PATIENT QUESTIONNAIRE

DATE OF VISIT: ________________________

PATIENT NAME_____________________________________DATE OF BIRTH_____________________ AGE__________

PLEASE PROVIDE THE FOLLOWING MEDICAL INFORMATION TO THE BEST OF YOUR ABILITY:

What problems are you here for today?	List any allergies to meds.	List Current Medications
	________________________ ________________________ ________________________	____ ____ ____ ____

Past Medical History(MA to elaborate on "YES" responses)

Please check the "Yes" or "No" box to indicate if you have/had any of the following illnesses.

	YES	NO		YES	NO
Arthritis/Joint Pain	___	___	Stomach or Intestinal Problems	___	___
Diabetes	___	___	Allergy Problems	___	___
High Blood Pressure	___	___	Kidney Problems	___	___
Thyroid Problems	___	___	Neurological Problems	___	___
Heart Disease/Cholesterol Prob.	___	___	Stroke	___	___
Respiratory Problems	___	___	Skin Cancer	___	___
Bleeding Disorder	___	___	Skin Disease	___	___
Cancer Other Than Skin	___	___			

PLEASE LIST YOUR CURRENT PRIMARY CARE PHYSICIAN ____

Please list any OPERATIONS/HOSPITALIZATIONS (and dates) you have ever had:

____
____
____

SOCIAL HISTORY:

Do you smoke?___YES ___NO: IF YES, AMOUNT____

If NO, Did You Smoke Previously?__________________

Do you drink alcoholic beverages? ___YES ___NO

If YES, frequency________________________

Have you been exposed to HIV? ___YES ___NO

OCCUPATION:________________________________

Have you been exposed to Hepatitis B/C? ___YES ___NO

Have you ever had a blistering sunburn? ___YES ___NO

Do you use sun screen? ___YES ___NO

If YES, what SPF______________

Have you been exposed to T.B.? ___YES ___NO

HOBBIES/LEISURE ACTIVITIES:______________________________

FEMALE PATIENTS CHILD BEARING AGE PLEASE ANSWER THE FOLLOWING:

Are you pregnant? ___YES ___NO Breast feeding? ___YES ___NO Planning a pregnancy? ___YES ___NO

____
____
____

FAMILY HISTORY:

Please check the "YES" or "NO" box to indicate whether any relatives have OR had any of the following illnesses.
If YES, please circle which relative(s) have the problem:

	YES	NO	MOTHER	FATHER	SIBLINGS	COMMENTS
DIABETES	_____	_____	MOTHER	FATHER	SIBLINGS	______________________________
SKIN CANCER	_____	_____	MOTHER	FATHER	SIBLINGS	______________________________
BLEEDING DISORDER	_____	_____	MOTHER	FATHER	SIBLINGS	______________________________
SKIN DISEASES	_____	_____	MOTHER	FATHER	SIBLINGS	______________________________
ECZEMA	_____	_____	MOTHER	FATHER	SIBLINGS	______________________________
PSORIASIS	_____	_____	MOTHER	FATHER	SIBLINGS	______________________________
CANCER (TYPE IF KNOWN)	_____	_____	MOTHER	FATHER	SIBLINGS	______________________________

PATIENT NAME_______________________________ DATE OF BIRTH_________ AGE_____

Please provide the following medical information to the best of your ability:

Review of Systems:

1. Please check the **"YES"** or **"NO"** box to indicate if you have any of the following symptoms.
2. For any **"YES"** responses, check the **"CURRENT"** box if this symptom relates to the reason for your visit today.

		YES	NO	CURRENT
GENERAL	CHILLS			
	FEVER			
	WEIGHT LOSS/GAIN			
ALLERGY	ITCHY EYES			
	WATERY EYES			
NEURO	HEADACHES			
	SEIZURES			
	WEAKNESS IN LIMBS			
	NUMBNESS/TINGLING			
EYES	VISION CHANGES			
	PAIN/PRESSURE			
ENT	HEARING LOSS			
	DIZZINESS			
	LIGHTHEADEDNESS			
RESPIRATORY	COUGH			
	SHORTNESS OF BREATH			
CVS	CHEST PAIN			
	VARICOSE VEINS			
	ANKLE SWELLING			
G.I.	HEARTBURN			
	DIFFICULTY SWALLOWING			
G.U.	PROSTATE PROBLEMS			
	FREQUENT URINATION			
MUSK	JOINT ACHES			
	BACK PAIN			
ENDO	EXCESSIVE SWEATING			
	EXCESSIVE THIRST			
	INTOLERANCE HEAT/COLD			

		YES	NO	CURRENT
HEME/LYM	SWOLLEN GLANDS			
	BLEEDING PROBLEMS			
	RECURRENT INFECTIONS			
	SWEATING AT NIGHT			
	EASY BRUISING			
NAILS	DISCOLORED			
	PAINFUL			
	BRITTLE			
	LOOSE			
PSYCH	DEPRESSION			
	ANXIETY			
SKIN	RASH			
	MOLE CHANGES			
	REDNESS			
	RAISED SCALY AREAS			
	OPEN SORES			
	ACNE			
	GROWTHS/SPOTS			
	HAIR LOSS			
	SUN SUSCEPTIBILITY			
	ITCHING			
	HIVES			
	BLISTERING SUNBURN			
	KELOIDS SCARS			
	DRY MOUTH/NOSE			
	DRY SKIN			
	JAUNDICE			
	EVER HAD A SKIN BIOPSY?			

My signature affirms that I have completed pages 1 and 2 of this form accurately and completely to the best of my ability.

PATIENT SIGNATURE: **DATE:**

COMMENTS: ***SEE ATTACHED DICTATION***

PG 1 & 2 REV'D BY: DATE: MEDICAL ASSISTANT

PG 1 & 2 REV'D BY: DATE: PHYSICIAN SIGNATURE

Updated May 2013 gjk

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, JENNIFER CAUDILL, MD PLLC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations. Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have been given the opportunity to review the Notice of Privacy Practices prior to signing this consent. Our office reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the office of JENNIFER CAUDILL, MD PLLC.

With my consent, the office may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. Additionally, with my consent, you may mail to my home appointment reminder letters and patient statements.

* ADDENDUM: I give special permission to the person(s) named and relationship listed below to receive medical information regarding my care and treatment in this office.

____________________________ ____________________________

____________________________ ____________________________

By signing this form, I am consenting to the above referenced office's use and disclosure of my Protected Health Information (PHI) to carry out treatment, payment and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon prior consent. If I do not sign this consent, JENNIFER CAUDILL, MD may decline to provide treatment to me.

____________________________ ____________________________

Signature of patient or legal guardian Date

____

Print name of patient

FINANCIAL ARRANGEMENTS AND INSURANCE

We are committed to providing you with the best possible care. We invite you to discuss any issues regarding our services and policies. If you have insurance, we are anxious to help you receive your maximum allowable benefits. It is important to note that our relationship is with you. YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY, not between us and your insurance company.

It is our goal to help you to understand the policies and requirements of our office. We participate with many insurance companies, and these companies offer different lines of coverage – PPOs, HMOs and Traditional coverage. We do participate with MEDICARE, but NOT Medicaid. If you have an HMO type plan, you must obtain a referral from your primary care physician (PCP). The referral needs to be faxed to our office prior to your appointment. Please be aware of the expiration of this referral, as you will need to obtain another one from your PCP before your next visit.

We are very happy to submit a claim to your insurance company for your visit to our office. However, many insurance plans have higher out-of-pocket expenses including deductibles and copayments that are the patient's responsibility. We would ask that you pay the balance you may owe us either as soon as you receive a statement from us, or at your next visit to our office – whichever comes first. We accept CHECKS, CASH, VISA, MASTERCARD, AND DISCOVER CREDIT AND DEBIT CARDS. If your insurance claim remains unpaid after 30 days, you may be asked by us to contact them directly regarding the delay in payment.

Please be aware of your own policy benefits. We are aware of general coverages, but if there are specifics to your plan, we will not know unless a claim is submitted for you. If the insurance company does not cover the services for any reason, it is your responsibility to pay us promptly for any services rendered. If a payment to us becomes 30 days past due it is considered delinquent. Delinquent accounts will be charged a monthly statement fee of $5.

We may sometimes use an OUTSIDE LABORATORY to perform certain tests. Lab tests are not included in the physician's fees. You are responsible for all costs incurred by the lab which are not covered by your insurance, and you will be billed separately by them. Please contact the laboratory directly with any questions you may have.

We understand that temporary financial problems may affect timely payment of your account. If this arises, we encourage you to contact us promptly for assistance in management of your account.

If you have any questions about the above information please do not hesitate to ask. We are here to assist you.

NAME____ DATE________________________

T: 248-623-9700 • F: 248-623-8996 • 5885 S. Main St., Suite 1, Clarkston, MI 48346 • jennifercaudillmd.com

PLEASE PRINT & FILL IN ALL BLANKS DATE: _______________

PATIENT NAME ____

DATE OF BIRTH ___________ AGE ____ M F SS# ________________

PATIENT HOME ADDRESS ______________________________________

CITY, STATE, ZIP ____

CELL PHONE _________________________ SECOND PHONE_______________________

MAY WE CONFIRM APPOINTMENTS BY TEXT? Circle **YES** or **NO**

INSURED POLICYHOLDER NAME _________________________

POLICYHOLDER'S DATE OF BIRTH ________________

E-MAIL ADDRESS ____

PATIENT OCCUPATION ___________________________

PATIENT EMPLOYER NAME _______________________________

PARENT (IF MINOR) OR SPOUSE ________________________________

EMPLOYER NAME __________________________WK PHONE __________________________

PERSON RESPONSIBLE FOR COPAYS AND DEDUCTIBLE ______________________________

HOW REFERRED ____

****

I authorize Jennifer Caudill MD, FAAD to bill my insurance company for covered services provided. I also authorize payment directly to the physician for services rendered, and understand that it is my responsibility to make sure the bill is paid in a reasonable time. I also understand that it is my responsibility to be aware of my insurance benefits. If, for any reason, any portion of my bill is not paid by my insurance, I further agree TO PAY ANY OUTSTANDING AMOUNTS NOT COVERED BY MY INSURANCE PROMPTLY. In the event of non-payment, I will bear the cost of collection proceedings should this be required. I understand that it is my responsibility to obtain referrals if required by my insurance plan. Additionally, I authorize the release of medical information necessary to process any claims in compliance with the HIPAA Privacy Policy Act of 1996. A photocopy of this authorization shall be considered as effective and valid as the original.

SIGNED: ____ DATE: _______________