FAIRVIEW CLINIC, P.C.

Specializing in Internal Medicine

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

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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.

— " Quality Care Through Service, Education, and Patient Participation" —

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	____	____	______________

FAMILY HISTORY

Mother's age and health ____________________

Father's age and health ____________________

Brother's age and health ____________________

Sister's age and health ____________________

ARE THE FOLLOWING PROBLEMS IN YOUR FAMILY:

	Yes	No	Who?
Diabetes?	____	____	____________
Heart disease?	____	____	____________
High blood pressure?	____	____	____________
Ulcers?	____	____	____________
Cirrhosis?	____	____	____________
Cancer?	____	____	____________
Do you smoke?	____	____	How much? ____________
Do you drink?	____	____	How often? ____________

Please list any problems, concerns, or symptoms you would like to discuss with the doctor:

____

____

OSTEOPOROSIS RISK ASSESSMENT

Have you ever had a bone density study? _______ When ____________ Where ____________

Have you had hip replacement surgery? _______ When ____________ Where ____________

Do you smoke? _______ If no, did you ever smoke? _______ How long? ____________

Do you have a family history of osteoporosis? _______ Do you take steroids (cortisone)? ____________

Have you had early menopause? _______ Do you take hormones? ____________

Do you take calcium? _______ How much? ____________

Have you had an outpatient procedure done in the last 72 hours? _______ If yes, what kind? ____________

____

Do you take medication for osteoporosis or thin bones? _______ What? ____________

Have you ever fractured a bone? _______ Which bone? ____________

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HIPAA Medical Information Release for Fairview Clinic, P.C.

By signing below, you indicate you have received a copy of the Notice of Privacy Practice of Fairview clinic, P.C. with an effective date of April 14, 2003. Due to **federal privacy guidelines under HIPAA,** we are required to have a medical release of information on file for each patient. By completing the sections below, you authorize our office to release medical and health information about yourself (or your minor child) to the family members, care givers, friends, or other people designated by you. This authorizes us to share this information, after proper identification, by verbal or written communication, phone, fax, mail, or e-mail as needed for your care to those identified below. **Powers of Attorney are to be authorized by a copy of the legal POA paperwork in the patient chart.**

You have two options. Place an "x" next to your choice:

☐ **OPTION 1:** DO NOT discuss my medical care with anyone other than me.

☐ **OPTION 2:** I authorize the following individual(s) to discuss my medical and health information with you and/or your staff. This information is confidential and will be placed in my medical record. Changes to this list must be made in writing.

Name	DOB or Relationship	Phone #

Patient Signature ______________________________ Date ______________

Relationship *(if minor)*______________________________

WITNESS ______________________________ Date ______________