FAIRVIEW CLINIC, P.C.

Specializing in Internal Medicine

Doctors Building, Suite 303
1118 Ross Clark Circle
Dothan, Alabama 36301

Telephone: 334-794-3192
FAX: 334-792-7513

Earle F. Mazyck, M.D.
Christopher L. Miller, M.D.
J. Ryan Conner, M.D.
James A. Robeson, Jr., M.D.
Jeffrey H. Fadil, D.C., M.D.
Karen D. Smith, C.R.N.P.

Thank you for choosing a physician at Fairview Clinic to be your healthcare provider. We want to give each patient the amount of time necessary to address their medical concerns during appointments.

Unfortunately, we sometimes cannot predict how much time will be needed and this can cause us to run behind. In addition, there are times when emergencies at the hospital require our doctors to leave the office on the spur of the moment.

We realize that you have a schedule to keep as well. We strive to stay on time for our scheduled appointments. We aim to inform you when we are running behind. Please let the front desk know if you have waited more than twenty (20) minutes in the lobby.

In order to provide the care that you need and to respect the time of all involved, we will see patients in the following order of priority:

1. **EMERGENCIES:** patients requiring urgent attention will ALWAYS be first priority.
2. **APPOINTMENTS:** patients who have scheduled appointments will be seen in as timely a manner as possible.
3. **WORK-INS:** patients needing to be seen on any given day when there are no more appointment slots will be advised of the best time to come and be worked-in to the day's schedule.
4. **WALK-INS:** patients who walk in without an appointment and without first calling to see what time they can be worked-in, will be seen after patients with scheduled appointments as well as after those who have called ahead. We will see walk-in patients as soon as possible, but we will not *bump* scheduled patients to later times, or delay start times, admissions, ER visits, etc., to accommodate walk-in patients.
5. **LATE ARRIVALS:** patients who arrive more than ten (10) minutes after their scheduled appointment time will be treated as walk-in patients. Please arrive on time for your appointment so that we may stay on schedule for everyone.

We understand that there will be times that you will not be able to wait if we are running behind. We will be happy to assist in rescheduling an appointment if you so desire. Please feel free to speak with the front desk clerk to do so. We appreciate the opportunity to be your healthcare provider. Thank you.

USBPi REORDER #12680 (REV. 11/09)

❑ New
❑ Update

NEW PATIENT INFORMATION (and *existing* patient UPDATE)

Name _____ (Last) _____ (Suffix), _____ (First) _____ (Middle Initial)

Prefers to be called _____ (First) _____ (Last)

Mailing Address _____

City _____ ST _____ Zip Code _____ Telephone: Home ( ) _____

Cell # ( ) _____ Employer _____ Telephone: Work ( ) _____

Gender: M or F Race: _____ Marital Status: *Single Married Widow Divorced* Date of Birth _____

Are you: Retired? _____ Employed? _____ Student? _____ Disabled? _____ Social Security Number _____

Which doctor will you see here? MAZYCK MILLER CONNER ROBESON
Did someone refer you here? _____ If YES, Who? -_____

INSURANCE INFORMATION – COPAY AMOUNT $_____

Primary Insurance _____ **Secondary Insurance**_____

Primary Ins: Policy holder DOB _____ Secondary Ins: Policy holder DOB _____

Please give your insurance cards to the receptionist so copies can be made for your chart and proper billing can be handled for you.

SPOUSE INFORMATION

Name of spouse/guardian _____ Spouse/Guardian Date of Birth _____

Social Security Number _____

Employer _____ Work Phone _____

EMERGENCY CONTACT INFORMATION

In case of emergency, whom should we contact? _____ Phone _____

PLEASE READ AND INITIAL THE FOLLOWING STATEMENTS:

1. *I understand that if my insurance is not accepted by Fairview Clinic, P.C., or if I have a deductible to satisfy, or if I receive a non-covered service, I WILL BE RESPONSIBLE FOR THE PATIENT'S BILL IN FULL, including any and all interest, collection fees, court costs, legal and attorneys fees necessary.* INITIALS: _____
2. *I hereby authorize my insurance company (or companies) to pay directly to Fairview Clinic, P.C. any medical benefits otherwise payable to me.* INITIALS: _____
3. *I hereby authorize the release of any medical information necessary to process an insurance claim for me.* INITIALS: _____

Patient (or guardian) signature_____ Date_____

Place label here

ENTERED IN COMPUTER BY _____

MEDICAL HISTORY QUESTIONAIRE

Name _____ Date _____

Date of birth _____ Age _____

Please state your current medical problem _____

Are you allergic to any medicine? YES or NO If yes, what? _____

What kind of allergic reaction do you have? _____

List the medications that you currently take:	**Previous surgery or hospitalization *(list cause, year, and hospital):***

HAVE YOU RECENTLY BEEN BOTHERED WITH ANY OF THE FOLLOWING:

	YES	NO	PLEASE EXPLAIN:
Fever, chills, weight loss, poor appetite	____	____	_____
Double or blurred vision	____	____	_____
Ringing in ears or hearing trouble	____	____	_____
Sinus trouble or hay fever	____	____	_____
Headaches	____	____	_____
Throat trouble or swallowing disorder	____	____	_____
Goiter, swelling or pain in neck	____	____	_____
Chest pain or heart trouble	____	____	_____
High blood pressure	____	____	_____
Shortness of breath	____	____	_____
Cough or sputum production	____	____	_____
Indigestion, nausea or vomiting	____	____	_____
Jaundice or liver trouble	____	____	_____
Constipation or diarrhea	____	____	_____
Burning with urination, getting up at night to urinate	____	____	_____
Abnormal color in urine or kidney stone	____	____	_____
Back ache, joint ache, leg pain or ankle swelling	____	____	_____
Hives, eczema, psoriasis, frequent boils	____	____	_____
Dizzy, light-headed, fainting, seizures, loss of consciousness	____	____	_____
Numbness, tingling of an extremity, paralysis	____	____	_____
Depression, anxiety, panic attacks, difficulty sleeping	____	____	_____
Unusual thirst, increased food consumption	____	____	_____
Intolerance to heat or cold	____	____	_____
Tiredness, weakness, loss of energy	____	____	_____
Easy bruising, bleeding, lymph nodes	____	____	_____
Sneezing, itching, rash	____	____	_____