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				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	_____

 CONTINUE ON BACK

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				YES	NO	CURRENT
GENERAL	CHILLS					**HEME/LYM**	SWOLLEN GLANDS			
	FEVER						BLEEDING PROBLEMS			
	WEIGHT LOSS/GAIN						RECURRENT INFECTIONS			
ALLERGY	ITCHY EYES						SWEATING AT NIGHT			
	WATERY EYES						EASY BRUISING			
NEURO	HEADACHES					**NAILS**	DISCOLORED			
	SEIZURES						PAINFUL			
	WEAKNESS IN LIMBS						BRITTLE			
	NUMBNESS/TINGLING						LOOSE			
EYES	VISION CHANGES					**PSYCH**	DEPRESSION			
	PAIN/PRESSURE						ANXIETY			
ENT	HEARING LOSS					**SKIN**	RASH			
	DIZZINESS						MOLE CHANGES			
	LIGHTHEADEDNESS						REDNESS			
RESPIRATORY	COUGH						RAISED SCALY AREAS			
	SHORTNESS OF BREATH						OPEN SORES			
CVS	CHEST PAIN						ACNE			
	VARICOSE VEINS						GROWTHS/SPOTS			
	ANKLE SWELLING						HAIR LOSS			
G.I.	HEARTBURN						SUN SUSCEPTIBILITY			
	DIFFICULTY SWALLOWING						ITCHING			
G.U.	PROSTATE PROBLEMS						HIVES			
	FREQUENT URINATION						BLISTERING SUNBURN			
MUSK	JOINT ACHES						KELOIDS SCARS			
	BACK PAIN						DRY MOUTH/NOSE			
ENDO	EXCESSIVE SWEATING						DRY SKIN			
	EXCESSIVE THIRST						JAUNDICE			
	INTOLERANCE HEAT/COLD						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 - HIPAA

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

By signing this form, I am consenting to the 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.

☐ I DO GIVE CONSENT to leave voicemail messages on the phone numbers provided regarding results or any medical information about my care, appointments, and payment information.

☐ I DO NOT GIVE CONSENT to leave detailed voicemail messages. Messages may contain ONLY call back information.

I give special permission to the person(s) named below to receive medical information regarding my care and treatment in this office, including biopsy results, lab results, and other medical information.

NAME	Relationship	Phone

_____ _____

Signature of patient or legal guardian Date

_____

Print name of patient

FINANCIAL ARRANGEMENTS AND INSURANCE

It is our goal to help you to understand the policies and requirements of our office. 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.

We participate with many insurance companies, and these companies offer different lines of coverage - PPOs, HMOs and Traditional coverage. We also do participate with MEDICARE, but do NOT participate with any form of MEDICAID! Please be aware of your own policy benefits. Every insurance policy is different. It is YOUR responsibility to obtain insurance referrals from your Primary Care if they are required by your insurance policy. The referral needs to be in our office prior to your appointment. Please be aware of the expiration of your referral, as. you may need to obtain a new one from your Primary Care for 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. These could include 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 or at your next upcoming appointment—whichever comes first. If the insurance company does not cover the services for any reason, it is your responsibility to pay us promptly for any service rendered. If a payment to us becomes 30 days past due it is considered delinquent.
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.

LABORATORY SERVICES
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 the lab themselves. Please contact the laboratory directly with any questions you may have.

I understand that is it my responsibility to be aware of my insurance benefits. If, for any reason, any portion of my bill is not paid by my insurance company, 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.

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

PERSON RESPONSIBLE FOR COPAYS & DEDUCTIBLE_____

Signed_____ Date_____

PLEASE FILL IN ALL BLANKS DATE_____

PATIENT NAME_____

DATE OF BIRTH_____ AGE_____ **M** **F**

PATIENT HOME ADDRESS_____

CITY, STATE, ZIP_____

CELL PHONE_____

SECOND PHONE_____

MAY WE CONFIRM APPOINTMENTS BY TEXT? **YES** OR **NO**

PARENT OF PATIENT **(IF MINOR)**_____

E-MAIL ADDRESS_____

INSURED POLICY HOLDER NAME_____

PATIENT RELATIONSHIP TO POLICY HOLDER_____

POLICY HOLDER DATE OF BIRTH_____

PATIENT OCCUPATION_____

PATIENT EMPLOYER_____

HOW REFERRED_____

PRIMARY CARE PHYSICIAN_____

YOUR PHARMACY_____

PHARMACY PHONE NUMBER_____