MULTICARE MEDICAL CENTER

CONFIDENTIAL PATIENT INFORMATION

The following information is needed for our files so we can better serve you as a patient. Please fill in all portions of this form. If you need any help, please ask the receptionist.

DATE :_____

First Name: _____ MI: _____ Last Name: _____

Address: (No P O Boxes)_____City: _____ST: _____Zip_____

SSN: _____ Home Phone: _____Cell Phone:_____Work Phone:_____

Marital Status: M S D W **Date of Birth**:_____ **AGE**_____ **Sex**: M F

Religion:_____ Race: _____ Ethnicity:_____

Preferred Language: _____ ☐ **Check box if you prefer not to answer.**

E-mail address_____ (If you'd like to receive confirmation e-mails and access to YOUR medical records online.)

Occupation:_____**Employer:**_____ FT PT

Company Address: _____City: _____ ST: _____ Zip_____

Family Physician: _____ Phone #: _____

Address: _____City: _____ST: _____

Emergency Contact Name: _____ Phone#: _____

Preferred Pharmacy:_____ City: _____Phone :_____

Reason for Visit: Work related ____ Auto Accident____ Personal Injury____ Other_____

Date of Injury:_____

POLICYHOLDER INFORMATION IF DIFFERENT THAN PATIENT

Name: _____DOB:_____SSN#_____Relationship_____

Employer: _____Occupation: (FT PT)_____ Phone #: _____

Address: _____ City: _____ ST: _____ Zip:_____

INSURANCE PLANS THAT REQUIRE REFERRALS

If you have an insurance plan that requires a referral from your primary care physician (PCP), other than a Multicare PCP, it is **your** responsibility to provide us with this referral **prior** to treatment in our office. If you do not get the proper referral for treatment in this office, you will be **solely** responsible for any balance in full for which the insurance company denies.
I understand my responsibility for providing your office with the proper referral and agree to be financially responsible for any unpaid balance incurred for failure to obtain a referral.

Patient Signature_____ Date_____

PLEASE PROVIDE THE RECEPTIONIST WITH YOUR INSURANCE & ID CARD

Medical History

Present Complaint: Why did you come to see the Doctor today?

Medical History: please check any of the following that apply to your medical history.

__Allergies	__Anemia	__ Arthritis
__Asthma	__Backaches	__Bowel Problems
__Breast Lump	__Cancer	__Chest pain/pressure
__Concussion	__Convulsion	__Diabetes
__Digestive problems	__Dizziness	__Epilepsy
__Hardening of arteries	__Urinary Bladder disease	__Skin disease/rash
__Head/spinal injury	__Heart trouble	__Hepatitis
__High blood pressure	__Impaired vision or hearing	__Kidney disease or stones
__Migraines/ headaches	__Multiple Sclerosis	__Lung disease/cough blood
__Nervousness/Depression	__ Permanent injury/illness	__Polio
__Prostate condition	__Rheumatic fever	__Seizures/Fits/Fainting
__Shortness of breath	__Sinus trouble	__Stroke
__Thyroid condition	__Tuberculosis	__Venereal Disease
__Vascular Disease	__Ulcers of the stomach	__Gout
__Extended Confinement from injury/illness	__Fracture/break/sprain/dislocation	
__Have you ever used marijuana, cocaine, LSD or other drugs?		__Lyme Disease

Explanation: please provide a brief explanation of the conditions you have checked.

_____

_____

Surgeries: list any surgeries and the date(s) of surgery.

_____

_____

Allergies: list any allergies you have. **IF NONE, WRITE NKA (**NO KNOWN ALLERGIES)

_____

_____

Medications: list all medications you are taking and the dosages.

_____

_____

Family History: list parent or grandparent(s) medical problem and/or cause of death and the age effected.

_____

_____

Social History:

Cigarette Smoker: ___Y ___N Packs per day_____How long_____

Alcohol: ___Y ___N Daily Consumption_____How long_____

Occupational History: Briefly describe your occupation and/or any hazardous exposures

_____

_____

Patient Signature:_____

Date:_____

Doctor's Signature:_____

Date:_____

MULTICARE MEDICAL CENTER

PERMISSION FOR GENERAL CARE

Permission is hereby granted to Multicare Medical Center, P.C. to perform any procedure of general care, medical treatment and/or tests that may be deemed necessary by my attending physician or the physician in charge.

Assignment of benefits and release of medical record authorization

I understand and agree that:

Any accident and health insurance policy covering me under is an agreement between the insurance company and myself, not this professional office.

I authorize the submission of all claims, on my behalf, for health insurance, Medicare or any other medical benefits, to HCFA, any Health Plans, or other third party payers. I authorize the release of any medical or other information necessary to process this claim to HCFA its agents, any Health Plan or third party payer, and any supplier of services related to my care. I also request payment of Government benefits either to myself or to the undersigned physician or supplier. (HCFA 1500).

I authorize payment from my payer(s) to the provider of services, Multicare Medical Center, P.C. for services described herein. I am financially responsible for any and all charges not covered or paid for by my payer(s). In the event of nonpayment I agree that I am responsible for any difference between clinic charges and the amount paid by an insurance carrier or third party liability, which amount is payable upon demand. I agree to pay Multicare Medical Center, P.C. all collection costs including attorney fees and court costs.

Should I suspend or terminate my care and treatment, I am responsible for any fees for professional services rendered to me, and agree to make payment for same.

_____ _____
Signature of patient, relative or guardian Date

_____ _____
Witness Date

Last Name:_____ First Name_____

DOB: _____Acct#_____

MULTICARE MEDICAL CENTER, P.C.

232 Boston Post Road
Milford, Ct 06460
Phone: (203) 876-2179

Acknowledgment of Receipt of Privacy Notice

I have been presented with a copy of **Multicare Medical Centers' Notice of Privacy Policies,** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: _____ **Date:** _____

If not signed by patient, please indicate relationship to patient (e.g.,Guardian, HealthCare Administrator)

Relationship: _____ **Date:** _____

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Internal Use Only:
If patient or patient's representatives refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time): _____

By: (name and title): _____

Patient's Last Name _____ First Name _____ Acct#_____

MULTICARE MEDICAL CENTER, P.C.
Missed Appointment Protocol

Multicare Medical Center strives to provide quality services at all times by scheduling patients in a timely manner. If a patient misses an appointment without providing proper notice, another patient is prevented from receiving care.

BECAUSE OF THE INCREASE OF MISSED APPOINTMENT, WE ARE FORCED TO INSTITUTE A CHARGE FOR THESE OCCURRENCES. A FEE OF $35 WILL BE CHARGED IF AN APPOINTMENT IS NOT CANCELLED WITHIN 24 HOURS OF THE SCHEDULED TIME.

Our new policy is as follows:

1. A member of our staff will call will call the patient within 24 hours to notify the patient that the appointment was missed. This communication will be documented.

2. If a patient cannot be reached by phone within 48 hours of the scheduled appointment, the patient will be sent a letter regarding our "NO SHOW" policy and informing them of the missed appointment and the charge incurred.

3. **After three (3) appointments missed without prior notification by the patient, Multicare Medical Center reserves the right to dismiss that offender from the practice.**

I acknowledge that I have read and understand this notice that it is the patient's responsibility to cancel and reschedule appointments and the consequences of not doing so.

Print name: _____

Signature: _____

Date: _____