

**New Patient Information**

DATE \_\_\_/\_\_\_/\_\_\_

NAME (FIRST, MI, LAST) \_\_\_\_\_

DATE OF BIRTH \_\_\_/\_\_\_/\_\_\_ SOCIAL SECURITY # \_\_\_/\_\_\_/\_\_\_

EMAIL ADDRESS \_\_\_\_\_

GENDER (please circle) MALE / FEMALE MARITAL STATUS \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

ETHNICITY \_\_\_\_\_ LANGUAGE \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIPCODE \_\_\_\_\_

PHONE NUMBER: HOME \_\_\_\_\_ CELL \_\_\_\_\_

**EMERGENCY CONTACT:**

EMERGENCY CONTACT PERSON: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

PHONE NUMBER: (\_\_\_\_)-\_\_\_\_-\_\_\_\_\_

**PHARMACY:**

PRIMARY PHARMACY \_\_\_\_\_ LOCATION \_\_\_\_\_

PHONE NUMBER (\_\_\_\_)-\_\_\_\_-\_\_\_\_\_

**PARENT OR LEGAL GUARDIAN (only fill out if patient is a minor):**

FATHER: \_\_\_\_\_ DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_

MOTHER: \_\_\_\_\_ DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_

OTHER: \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

**INSURANCE:**

INSURANCE COMPANY I WOULD LIKE JONES FAMILY CARE TO BILL FOR MY VISIT:

\_\_\_\_\_ ID NUMBER: \_\_\_\_\_

NAME OF PERSON THE POLICY IS THROUGH: \_\_\_\_\_

DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

**IS THERE A SECONDARY INSURANCE? YES/NO (circle One)**

Do you have an advanced directive? \_\_\_\_\_ **YES / NO**

If no, would you like information on how to obtain one? \_\_\_\_\_ **YES / NO**



**Please agree with each statement below by initialing:**

\_\_\_\_\_ I have reviewed your "Notice of Advanced Practice Registered Nurse Clinic" and agree to the terms.

\_\_\_\_\_ I have reviewed your "Notice of Assignment of Insurance Benefits" Agreement and agree to the terms.

\_\_\_\_\_ I have reviewed your "Patient/Practice Privacy Policy" and agree to the terms.

\_\_\_\_\_ I WOULD/WOULD NOT (circle one) like to use e-mail communication for appointment reminders and Jones Family Care website access.

\_\_\_\_\_ If, at any time, I provide a wireless telephone number where I may be contacted, I consent to receive calls (including auto-dialed calls and prerecorded messages) at that wireless number from the {hospital, bank, college/university, etc.}, its successors and assignees, and the affiliates, agents, and independent contractors, including servicers and collection agents, of each of them regarding the serviced rendered, or my related financial obligations.

\_\_\_\_\_ I understand it is my responsibility to make sure any referrals or services scheduled for me outside of this clinic are covered by my insurance and are in my insurance network. This is not the responsibility of Jones Family Care, APRN LLC. I understand I can locate providers in my network by contacting my insurance company.

I have reviewed and initialed all the statements above:

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

**HIPAA E-mail Consent**

When we send you an e-mail, or you send us an e-mail, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the internet. In addition, once the e-mail is received by you, someone may be able to access your e-mail account and read it.

HIPAA guidelines state that if a patient has been made aware of the risks of unencrypted e-mail and provides consent to receive health information via e-mail then a health entity may send the patient or someone, they verbally designate personal medical information via unencrypted e-mail.

I understand the risk of unencrypted e-mail and do hereby give permission to Jones Family Care, APRN, LLC to send me or others. I designate personal health information via unencrypted e-mail.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

## **FINANCIAL POLICY**

Thank you for choosing us as your health care provider. This statement of Financial Policy must be read and signed by you prior to any treatment.

All co-pays, deductibles and co-insurance are due at the time services are rendered. It is your responsibility to make sure we have your correct billing address and contact numbers.

If you have a past due balance that is sent to an outside source for collections, we will also add a \$40.00 recurring billing fee.

We accept cash, checks, VISA or Mastercard.

### **Regarding Insurance:**

The balance on your account is still your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information.

Your insurance policy is a contract between you and your insurance company. In some cases, if you fail to pay the provider your co-pay, deductible, and co-insurance, your insurance company can terminate your coverage.

Please be aware that some, and perhaps all, of the services provided by the provider may be non-covered services and are not considered reasonable and necessary under your medical insurance.

Due to recent problems with insurance coverage, you must inform us if your insurance or your Primary Care Provider changes. If you fail to notify us about any changes, you will be responsible for all charges incurred.

I, \_\_\_\_\_, have read the above information and agree with the terms of the Financial Policy.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### **NARCOTIC PRESCRIPTION STATEMENT**

**We do NOT provide chronic pain management services and will NOT refill chronic pain medications. We DO NOT prescribe hydrocodone or morphine containing products such as Lortab, Norco, Vicodin, or Oxycodone. We DO NOT routinely refill DEA monitored medications. Examples include Xanax and Ambien. If you need this type of medication, you will be referred to a pain management specialist.**

**There may be a wait for the referral and appointment.**

**Pharmacy:** \_\_\_\_\_ **Patient Phone:** \_\_\_\_\_

**Legal Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Date of Visit:** \_\_\_\_\_ **Ins: (PLEASE CIRCLE)** AARP / AETNA / AMBETTER / BCBS  
HEALTHCHOICE / MEDICARE / UHC / UMR / SELF-PAY / OTHER \_\_\_\_\_

**SoonerCare Plan Type: PCP -Y / N** - Expansion / Title 19 / SoonerCare Choice / Oklahoma Complete / Aetna  
Better Health

**Reason for Visit:** \_\_\_\_\_

**ROOM 1 2 3 1N 2N 3N Patient ID:** \_\_\_\_\_

**TRIAGE**

**Medication Allergies** \_\_\_\_\_

**Height/Length** \_\_\_\_\_ **Flu Vaccine: Yes or No**

**Weight** \_\_\_\_\_

**Temp** \_\_\_\_\_

**Pulse** \_\_\_\_\_

**BP** \_\_\_\_\_

**Respiration** \_\_\_\_\_

**Pulse Ox** \_\_\_\_\_

**HISTORY:**

**Medical History/Diagnosis** \_\_\_\_\_

\_\_\_\_\_

**Daily Medications** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Surgical History** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Family History** \_\_\_\_\_

**Tobacco:** Yes or No \_\_\_\_\_

**Alcohol:** Yes or No \_\_\_\_\_

**Illicit Drugs:** Yes or No \_\_\_\_\_

**Female:** \_\_\_\_\_ **Male:** \_\_\_\_\_

- Pneumovax - Pneumovax

- Zostavax - Zostavax

- Influenza, Tdap - Influenza, Tdap

- Colonoscopy - Colonoscopy

- Mammogram - PSA

- DEXA - Wellness Handout

- WWE - Hepatitis C

- Wellness Handout - Low Dose CT (smoker)

- Hepatitis C - Chest X-ray

- Chest X-Ray - Eye exam

- Low Dose CT (SMOKER)

<b>ORDER</b>	<b>REFERRAL</b>	<b>PRESCRIPTION</b>
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