

# WELCOME

Date: \_\_\_\_\_

## Patient Information

Name: \_\_\_\_\_  
Last First MI

Email address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone # \_\_\_\_\_  
City State Zip Code  
(H) (W) (Other)

Can we call you at work?  Yes  No

Date of Birth: \_\_\_\_\_ Sex:  Male  Female SS#: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Separated  Minor

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

Emergency contact: Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_

Phone #: (H) \_\_\_\_\_ (W) \_\_\_\_\_

## Accident Information

Is this visit due to an accident?  Yes  No If yes, what type?  Auto  Work  Other \_\_\_\_\_

Has it been reported?  Yes  No If yes, to whom? \_\_\_\_\_

## Financial Information

Name of person responsible for this account: \_\_\_\_\_

Relationship to patient (if other than self): \_\_\_\_\_ Phone # \_\_\_\_\_

Do you have health insurance?  Yes  No Name of Carrier: \_\_\_\_\_

Do you have secondary insurance?  Yes  No Name of Carrier: \_\_\_\_\_

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S) (Blue Cross Blue Shield Only)

## Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO Millstone Medical; INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) \_\_\_\_\_ DATE \_\_\_\_\_

# **Acknowledgement of Receipt of Notice of Privacy Practices**

Millstone Healthcare Associates, PA  
3029 White Horse Rd.  
Greenville, SC 29611

I understand and have been provided with the opportunity to review a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

The right to review the notice prior to signing this consent,  
The right to object to the use of my health information for directory purposes, and  
The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

\_\_\_\_\_ I have received a paper copy of the Privacy Notice and Notice of Patient Rights & Responsibilities.

## **Appointment Reminders and Health Care Information Authorization**

Your doctor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

\_\_\_\_\_ I acknowledge that it is the policy of Millstone Healthcare to leave a reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

\_\_\_\_\_ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer, Beth Mills, about my concerns.

Patient/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

If not signed by the patient, please indicate relationship.

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

Name of Patient: \_\_\_\_\_

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### ***For Office Use Only:***

Signed form received by: \_\_\_\_\_

Acknowledgement refused: (Efforts to Obtain/ Reasons for refusal)

\_\_\_\_\_

# Consent to Care

A patient coming to the doctor gives him/ her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/ she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/ she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I have read and understand the foregoing.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

## X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: \_\_\_\_\_

There is a possibility that I a may be pregnant at this time.

Yes, I am definitely pregnant

No, I am definitely not pregnant at this time

I request that x-ray films not be taken because: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of last menstrual period: \_\_\_\_\_

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

# Health History

Who is your primary care physician? (doctor and/or practice) \_\_\_\_\_

**Please check to indicate if you are currently experiencing any of the following conditions:**

- |  |  |   |  |                                     |
|--|--|---|--|-------------------------------------|
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Arms  | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Sudden Weight Loss    | <input type="checkbox"/> Nausea     |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Legs  | <input type="checkbox"/> Depression         | <input type="checkbox"/> Loss of Taste         | <input type="checkbox"/> Cold Feet  |
| <input type="checkbox"/> Arm/Hand Pain       | <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Nervousness        | <input type="checkbox"/> Loss of Memory        | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Leg/Knee Pain       | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Tension            | <input type="checkbox"/> Jaw Problems          | <input type="checkbox"/> Fever      |
| <input type="checkbox"/> Headaches           | <input type="checkbox"/> Loss of Smell         | <input type="checkbox"/> Cold Sweats        | <input type="checkbox"/> Constipation          | <input type="checkbox"/> Fainting   |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Allergies             | <input type="checkbox"/> Stomach Problems   | <input type="checkbox"/> Shortness of Breath   |                                     |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Blurred Vision        | <input type="checkbox"/> Night Pain         | <input type="checkbox"/> Bowel/Bladder Changes |                                     |

**Please check to indicate if you have ever had any of the following:**

- |   |  |   |   |   |
|---|--|---|---|---|
| <input type="checkbox"/> Aids/HIV           | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Alcoholism         | <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Hernia             | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Suicide Attempt    |
| <input type="checkbox"/> Allergy Shots      | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herniated Disc     | <input type="checkbox"/> Parkinson's Disease  | <input type="checkbox"/> Thyroid Problems   |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Herpes             | <input type="checkbox"/> Pinched Nerve        | <input type="checkbox"/> Tonsillitis        |
| <input type="checkbox"/> Anorexia           | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> Pneumonia            | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Appendicitis       | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Polio                | <input type="checkbox"/> Tumors/Growths     |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Prostate Problems    | <input type="checkbox"/> Typhoid Fever      |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Fractures           | <input type="checkbox"/> Measles            | <input type="checkbox"/> Prosthesis           | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Migraines          | <input type="checkbox"/> Psychiatric Care     | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Breast Lump        | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Bronchitis         | <input type="checkbox"/> Gonorrhea           | <input type="checkbox"/> Mononucleosis      | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Whooping Cough     |
| <input type="checkbox"/> Bulimia            | <input type="checkbox"/> Gout                | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever        |   |
|   | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Other _____          |   |

Are you currently under drug and/or medical care?  Yes  No If yes, explain \_\_\_\_\_

Please list any medications you are currently taking (Be sure to include dosage and frequency): \_\_\_\_\_

Please list any surgeries and/or hospitalizations you have had (type & date): \_\_\_\_\_

Please list any allergies: \_\_\_\_\_

Please list any supplements you are currently taking (vitamins/herbs/minerals): \_\_\_\_\_

Is there a family history of any of the following conditions? (indicate family member including parents, grandparents & siblings)

- |  |  |
|--|--|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Diabetes _____  |
| <input type="checkbox"/> Cancer _____        | <input type="checkbox"/> Arthritis _____ |
|  | <input type="checkbox"/> Other _____     |

Do you exercise:  Frequently  Moderately  Occasionally  None

Do your work activities mostly involve:  Sitting  Standing  Light Labor  Heavy Labor

Do you sleep on your:  Back  Side  Stomach Do you use a cervical pillow?  Yes  No

What is your daily/weekly intake of the following:

Caffeine \_\_\_\_\_ cups/day Alcohol \_\_\_\_\_ drinks/week Cigarettes \_\_\_\_\_ packs/day

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) \_\_\_\_\_ DATE \_\_\_\_\_

Reviewed by Provider: \_\_\_\_\_ (initials)