms. **If you have ANY concerns beyond the scope of a well-care visit, then additional charges will be incurred for those services. Alternatively you can book another visit to address these concerns.**

What is a Well-Care Visit?

Yes	No
A review of your current health and medical history	Treatment or consultation for a specific medical condition
Counseling about ways to improve your health	Recommendations for treats a new symptom
A physical exam tailored to your preventive care needs	Disease care/ management
Immunization and medication refills for current medical conditions	Treatment for a cold

Your scheduled appointment today is for an Annual Exam, which is a well-care visit. Wellness exams are often covered 100% by your insurance provider. This is for the purpose of insuring that all the recommended health screening tests and procedures have been done. These annual visits are not normally for testing conditions or disease. Unfortunately, it is impossible of rush to know your contract; we cannot advise your on your insurance billing policy.

* If you are uncertain of your coverage, please contact your insurance company regarding your benefits.

I fully understand the meaning of a well-care visit and agree to pay the healthcare providers of Weston Family Medicine for this service if my insurance company denies my claim.

____   _______/______/______

Print Name   **Date**

____

Signature of Patient or Guardian

Weston Family Medicine

Weston Family Medicine
2300 North Commerce Parkway
Suite 313
Weston, FL 33326

Patient Name: ____ Date: ____________
Address: ____ Apt # : __________
City: ____________________ State: ____________________ Zip: ____________
Cell Phone: __________________________ Home Phone: ______________________
Email: ____

Pharmacy: ____
Pharmacy Phone Number: ____
Pharmacy Address: ____

Emergency Contact: ____
Cell Phone: __________________________ Home Phone: ______________________
Relationship to patient: ________________________________
Can we talk to the above person regarding your medical information? Yes No
May we discuss PHI, or Personal Health Information, with this person? Yes No

Secondary Emergency Contact: ____
Cell Phone: __________________________ Home Phone: ______________________
Relationship to patient: ________________________________
Can we talk to the above person regarding your medical information? Yes No
May we discuss PHI, or Personal Health Information, with this person? Yes No

Insurance Verification

Patient Name: ______________________________ Date: ____/____/____

Insurance Company: ____________________ Name of Insurance Agent: ______________

Policy Subscriber: ____________________ Relationship to Patient: ______________

Group Number: ____________________ Policy ID Number: ______________

Policy Subscriber's Date of Birth: ____/____/____ Effective Date of Policy: ____/____/____

Is there a deductible? Y N Co-payment/Co-insurance? Y N How Much? ________

Maximum number of visits per year: ____________ Dollar amount per year: ____________

Are routine physicals, sick visits, vaccinations, and women's well visits covered? ____________

Is Weston Family Medicine in Network? Y N

Secondary Insurance (if applicable)

Insurance Company: ____________________ Name of Insurance Agent: ______________

Policy Subscriber: ____________________ Relationship to Patient: ______________

Group Number: ____________________ Policy ID Number: ______________

Financial Policy of Weston Family Medicine, LLC

Regardless if you are self pay or using insurance, you are always ultimately responsible of your bill. Weston Family Medicine expects payment at the time of service, so please make arrangements to pay when you arrive for your appointments.

Responsibility of Weston Family Medicine

We will verify your insurance benefits
We will bill your insurance for you as a courtesy
We will correct any errors we have made when there is a billing dispute

Responsibility of Patient

Please know and understand your insurance coverage
Please pay your deductible, coinsurance or copayment at the time of your treatment
Please check to see that you are covered for the visit you are bing seen for
Please follow up promptly with claims that are not paid by your insurance company or you will be billed directly for them.
Please make any cancellations with at least 24 hours notice or you may be billed for an office visit.

Patient Signature: ______________________________ Date: ____/____/____