MILL CITY MEDICAL GROUP

PATIENT INFORMATION FORM

Name:_____DOB:_____

Address:_____

City:_____State:_____Zip Code:_____

Home Phone:_____Cell Phone:_____

Ok to leave message with results at home or cell number: YES NO

SS#_____Email:_____

Gender: _____Race:_____Ethnicity:_____

Primary Language:_____

Insurance Name/Policy #_____

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD

Emergency Contact Information:

Name:_____Relationship:_____

Home phone:_____ Work or Cell_____

Pharmacy Information:

Name:_____

Address:_____

City:_____State:_____Zip Code:_____

Phone:_____ Fax:_____

Do you smoke cigarettes? Y N How many per day?_____

Do you drink alcohol? Y N How many drinks per week?_____

Allergies:_____

_____

Current Medications:

(Include regularly taken over the counter medications and birth control pills):

_____ _____

_____ _____

_____ _____

_____ _____

Date of last physical examination_____

PERSONAL HEALTH HISTORY					
				hernia	**Y N**
				constipation	**Y N**
DO YOU HAVE COMPLAINTS OF?				diarrhea	**Y N**
frequent or severe headaches	**Y N**			blood in bowel movement	**Y N**
fainting spells	**Y N**			rectal pain with bowel movement	**Y N**
dizziness	**Y N**			pain on urinating	**Y N**
unconscious spells	**Y N**			difficulty starting urination	**Y N**
blurred spells	**Y N**			do you get up at night to urinate	**Y N**
earaches	**Y N**			frequent urination	**Y N**
ringing in ears	**Y N**			blood in urine	**Y N**
decrease in hearing	**Y N**			Full feeling of bladder, but small	
recurrent nose bleeds	**Y N**			amount of urination	**Y N**
sinus trouble	**Y N**			lose urine on coughing/sneezing	**Y N**
hay fever	**Y N**			recurrent back pain	**Y N**
persistent hoarseness	**Y N**			Backaches	**Y N**
difficulty swallowing	**Y N**			joint pain	**Y N**
enlarged glands	**Y N**			swelling of any joints	**Y N**
recurrent sore throats	**Y N**			Redness or heat of any joints	**Y N**
recurrent sores in mouth	**Y N**			gout	**Y N**
chest pain	**Y N**			loss or change of sensation in	
angina pectoris	**Y N**			hands or feet	**Y N**
coughing up blood	**Y N**			trembling of any extremity	**Y N**
pain in arms	**Y N**			growth in neck or throat	**Y N**
night sweats	**Y N**			hot flashes	**Y N**
chronic or frequent cough	**Y N**			tiredness w/ no apparent reason	**Y N**
shortness of breath	**Y N**			easy bruising	**Y N**
palpitations or fluttering of heart	**Y N**			Have you had a tetanus injection	**Y N**
heart murmur	**Y N**			When:	
rheumatic fever	**Y N**			When was your last TB skin test?	
high blood pressure	**Y N**			**FAMILY HEALTH HISTORY:**	
swelling of hands, feet, or ankles	**Y N**			Has any blood relative ever had:	
leg cramps on walking	**Y N**			Heart disease	**Y N**
enlarged veins in legs	**Y N**			Cancer	**Y N**
recurrent stomach pains	**Y N**			Tuberculosis	**Y N**
belching or heartburn relieved by				Diabetes	**Y N**
food or medication	**Y N**			High blood pressure	**Y N**
appetite: good___fair___poor____				Stroke	**Y N**
recent weight loss or gain	**Y N**			Asthma, bronchitis	**Y N**
nausea or vomiting	**Y N**			Kidney disease	**Y N**
vomited blood	**Y N**			Thyroid disorder	**Y N**
abdominal cramping	**Y N**			Epilepsy	**Y N**
ulcers	**Y N**			Other:	

INSURANCE COMPANY (PRIMARY)_____

INSURANCE COMPANY (SECONDARY)_____

I, _____, authorize the release of medical information to the above noted insurance company(s) and payment of medical benefits directly to Mill City Medical Group Ltd. This authorization is given for all claims processed in connection with my medical treatment.

If I am a MEDICARE patient, I understand that I will be responsible for payment of uncovered Medicare services . Further, I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts the assignment.

_____

Patient's Signature

PLEASE READ THE FOLLOWING CAREFULLY:

It is our office policy that bills incurred by patients through visits to this office be paid at the time of visit unless they are insured by one of the carriers we contract with. If you are unsure, please check with your insurance company directly or check with our billing department before your visit.

All patients who are required to pay at the time of their visit will be given, upon their payment, a receipt for services for that office visit. This receipt will contain all of the necessary explanation; including diagnosis and procedure codes, needed for direct reimbursement by their own insurance carrier. If you are one of these patients, please request this copy at check out.

All copayments are due at the time of the visit. As with any outstanding balances, we are more than happy to arrange a payment plan if need be. Please ask to speak with the billing department to make arrangements.

I,_____, have read and understand the conditions for payment to the physician as outlined above.

Mill City Medical Group, LTD

I acknowledge having received a copy of the practice's Notice of Privacy Practices.

_____ _____

Signature Date

_____

Print your name

MILL CITY MEDICAL GROUP

Consent to Health Information Exchange

Mill City Medical Group participates in Health Information Exchange (HIE) which are secure computer networks that allow participating health care and insurance providers nationwide to access information about you so that each provider has a complete picture of your health. Patient participation is intended to enhance coordination of care amount multiple providers and may avoid the need for you to undergo duplicate tests. The information that may be provided to an information exchange includes both your medical and demographic information. Participation is optional. Please opt in or out by checking a box below and signing.

_____ OPT IN/Agree to Share **_____ OPT OUT/Do Not Share**

Printed Name of Patient **Signature of Patient/Guardian** **Date**

Witness Signature **Date**

Consent to External Prescription History
Please sign only after you have read and understand the following

I authorize Mill City Medical Group and its affiliated providers to view the external prescription history via the Rx Hub service for the patient listed below.

I understand that a prescription history from multiple unaffiliated medical providers, insurance companies and pharmacy benefits mangers may be view-able by the providers and staff of Mill City Medical Group and may include past prescriptions from several years ago.

My signature certifies that I have read, understand, and authorize the access of external prescription history.

Printed Name of Patient/Guardian **Date**

Signature of Patient/Guardian **Date**

Consent to Discuss

I give permission to discuss any information regarding my medical treatment to the following person(s):

_____ _____

_____ _____

Signature of Patient/Guardian **Date**

Helping You Prepare For Your Visit

Dear Patient,

In an effort to improve your care and better understand your concerns during your upcoming visit, please take a moment to fill out the questions below.

1. What concerns would you like the provider to focus on?

   _____

   _____

   _____

   _____

   _____

   _____

2. Please list any Specialists you have seen and tests you have had since last year:

   _____

   _____

   _____

   _____

   _____

   _____

3. Please list any prescriptions you may need refilled:

   _____

   _____

   _____

   _____

   _____

   _____

Patient Name: _____ **Date:** _____

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly everyday

2. Feeling down, depressed, or hopeless

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly everyday

3. Trouble falling or staying asleep, or sleeping too much

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly everyday

4. Feeling tired or having little energy

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly everyday

5. Poor appetite or overeating

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly everyday

6. Feeling bad about yourself, or that you are a failure or have let yourself or your family down

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly everyday

7. Trouble concentrating on things, such as reading the newspaper or watching TV

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly everyday

8. Moving or speaking so slowly that other people could have noticed or the opposite, being so fidgety or restless that you have been moving around a lot more than usual

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly everyday

9. Thoughts that you would be better dead, or of hurting yourself in some way

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly everyday

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with others?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult