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: _____

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:

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
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: _____/_____/_____