Weston Family Medicine, LLC
Intake Forms

First Name_______________________________ Last Name___________________________________

Date of Birth _______________ Today's Date _______________ Gender Female Male Non-Binary

Permanent Street Address :____

City: _________________________ State: ______________________ Zip: __________________________

Email Address: ____

Home Phone Number __________________________ Cell Phone Number ___________________________

May we leave medical information on the voicemail of the above numbers? Yes No

Occupation _____________________________ Employer/School __________________________________

How do you wish us to contact you? Cell # Home # Patient Portal

Marital Status (Circle One) Single Married Divorced Separated Widowed Other

Spouse's Name (If Applicable) __________________________ Spouse's Phone #_____________________

Emergency Contact Name ___________________________________ Relationship ___________________

Can we speak to the above person regarding your personal, medical information? Yes No

Phone Number _____________________________ Alternative Number ____________________________

Primary Insurance________________________________ Policy # _________________________________

Group # ____________________________ Policy Holder's Name ___________________________________

Relationship to Patient _____________________ Policy Holder's Date of Birth ______________________

Is Weston Family Medicine your Assigned PCP? Yes No N/A

Secondary Insurance (If Applicable)________________________________ Policy #___________________

Group #__________________________ Policy Holder's Name ____________________________________

Relationship to Patient _____________________ Policy Holder's Date of Birth ______________________

Please read and sign below

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 visits, labs, counseling and 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. Other health issues and new medical problems MUST be addressed at a separate office visit.
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.
Please remember, insurance is considered a method of reimbursing the patient for fees paid to the physician and not a substitute for payment. Some companies pay fixed allowances for certain procedures; others pay a percentage of the total charges. It is your responsibility to meet deductibles, pay coinsurance fees or any other balance not paid by your insurance.

I acknowledge the information and accept financial responsibility for any non-covered services rendered.
I accept financial responsibility for charges incurred on my behalf including cost of collection (if applicable). I herby authorize Weston Family Medicine to release information to my insurance company and assign benefits directly to Weston Family Medicine. After insurance is paid any remaining balance is due and payable by me.

Patient or Guardian Signature	Today's Date
Guardian's Name	Relationship

Patient Name: ____

Date of Birth: ____________________

Date of Last Exam ______________________ Reason For Today's Visit ______________________________

Personal Medical History:			
☐Acid Reflux	☐Chronic Liver Disease	☐Heart Palpitations	☐Osteoporosis
☐Allergies	☐Clotting Disorder	☐Hepatitis	☐Pregnant Currently
☐Anemia	☐COPD	☐High Blood Pressure	☐Prostate Disease
☐Arthritis	☐Elevated Cholesterol	☐HIV Infection	☐Sexually Transmitted Infections
☐Asthma	☐GI Disorder	☐Iron Deficiency	
☐Breast Feeding	☐Gout	☐Kidney Disease	☐Sickle Cell Disease
☐Bowel Irregularity	☐Headache	☐Iron Deficiency	☐Stroke/TIA
☐Bronchitis	☐Heart Disease	☐Lactose Intolerance	☐Thyroid Disorder
☐Cancer	☐Heart Murmur	☐Post/Menopausal	

Review of Systems: (Check any that you have recently experienced)	
Cardiorespiratory	☐chest pain ☐shortness of breath ☐palpitations ☐wheezing ☐swelling of legs
Ear, Nose & Throat	☐hearing loss ☐dizziness ☐earache ☐sore throat ☐nose bleeds ☐ringing in ears ☐sores in mouth
Endocrine	☐excessive thirst ☐excessive urination ☐cold intolerance ☐heat intolerance ☐hot flashes ☐hair loss
Eyes	☐diminished vision ☐eye irritation ☐drainage from eyes ☐blurring of vision ☐loss of vision
Gastointestinal	☐nausea ☐heartburn ☐vomiting ☐difficulty swallowing ☐diarrhea ☐constipation ☐blood in stool ☐change in bowel habits or consistency ☐abdominal pain
General	☐change in weight ☐loss of appetite ☐excessive fatigue ☐fever
Musculoskeletal	☐joint swelling ☐joint pain ☐joint stiffness ☐muscle pain/ache ☐muscle weakness
Neurologic	☐frequent headaches ☐tingling/numbness ☐seizures ☐memory loss ☐difficulty walking ☐weakness
Psychological	☐depression ☐anxiety ☐panic ☐irritability
Skin	☐rash ☐new or changing moles ☐lump
Urinary	☐pain during urination ☐genital sores ☐difficulty urinating ☐irregular discharge

Surgeries/Hospitalizations		
Year	Reason	Hospital

List your prescribed drugs and over the counter drugs:			**☐Not Taking any Medications**
Drug Name	Strength/ Mg Amount	Frequency	Reason

Patient Name: ____

Date of Birth: ___________________

Allergies:	☐ **No Known Allergies**
Drug Name	Reaction You Had

Family Health History:		☐ **Adopted/Unknown**	
Relative	**Alive or Deceased**	**Age**	**Significant Heath Problems/Cause of Death**
Father			
Mother			
Sibling ☐ M ☐ F			
Sibling ☐ M ☐ F			
Sibling ☐ M ☐ F			

Screening Tests for Men and Women:		
Test	Date	Results
Colonoscopy		
Bone Density		
Rectal Exam		
Test for Blood In Stool		
Pelvic and Pap test (Women Only)		
Mammography		
PSA (Men Only)		
Eye Exam		

Social History:	
Exercise	☐ No Exercise ☐ Mild Exercise (i.e. climb stairs, walk 3 blocks) ☐ Occasional Vigorous Exercise (i.e. less than 3x/week for 30 min or less) ☐ Regular Vigorous Exercise (i.e. 4x/week or more for 30 min or more)
Caffeine	☐ None ☐ Coffee ☐ Tea ☐ Cola # of Cups/Cans per day? ___________
Alcohol	Do You Drink alcohol? ☐ Yes ☐ No If yes, what types? ______________________________ How Many Drinks per Day? ___________ How Many Drinks per Week? ____________
Tobacco	Do You Use Tobacco? ☐ Yes ☐ No ☐ Previous Smoker Year Started________ Year Quit________ ☐ Cigarettes – _____ Pks./day ☐ Chew-_____x/day ☐ Pipe-_____x/day ☐ Cigars-_____/day

Women Only:
Age at Onset of Menstruation: ________________ Date of Last Mensuration: __________________
Have you been experiencing: ☐ Heavy Periods ☐ Irregularity ☐ Spotting ☐ Pain ☐ Discharge
Number of Pregnancies: _____________ Number of Births: ___________ Number of Children:
Have you had a ☐ D&C ☐ Hysterectomy ☐ Cesarean ☐ Natural Birth
Experienced any recent breast tenderness, lumps, or nipple discharge? ☐ Yes ☐ No

Patient Name: ____
Date of Birth: ____________________

Weston Family Medicine Policies

Cancellation Policy

At Weston Family Medicine your scheduled appointment time is reserved for you. There will be a $25.00 charge if you do not cancel or reschedule your scheduled appointment with a minimum of 24 hours in advance. If you miss your appointment, it is your responsibility to reschedule that appointment. ___________ (initial)

Financial Policy

It is your responsibility to be aware of your health insurance coverage, including but not limited to, the healthcare provider's participation in your particular plan and that you are financially responsible for any balance *not covered* by your health carrier. ___________ (initial)

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

Weston Family Medicine, LLC will release any medical information that might be necessary for your medical care or in processing your medical claims, with your permission. _____________ (initial)

Follow Up Policy

Your healthcare provider may request an office visit to discuss abnormal results. Otherwise a message from the healthcare provider will be relayed by the medical office staff. If you have any questions, regarding that message, an office visit with the healthcare provider is recommended. ___________ (initial)

During an office visit your medications are prescribed in an amount equal to the amount you will need until your next office visit. Your healthcare providers ask that you bring all of your medications, or an updated list of medications and dosages, to your appointments as it is crucial to proper medical treatment. ___________ (initial)

If after an appointment, your symptoms worsen or don't improve, it's your responsibility to make an appointment to return to the office or go to the Urgent Care Failure to follow instructions can result in injury or death. ___________ (initial)

Referral Policy

You must give 5 days business notice for a referral to be approved and issued appropriately. Your healthcare provider must examine you and determine that a referral is necessary. ___________ (initial)

Medication Refill Policy

You must give 5 days business notice for a medication refill to be approved and processed appropriately. Your healthcare provider may need to examine you before issuing a refill. If this is necessary a refill will not be issued without a follow up visit. ___________ (initial)

Contact Policy

Your tests results will be relayed to you as soon as possible. Weston Family Medicine will make only 2 attempts to reach you, either by phone call and/or secured message via patient portal, with important, <u>normal test results</u>. With <u>abnormal test results</u>, Weston Family Medicine will make only 2 attempts to reach you by either a phone call and/or a secured message via the patient portal and 1 attempt by letter. It's your responsibility to update all of your contact information for better communication with the office. ___________ (initial)

With your permission Weston Family Medicine will contact you through our HIPAA compliant patient portal. We may send messages to you regarding lab results, referrals, prescription refills, and/or diagnostic results. ___________ (initial)

By signing my initials and a smiley face, I acknowledge that I have read and agree to the above. ___________ (initial)

____   ______/_________/_________

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

Patient Name: ____

Date of Birth: ___________________

Appointment Cancellation and No Show Policy

Thank you for trusting your medical care to Weston Family Medicine. When you schedule an appointment with Weston Family medicine we set aside enough time to provide you with the highest quality of care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible and no later than **24 hours** prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation and No Show Policy below:

- Effective February 1st, 2020 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours** notice will be considered a No Show and charged a **$25.00 fee**.
- Any established patient who fails to show or cancels/reschedules an appointment without 24 hours notice a **second** time will be charged **$50.00 fee**.
- If a **third** No Show or cancellation/reschedule without 24 hour notice should occur the patient may be **grounds for dismissal** from Weston Family Medicine,LLC.
- Any new patient who fails to show fo their initial visit will not be rescheduled.
- The fee is charged to the patient, not the insurance company, and is **due at the time of the patients next office visit**, if not paid prior.
- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receipt reminder call or message, the above policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, Mallory, who may be able to waive the No Show fee.

I have read and understand the Appointment Cancellation and No Show Policy and agree to its terms.

____

Patient/Guardian Signature

Patient Name: ______________________________________

Date of Birth: __________________