FOUR RIVERS
INTERNAL MEDICINE, PLLC
3131 Parisa Dr, Paducah KY 42003

P: 270-444-8000
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NEW PATIENT INFORMATION

PRIMARY CARE PHYSICIAN:

Today's Date:	**Reason for the visit:**

Last Name First Name **Marital Status:** *(circle one)* S M D W

Address City State Zip

Email Date of Birth

Phone (C) Maiden Name:

Phone (H) Social Security #

Race (Check One):

- o American Indian or Alaska Native
- o Asian
- o Native Hawaiian or Pacific Island
- o Black or African American
- o White
- o Hispanic
- o Other Race
- o Refuse to Report

Male ***Female***

Language: o English o Spanish o French o Japanese o Chinese o Other

Ethnicity: (check one) o Hispanic or Latino o Non-Hispanic o Refuse to Report

PATIENTS EMPLOYER: **Phone #:**

May We Leave a Message at: o *Home* o *Cell* o *Work*

RESPONSIBLE PARTY AND EMERGENCY CONTACT INFORMATION

RESPONSIBLE PARTY:	**EMERGENCY CONTACT:**
RELATION: **PHONE:**	**PHONE:**
ADDRESS:	**ADDRESS:**

INSURANCE INFORMATION

Primary Insurance: ID Number Group

Subscribers Name Address Phone

Subscribers SSN#: Subscribers DOB:

Secondary Insurance: ID Number Group

Tertiary Insurance: ID Number Group

Is your visit related to Workers Comp? (circle one) ***yes*** ***no***

If yes, Workers' Comp Name **Agent** **Claim #** **Phone**

PHARMACY INFORMATION

Local Pharmacy Name

Location/City

Mail Order Pharmacy Name

Medicare Part D Insurance Name

I understand that I am responsible for all charges that result from services rendered to me by Four Rivers Internal Medicine, PLLC and QuickCare staff. I hereby authorize payment to be made directly to me or in the case of assignment to Four Rivers Internal Medicine, PLLC and QuickCare. I also authorize release of information to my insurance carrier. I have received and reviewed a copy of the "Patients Rights and Responsibilities" and have reviewed the HIPAA privacy statement. I attest that the above information is true and current.

Patient/Responsible Party Signature _____ ***Date*** _____

LIST ALL PHYSICIANS YOU HAVE SEEN IN THE LAST 10 YEARS

TOBACCO AND ALCOHOL USE

Do you smoke?	Yes	No	Do you drink alcoholic beverages?	Yes	No
Under 1 pack	, 1-2	, 3 or more	Do you use controlled substances?	Yes	No
Quit?	How Long?		If yes, is it prescribed?	How often taken?	

FOR WOMEN:

ARE YOU CURRENTLY PREGNANT?

Last Mammogram:

Last Menstrual Period:

Regular or Irregular

Pregnancies (#of) *Miscarriages (#of)*

FOR MEN:

Last Prostate Exam:

Last PSA:

Past Medical History (Please check all that apply)

- o Ulcers
- o Colon Polyps
- o Hernia
- o Pancreatitis
- o Ulcerative Colitis
- o Hypertension
- o Anemia
- o COPD
- o Heart Attack
- o Atrial Fibrillation
- o GERD/Heartburn
- o Coronary Artery Disease
- o Diabetes
- o Thyroid Problems
- o Elevated Cholesterol
- o Stroke
- o Kidney Stones
- o Fibromyalgia
- o Arthritis
- o Chronic Back Pain
- o Cancer
- o Kidney Disease
- o Congestive Heart Failure
- o Seizures
- o History of Mental Illness
- o Depression
- o Paralysis
- o Asthma
- o Gout
- o Tuberculosis
- o Prostate Problems
- o Liver Disease
- o AIDS
- o Pneumonia
- o Pacemaker

Past Surgical History (Please check all that apply)

- o Colonoscopy
- o Colon Surgery
- o Back Surgery
- o Hysterectomy
- o Hip Surgery
- o EGD (upper endoscopy)
- o Cholecystectomy
- o Appendectomy
- o Breast Cancer Surgery
- o Ovaries Removed
- o Knee Surgery
- o Ulcer Surgery
- o Hemorrhoidectomy
- o Bypass surgery
- o Heart Valve Replacement
- o Prostate Surgery
- o Weight Loss Surgery

ANY OTHER SURGERIES, INJURIES OR FRACTURES:

Family History (mark only those that apply or NONE)

Mother: o Alive o Deceased	o Heart Disease o Arthritis o Stroke	o High Cholesterol o Diabetes Mellitus o Hypertension	o Cancer: _____ o Other: _____ o Healthy:	
Father: o Alive o Deceased	o Heart Disease o Arthritis o Stroke	o High Cholesterol o Diabetes Mellitus o Hypertension	o Cancer: _____ o Other: _____ o Healthy:	
Siblings: o Alive o Deceased	o Heart Disease o Arthritis o Stroke	o High Cholesterol o Diabetes Mellitus o Hypertension	o Cancer: _____ o Other: _____ o Healthy:	
Grandparents: o Alive o Deceased	o Heart Disease o Arthritis o Stroke	o High Cholesterol o Diabetes Mellitus o Hypertension	o Cancer: _____ o Other: _____ o Healthy:	

MEDICATION LIST

(PLEASE BRING ALL MEDICATIONS IN WITH YOU FOR VERIFICATION)

PLEASE NOTE IF ANY CONTROLLED SUBSTANCES ARE PRESCRIBED BY PAIN MANAGEMENT OR BEHAVIORIAL HEALTH, YOU MUST CONTINUE TO FOLLOW THEM FOR THOSE MEDS.

MEDICATION NAME	STRENGTH	WHEN AND HOW OFTEN TAKEN	PRESCRIBING PHYSICIAN & DO YOU CONTINUE TO SEE?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			

ALLERGIES (PLEASE LIST ALL ALLERGIES)

STATEMENT TO PATIENTS

It is our pleasure to welcome you to our office. All information provided will be strictly confidential. Please read the following statements about our office policies:

- Please notify us upon arrival if any of your information has changed: name, address, phone# and insurance information
- It is your responsibility to know what procedures are covered by your insurance policy. If your insurance required referrals to specialists or for a procedure, please notify our staff before the referral or procedure is made.
- In consideration for those patients who already have scheduled appointments, please call in advance to reschedule or cancel. There will be a fee of $25.00 assessed for all no call no show visits.
- All co-pays and any balances owed are collected on day of appointment; If you are unable to pay your account then a payment plan must be set up and adhered by in order to keep your account of collections.
- Self-Pay patients are required to pay up front on the day of the appointment. Arrangements can be made to make on time monthly payments for the balance.
- If you have a previous balance on your account and have not paid by the monthly statement, this will be collected before seen on next appointment.
- Quick Care patients are NOT established patients of Four Rivers Internal Medicine, PLLC; if you wish to establish us as your PCP, then the New Patient Packet must be signed and records received from your previous physicians.
- If you are here to be seen for a Quick Care visit, this is NOT a comprehensive visit. Quick Care is a focused problem visit for one or two particular issues only. More comprehensive testing, if necessary is referred to your primary care provider. This includes follow up of chronic issues and also routine preventable services.
- We believe patients should be an active participant in their health care. As such, you are ultimately the one responsible for the results of diagnostic testing, including procedures, radiology tests and lab services. On occasion, results are not sent to us from outside facilities or affiliated labs. If you have not heard any results of diagnostic tests within 2 weeks, please contact our office so we can review your situation further and provide recommendations.

By signing I agree to adhere to the above statements:

Patient/Legal Representative Date

AUTHORIZATION TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

I,_____, and my date of birth is_____, hereby authorize Four Rivers Internal Medicine and QuickCare to access the external prescription history from any pharmacy or drug monitoring agency.

- Unless otherwise stated, the information to be disclosed is the Complete Prescription History for the above named patient.
- The purpose of this requested disclosure is to best manage the coordination of care and for my physicians to be aware of my prescription history.
- The person(s) authorized to disclose this information are any pharmacy or drug monitoring agency, including, but not limited to , the Rxhub and SureScripts Service.

I acknowledge the following statements: (FRIM-Four Rivers Internal Medicine, PLLC and QuickCare)

- _____*initials:* I understand that I may revoke this authorization at any time by notification in writing to: Four Rivers Internal Medicine, 3131 Parisa Dr, Paducah KY 42003, of my intention to revoke this authorization, except that if I do notify FRIM of Paducah, in writing on my intent to revoke this authorization, such revocation will not have any effect on any actions by FRIM before the revocation.
- _____*initials:* Unless otherwise revoked, this authorization will expire at such time as I am no longer a patient of FRIM.
- _____*initials:* I understand that FRIM will not condition treatment, payment, enrollment, or eligibility for benefits on my providing or refusing to provide this authorization.
- _____*initials:* I understand that the disclosed information, unless expressly limited by me in writing, may, if applicable, include information relating to: Acquired Immunodeficiency syndrome (AIDS) or human immunodeficiency virus(HIV), treatment for drug or alcohol abuse and/or mental, behavioral health or psychiatric care.

_____

Signature of Patient or Patient's Legally authorized representative ***Date***
(signers other than the patient must present legal documentation that authorizes them to act on the patient's behalf)

_____

Printed name of Patients Legal Representative (if applicable) ***Relationship***

Office Policy Regarding Controlled Substances for New Patients

The Providers at Four Rivers Internal Medicine and QuickCare do not routinely participate in the long term dispensing of Controlled Substances. If narcotics, in the provider's opinion, are deemed necessary, you will be referred for this treatment to a pain management facility or other appropriate specialist for the proper treatment of your individual medical needs.

I acknowledge that I have been informed of the "Office Policy regarding Controlled Substances for New Patients" as noted above, and agree to adhere to the above Policy and understand that my initial visit <u>WILL NOT</u> consist of prescribed controlled medications.

Patient Signature_____ **Date**_____

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Phone: 270-444-8000 | Fax: 270-444-8302 | www.QuickCarePaducah.com | www.fourriversinternalmedicine.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: PHONE: DATE OF BIRTH:

Previous Name: Social Security #:

RELEASE INFORMATION TO: FOUR RIVERS INTERNAL MEDICINE 3131 PARISA DR PADUCAH KY 42003

REQUESTED INFORMATION FROM PREVIOUS PHYSICIANS:

NAME: **FAX:**

NAME: **FAX:**

NAME: **FAX:**

NAME: **FAX:**

NAME: **FAX:**

NAME: **FAX:**

NAME: **FAX:**

NAME: **FAX:**

NAME: **FAX:**

This authorization permits the above listed entity to disclose the following individually identifiable health information (PHI) about me. o Entire Medical Record-including histories, office notes and referrals o Medication lists o Labs, tests, and x-rays reports o Hospital Records O Other_____	*I understand that I have the right to revoke this request at any time; I understand that I may request a copy of this request; I understand that by signing this authorization is voluntary, my treatment, payment, enrollment in a health plan or eligibility benefits will not be conditioned upon my authorization of this disclosure*_____

THIS HIPAA AUTHORIZATION IS VALID FOR 1 YEAR FROM DATE OF MY SIGNATURE

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date signed: [Date]