NARCOTIC PAIN

MEDICATIONS

DUE TO THE NATURE OF THE FOLLOWING

MEDICATIONS THE PROVIDERS OF

MCCLINTOCK FAMILY MEDICINE

WILL NOT PRESCRIBE THESE MEDICATIONS:

ATIVAN ** XANAX ** VICODIN

HYDROCODONE ** OXYCODONE

LORTAB ** METHADONE ** NORCO

SOMA ** DIET PILLS ** SLEEPING PILLS

MCCLINTOCK FAMILY MED **does not complete DISABILITY PAPERWORK.**

Patient Questionnaire

Thank you for your interest in The Leslie Clinic. In order for our providers to care for you with the best possible way we need to get your medical history. Please fill out this New Patient Questionnaire and return it to our office as soon as possible for the Providers to review.

Name: ______________________ Date of Birth: ______________
Address: ______________________ Male ☐ Female ☐
______________________ Primary Language: ______________
______________________ Ethnicity: ______________
In Case of Emergency, Notify: ______________________
Date of last Pneumonia Vaccine: ______________ Date of last Flu Vaccine: ______________

Allergies: Please list any drug, food, substances to which you have had an allergic or bad reaction.

Allergy	Reaction Experienced

Medications: INCLUDE ALL YOU HAVE TAKEN IN THE PAST 12 MONTHS!

Please list any prescription medications, over the counter medications, vitamins, herbs or nutritional supplements that you ***HAVE TAKEN IN THE PAST 12 MONTHS.***
Please include the dosage amount and the prescribing physician.

Medication Name	Dosage	How often do you take this Medication?	Prescribing Physician

Physicians & Other Healthcare Providers involved in your care: Please include former Primary Care Physicians.

Name	Telephone	Specialty

Patient Questionnaire

Medical / Surgical History: Please list an illness/Operations/Injuries and the dates on which they occurred.

Procedure/Illness	Date of Surgery/Illness began

Social History

Have you ever smoked? Yes ☐ No ☐ Packs per day? _____ How many years have you smoked? _____ Years

If you are a Former Smoker, when did you quit? ____________________

Do you use other forms of Tobacco? Yes ☐ No ☐ How often/How much? ____________________

Do you drink alcohol? Yes ☐ No ☐ How often/How much? ____________________

Do you use illegal drugs? Yes ☐ No ☐ How often/How much? ____________________

Medical History

Have you ever been treated for:

Anemia	☐	Epilepsy	☐	Liver Disease	☐
Arthritis	☐	Glaucoma	☐	Leukemia	☐
Asthma	☐	Heart Disease	☐	Lung Disease	☐
Alcohol Problems	☐	Heart Murmur	☐	Lupus	☐
Bleeding Tendency	☐	Hepatitis	☐	Rheumatic Fever	☐
Cancer	☐	High Blood Pressure	☐	Stroke/TIA	☐
Congenital Heart Problem	☐	High Cholesterol	☐	Tuberculosis	☐
Depression	☐	Jaundice	☐	Thyroid Disease	☐
Diabetes	☐	Kidney Disease	☐	Ulcers	☐

Other Health Problems: ____

____

Family Medical History

Do you have a Family History of:

Diabetes ☐ YES ☐ NO Family Member affected : ____________________

Heart Disease ☐ YES ☐ NO Family Member affected : ____________________

Hypertension ☐ YES ☐ NO Family Member affected : ____________________

Cancer ☐ YES ☐ NO Family Member affected/Type : ____________________

Kidney Disease ☐ YES ☐ NO Family Member affected : ____________________

Are your parents still living?

Father: ☐ YES ☐ NO Age at death __________ Cause of Death ____________________

Mother: ☐ YES ☐ NO Age at death __________ Cause of Death ____________________

Do you have Siblings?/How many? ☐ YES ☐ NO ________ Sisters ________ Brothers

Do you have Children?/How many? ☐ YES ☐ NO ________ Daughters ________ Sons

How did you hear about The Leslie Clinic? ____

____

PATIENT INFORMATION- PLEASE PRINT

SOC SEC #: ________-________-________

MRN#: ________

Name: ____________________________________
Last First Mid Initial

Address: ____________________

City: ____________________

State: ________ Zip Code: ________

SEX: ▯ Male ▯ Female

MARITAL STATUS: ▯ Married ▯ Single ▯ Divorced ▯ Partner ▯ Widowed Separated

PRIMARY CARE PHYSICIAN: ____________________

Home Phone: ____________________

Work Phone: ____________ Ext: ______

Cell Phone: ____________________

Date of Birth: ____-____-____ Age: ____yrs

Employer: ____________________

Work Address: ____________________

City: __________ State: ____ Zip: ______

Occupation: ____________________

Email: ____________@________

RELEASE OF INFORMATION (spouse, children, parents, etc)

Who may we discuss your information with? For example: Medical issues/care, results, billing, etc.

Name: ____________________ Relation to Patient: ____________

Name: ____________________ Relation to Patient: ____________

Name: ____________________ Relation to Patient: ____________

SPOUSE/PARENT INFORMATION

Spouse/Parent Name: ____________________

Employer: ____________________

Work Address: ____________________

City: __________ State: ______ Zip: ______

Occupation: ____________________

Cell: ____________________

Work: ____________ Ext: ______

Spouse/Parent SEX: ▯ Male ▯ Female

Spouse/Parent Date of Birth: ____/____/____

Social Sec. #: ______-______-______

EMERGENCY CONTACT INFORMATION

Emergency contact: ____________________

Address: ____________________

City: __________ State: ______ Zip: ______

Cell Phone: ____________________

Home Phone: ____________________

Relationship to Patient: ____________

GENERAL INFORMATION

Who is responsible for Payment?: ☐ Myself ☐ Other:________________ (FILL OUT BELOW)

Responsible Party Name: ______________________ Responsible Party DOB: ____/____/____

Relationship to Patient: ☐Self ☐Spouse ☐Child ☐OTHER SS#________-________-__________

Address: ______________________________ Phone#:______________________

Preferred Language: ☐English ☐Spanish ☐DECLINE OTHER: ______________

Race: ☐ White ☐African American ☐ Asian ☐ Native Hawaiian/Other Pacific Islander

☐ Native American Indian/ Alaskan ☐Hispanic ☐Unknown ☐ DECLINE

Ethnicity (Origin): ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐Unknown ☐DECLINE

PREFERRED PHARMACY: ______________ **LOCATION:** ______________

I authorize release of any medical information necessary to process my claim to all my insurance companies. I authorize direct payment of medical benefits to the provider. I permit a copy of this authorization to be used in the place of the original. I consent for my photo to be taken. I understand that I amresponsible for any amount not covered by insurance. I permit the faxing and electronic transmission of medical information to other health care providers, attorneys, or insurance companies involved in my care. I give my permission for messages to be left on my answering machine or sent by email. I, the undersigned authorize and consent to the rendering of medical care, including diagnostic procedures, and medical treatment by authorized members of The Leslie Clinic, PA, as may in their professional judgment be necessary for the above named patient. I acknowledge that no guarantees have been made as to the effect of such examinations or treatment. I have received a copy of the Privacy Practices of the clinic. I permit this facility to obtain my medication history electronically.

Patient Name:______________________________

X______________________________________
Signature (Patient or Parent/Guardian if minor)

Date: ________/________/________

Please Complete

Patient Name: ____________________

PRIMARY INSURANCE

Patient's Relationship to ***Main Policy Holder***: ☐ Myself ☐ Spouse ☐ Child ☐ OTHER: ____________

Name of Insurance Company: ____

Insurance Company Address: ____

____

City: ________________________ State: ________________ Zip: __________

ID# ________________________ Group # ____________________________

Insurance Company's Phone Number: ____________________________________

____

Main Holder's Name: ____________________

Main Holder's Address: __________________

City: ______________________________

State: ____________ Zip: ____________

Main Holder's Date of Birth: _____/_____/_____

Main Holder's Soc Sec#: _______-______-______

SECONDARY INSURANCE

Patient's Relationship to ***Main Policy Holder***: ☐ Myself ☐ Spouse ☐ Child ☐ OTHER: ____________

Name of Insurance Company: ____

Insurance Company Address: ____

____

City: ________________________ State: ________________ Zip: __________

ID# ________________________ Group # ____________________________

Insurance Company's Phone Number: ____________________________________

____

Main Holder's Name: ____________________

Main Holder's Address: __________________

City: ______________________________

State: ____________ Zip: ____________

Main Holder's Date of Birth: _____/_____/_____

Main Holder's Soc Sec#: _______-______-______

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MCCLINTOCK FAMILY MEDICINE - Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. **Knowing your insurance benefits is your responsibility**. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles**. All co-payments and deductibles must be **paid at the time of service**. This arrangement is part of your contract with your insurance company.

3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. **If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.**

5. **Claims submission**. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits

7. **Nonpayment**. If your account is **over 60 days past due**, you will receive a letter stating that you have 10 days to pay your account in full. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. You and your immediate family members will be discharged from this practice.

8. **Missed appointments**. Please help us to serve you better by keeping your regularly scheduled appointment. **Three or more No Show Appointments will cause immediate dismissal**.

9. **Discharge Policy**. This practice can discharge you for any reason. Your immediate family members may also be discharged. For 30 days our providers will only be available to you on an emergency basis only.

I have read and understand the payment policy and agree to abide by its guidelines:

______________________________ ________________

Signature of patient or responsible party Date