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.

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 _____

FAIRVIEW CLINIC

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Telephone: (334) 794-3192 • FAX: (334) 792-7513

Name: _____ Date of Birth: _____ Marital Status: S M W D
Last First Middle M D Y

How do you wish to be addressed?: _____

FAMILY HISTORY	Age	If Living, Health	Age	If Deceased, Cause	Has any blood relative ever had:	Please Circle		Relation?
Father					Cancer	No	Yes	Type?
Mother					Tuberculosis	No	Yes	
Brother or Sister 1.					Diabetes	No	Yes	
2.					Heart Trouble/Bypass Surgery	No	Yes	
3.					Pacemaker	No	Yes	
4.					Hypertension	No	Yes	
5.					Kidney Failure	No	Yes	
6.					Stroke	No	Yes	
7.					Seizures	No	Yes	
					Alcoholism	No	Yes	
Husband or Wife					Nerve Problems	No	Yes	
Children 1.					Asthma/Emphysema	No	Yes	
2.					Thyroid Trouble	No	Yes	
3.					Pernicious Anemia	No	Yes	
4.					Cirrhosis	No	Yes	
5.					Senility	No	Yes	
6.					Depression/Suicide	No	Yes	
7.					Rheumatoid Arthritis	No	Yes	

PAST HISTORY
SURGERY: List Surgical operations you have had with dates (year only) and details you know: (specify Broken bones)

_____

_____

_____

_____

PREVIOUS MEDICAL HOSPITAL ADMISSIONS: List previous medical admissions in order by date, hospital, and reason:

_____

_____

_____

_____

_____

MEDICAL HISTORY
ILLNESS: Have you had: (circle yes or no)

Pneumonia	No	Yes
Whooping Cough/Diptheria	No	Yes
Measles	No	Yes
Influenza	No	Yes
Rheumatic Fever, Polio, or Meningitis	No	Yes
Kidney Disease	No	Yes
Clap, Gonorrhea, Herpes, or Syphillis	No	Yes
Anemia	No	Yes
Tuberculosis	No	Yes
Diabetes	No	Yes
Cancer (Type)	No	Yes
Heart Attack/Valve Problems	No	Yes
Asthma, Hay Fever, or Sinusitis	No	Yes
Shingles	No	Yes
Colon Polyps	No	Yes
Ulcers	No	Yes

ALLERGIES: Are you allergic to: (circle any)
Penicillin Tetracycline Sulfa Demerol

Aspirin Codeine Morphine Mycins

Tetanus Antitoxin Serums

Are you allergic to any other drugs? ____ No Yes

What are they? _____

_____

_____

Any foods, milk, eggs? _____

PERSONAL HEALTH
Weight: Now_____ One year ago_____

Maximum_____ When was this? _____

TRANSFUSIONS: Have you ever had a blood or plasma Transfusion? No Yes
When? _____ # of units? _____

Have you ever been tested for AIDS virus? No Yes

Would you like to discuss this further? No Yes

XRAYS: Have you ever had X-rays of : (Please specify year last done)

Chest/Mammogram	No	Yes
Upper GI or Barium Enema	No	Yes
Gall Bladder	No	Yes
Cat Scan/MRI	No	Yes

ENDOSCOPY: Have you ever had:

Upper Endoscopy (Light looking into the stomach)?	No	Yes
Colonoscopy (Light looking into colon)	No	Yes

HEART TEST: Have you ever had: (Please specify year last done)

EKG	No	Yes
Stress Test (GXT)/Thallium	No	Yes
Echocardiogram/Cardiac Catheterization	No	Yes
24 Hour Holter Monitor	No	Yes

IMMUNIZATIONS: Have you had:

Flu Vaccination	No	Yes
Pneumonia Vaccination	No	Yes
Tetanus Vaccination	No	Yes
Pertussis Vaccination	No	Yes

REVIEW OF SYSTEMS: Do you now have or have you ever had? Explain.

Headaches more than 2/week _____ No Yes

Severe Dizziness or Light Headedness _____ No Yes

Pain in the eyes or Glaucoma _____ No Yes

Loss of vision or Double/Blurred vision _____ No Yes

Large blind spots in the eyes _____ No Yes

Earaches, Prolonged Ear Drainage or Hearing Problems _____ No Yes

Nosebleeds or Sinus Infection _____ No Yes

Sore gums, mouth or tongue _____ No Yes

Persistent hoarseness _____ No Yes

Frequent colds or sore throat _____ No Yes

Enlarged thyroid gland or goiter _____ No Yes

Persistent cough or Spitting Phlegm _____ No Yes

Wheezing or Asthma _____ No Yes

Chest pains or deep breathing or Pleurisy _____ No Yes

Coughing or spitting of blood _____ No Yes

Night sweats _____ No Yes

Shortness of breath on exertion _____ No Yes

Chest pain, heaviness or tightness on exertion _____ No Yes

Palpitations, fluttering or skipping of the heartbeat _____ No Yes

Swelling of the feet and ankles _____ No Yes

Varicose veins or phlebitis (blood clot) _____ No Yes

Leg cramps at night _____ No Yes

Pain in the legs or buttocks on walking _____ No Yes

Indigestion, gas, heartburn or difficulty swallowing _____ No Yes

Frequent diarrhea _____ No Yes

Pain in the abdomen _____ No Yes

Yellow jaundice _____ No Yes

Constipation requiring laxative use _____ No Yes

Change in the bowel habits _____ No Yes

Bleeding from the rectum _____ No Yes

Difficulty in urination (dribbling, hesitancy) _____ No Yes

Kidney Infection or stones, cystitis _____ No Yes

Frequent urination at night _____ No Yes

Blood in the urine _____ No Yes

Arthritis or rheumatism _____ No Yes

Bone or joint disease _____ No Yes

Skin disease, hives, eczema or psoriasis _____ No Yes

Frequent boils _____ No Yes

Fainting spells _____ No Yes

Loss of consciousness, Epilepsy or Seizures _____ No Yes

Numbness, Tingling, Weakness, or Paralysis of a limb _____ No Yes

Depression or despondency _____ No Yes

Severe anxiety, fear or feelings of panic _____ No Yes

Difficulty sleeping (Falling asleep or Staying asleep) _____ No Yes

Weight Loss _____ No Yes

Poor Appetite _____ No Yes

Chills or fever _____ No Yes

Unusual thirst _____ No Yes

Increase in food consumption _____ No Yes

Extreme tiredness, weakness, or loss of energy _____ No Yes

HABITS: Do you salt your food Before or After you taste it? _____

Coffee _____ cups per day Caffeinated? No Yes

Tea _____ cups per day Caffeinated? No Yes

Soft drinks _____ cups per day Caffeinated? No Yes

Alcoholic beverages? never ❑ rarely ❑ moderate ❑ daily ❑

Have you ever been treated for alcoholism? No Yes When? _____

Have you EVER used Tobacco? No Yes Are you using Tobacco now? No Yes

Cigarettes ❑ _____ packs per day Cigars ❑ Pipe ❑

Chewing Tobacco ❑ Snuff ❑

What year did you stop using Tobacco? _____ Why? _____

Do you exercise regularly? No Yes How many times per week? _____

When do you go to sleep? (Hour) _____ When do you wake? (Hour) _____

Do you use Laxatives? No Yes How often? _____ What type? _____

WOMEN ONLY

Menstrual History

Age at onset _____ Are you regular? No Yes

Cycle _____ days (from start to start) Usual duration _____ days

Heavy ❑ Medium ❑ Light ❑ Clots ❑

Pains or cramps? Yes ❑ No ❑ Date of last period _____

Have you ever been through Menopause? No Yes

Do you now or have you ever taken Hormones? No Yes

Hormone Type? _____ Any side effects? No Yes

Do you have Hot Flashes or Vaginal Dryness? No Yes

Pregnancies

How many children born alive? _____

How many still births? _____

How many prematures? _____

How many Cesarean Sections? _____

How many miscarriages? _____

Any complications with any pregnancy? _____ No Yes

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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 _____