LEGACY
MEDICAL CENTERS

New Patient Information

Name _____ **Date of Birth** _____ (mm/dd/yyyy) **Sex:** ☐ Male ☐ Female

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other _____ **Email** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone _____ **Cell Phone** _____ **Work Phone**_____

Preferred Contact Method: ☐ Home ☐ Cell ☐ Work **Emergency Contact Name** _____

Emergency Contact Phone Number _____ **Relationship to You** _____

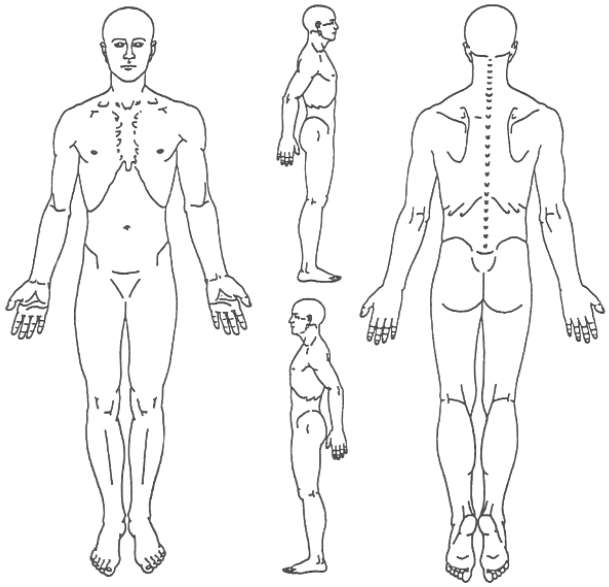
Primary Care Physician (PCP) _____ **PCP Phone Number** _____

Insurance Carrier _____ **Member ID Number** _____

Current Issues (Reason for Consultation):

Prior Treatments and/or Tests Performed for Issues Listed Above:

Please circle the areas where you are currently experiencing pain.



Please indicate how you would rate your pain (LOW) 0 1 2 3 4 5 6 7 8 9 10 (HIGH)

Medications: (Dosage and Frequency)	Allergies: (Medications, Food, Environmental)	Vitamins/Supplements: (Dosage and Frequency)

Prior Illness, Injury, Hospitalization, Surgery, and/or Trauma:	Date:

Health History: Please check the boxes to indicate if you currently have, or have had, any of these conditions:

YES	NO	
☐	☐	Alcohol Abuse
☐	☐	Anemia
☐	☐	Anxiety
☐	☐	Arthritis
☐	☐	Asthma
☐	☐	Atherosclerosis
☐	☐	Autoimmune Disorder
☐	☐	Bleeding Disorder
☐	☐	Blood Clots
☐	☐	Cancer
☐	☐	COPD/Emphysema
☐	☐	Depression
☐	☐	Diabetes
☐	☐	Diverticulitis
☐	☐	Heart Attack
☐	☐	Herniated Disc
☐	☐	High Blood Pressure
☐	☐	HIV
☐	☐	Inflammatory Bowel Disease
☐	☐	Irritable Bowel Syndrome
☐	☐	Irregular Heartbeat
☐	☐	IV Drug Abuse
☐	☐	Kidney Disease
☐	☐	Kidney Stone(s)
☐	☐	Liver Disease
☐	☐	Memory Loss
☐	☐	Migraines
☐	☐	Multiple Sclerosis
☐	☐	Osteoporosis
☐	☐	Reflux or GERD
☐	☐	Seizure Disorder
☐	☐	Stroke
☐	☐	Stomach Problems
☐	☐	Thyroid Problems
☐	☐	Transient Ischemic Attack
☐	☐	Urinary Tract Infections
☐		Other:
☐		Other:

Review of Systems – Please indicate if you have any of the following:

YES	NO		
☐	☐	General	Unexplained weight loss or gain, night sweats, fatigue, sleeping pattern changes, appetite changes, fever, itch, rash, trauma, lumps, masses
☐	☐	Eyes	Visual changes, headache, eye pain, double vision, blind spots, floaters
☐	☐	Ears, Nose, Mouth, Throat	Sinus pain, ear pain, ringing in ears, toothache, sore throat, difficulty or pain with swallowing
☐	☐	Cardiovascular	Chest pain, exercise intolerance, leg swelling, palpitations, leg pain with walking, fainting
☐	☐	Respiratory	Cough, sputum, wheeze, shortness of breath
☐	☐	Gastrointestinal	Abdominal pain, indigestion, bloating, cramping, anorexia, nausea, vomiting, diarrhea, constipation, blood in stool
☐	☐	Genitourinary	Incontinence, pain with urination, blood in the urine, in ability to urinate, timing or frequency of urination, decreased force of stream, irregular menses
☐	☐	Skin, Breast	Itchiness, rashes, stretch marks, excessive dryness and/or discoloration, breast pain or soreness
☐	☐	Neurological	Changes in smell, hearing, taste, seizures, headache, pins and needles, numbness, weakness, poor balance, speech problems, tremor
☐	☐	Psychiatric	Depression, anxiety, difficulty concentrating, personality change
☐	☐	Endocrine	Prefer cold or hot weather, tired, thin hair, heavy periods, constipation, dry skin, excessive thirst, excessive urination, dizziness, sweating, vaginal bleeding irregularities
☐	☐	Hematologic	Anemia, prolonged or excessive bleeding after injury

Family History: Indicate any immediate family member who has had:

Condition	Relationship to You	Age at Diagnosis
☐ Arthritis		
☐ Cancer		
☐ Diabetes		
☐ Heart Disease		
☐ High Blood Pressure		
☐ Thyroid Disease		
☐ Other _____		
☐ Other _____		

Social History:

Marital Status**:**	☐ Single	☐ Married	☐ Divorced
Employment status:	☐ Employed	☐ Unemployed	☐ Student
Occupation:			
Do you currently smoke cigarettes?	☐ YES	☐ NO	If yes, _____years, _____packs per day
Did you ever smoke?	☐ YES	☐ NO	If yes, when did you quit? _____
Do you drink alcohol?	☐ YES	☐ NO	If yes, _____ drinks per week
Do you use recreational drugs?	☐ YES	☐ NO	If yes, which? _____
Do you manage stress well?	☐ YES	☐ NO	☐ Not sure
Is your diet healthy enough?	☐ YES	☐ NO	☐ Not sure
Do you exercise regularly?	☐ YES	☐ NO	If no, why? _____
Do you allow time to relax?	☐ YES	☐ NO	If no, why? _____
Do you sleep soundly?	☐ YES	☐ NO	If no, why? _____
Do you enjoy your job?	☐ YES	☐ NO	If no, why? _____
Are you currently pregnant?	☐ YES	☐ NO	☐ Not sure

Patient Consent for Use and Disclosure of Protected Health Information

Thank you for choosing **Legacy Medical Centers** for your health care needs. This consent form specifies your rights in regards to your Protected Health Information (PHI) and our Treatment, Payment, and Health Care Operations (TPO). You have the right to review our Notice of Privacy Practices prior to signing this consent, as the Notice of Privacy Practices outlines the use and disclosure of PHI and TPO in detail. **Legacy Medical Centers** reserves the right to revise its Notice of Privacy Practices at any time, and will provide a revised copy upon request. Please carefully read the terms and conditions below:

I hereby give my consent for **Legacy Medical Centers** to use and disclose my Protected Health Information (PHI) to carry out Treatment, Payment, and Health Care Operations (TPO).

With this consent, **Legacy Medical Centers** may call my home (or other alternative location) and leave a message on voicemail (or speak with me directly) in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and issues pertaining to my clinical care.

With this consent, **Legacy Medical Centers** may mail to my home (or other alternative location) any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **Legacy Medical Centers** may send me e-mails regarding any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that **Legacy Medical Centers** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Legacy Medical Centers** to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. I understand that if I do not sign this consent form, or later revoke it, **Legacy Medical Centers** may decline to provide treatment to me.

Patient Name (printed): _____ Date: _____

Signature: _____ Relationship to Patient: Self / Parent / Spouse / Guardian / Other: _____

Acknowledgement of Privacy Practices

I acknowledge that I have received a copy of, and have read, the Notice of Privacy Practices.

Patient Name (printed): _____ Date: _____

Signature: _____ Relationship to Patient: Self / Parent / Spouse / Guardian / Other: _____

Patient Financial Responsibility Agreement

Thank you for choosing Legacy Medical Centers for your healthcare needs. This agreement specifies your financial responsibility for all medical claims related to the treatment and services rendered at our facility.

Legacy Medical Centers verifies health insurance benefits as a courtesy to our patients, however, it is the patient's responsibility to verify his or her own benefits, including (but not limited to) the deductible, out-of-pocket maximum, copayments, and coinsurance. Verification of benefits does not guarantee payment, as benefits are not guaranteed until the Explanation of Benefits are received from your insurance company.

Legacy Medical Centers will submit your claims to your primary (and/or secondary) health insurance carrier, and all claims submitted to your health insurance carrier are subject to the deductible, copayments, and/or coinsurance specified by your healthcare plan. If you do not have health insurance, you will be charged a 'cash' rate as a self-pay patient. All copayments and self-pay fees are due on the dates that services are rendered. Please carefully read the terms and conditions of our agreement below.

I, _____, authorize the use of my signature on all insurance submissions, and understand that I am financially responsible for all costs not paid by my primary (and/or secondary) insurance carrier. I understand that verification of benefits does not guarantee payment, and it is my responsibility to verify my coverage and benefits for medical claims.

Furthermore, I agree to pay my copayments (and/or self-pay fees) on the dates that services are rendered. I agree to pay any and all additional costs billed to me upon receipt, and understand that if I do not pay my bills on or before the due date, my balance will be sent to a collections agency to collect my unpaid debt.
I understand that I am entering into a legally binding agreement by signing this form, and accept the terms and conditions herein.

_____ _____

Patient Signature Date

Relationship to Patient: Self / Parent / Spouse / Legal Guardian / Other: _____

Thank you for choosing Legacy Medical Centers!

How did you hear about us?

[Please check all that apply]

- ☐ Internet Search
- ☐ Facebook / Instagram / Twitter
- ☐ Yelp
- ☐ Patient Referral (Name of Patient: _____)
- ☐ Doctor Referral (Name of Doctor: _____)
- ☐ Electronic Billboard/Marquee
- ☐ 'IN Community' Magazine
- ☐ High School Sporting Event
- ☐ Local Community Event
- ☐ Other _____