Patient Name:_____ Patient Birthdate: _____/_____/_____
(last) (first) (middle initial)

Patient Sex: Male Female Patient Social Security #:_____/_____/_____ Marital Status:_____

Ethnicity: (circle) American Indian Black Caucasian Hispanic Non Hispanic Other

Race: (circle) American Indian Asian Black or African American Caucasian/White Hispanic Non Hispanic Other

Mailing Address or PO Box:_____

City:_____State:_____Zip:_____ E-mail:_____

Home Phone:(____)_____-_____ Cell:(____)_____-_____ Work Phone:(_____)_____-_____

Employment Status: □ Full-Time □ Part-Time □ Unemployed □ Student □ Retired

Employer:_____

Emergency Contacts

Name:_____ Relationship:_____

Home Phone:(____)_____-_____ Cell Phone:(____)_____-_____ Work Phone:(_____)_____-_____

Person responsible for any balance on this account-(only if the patient is a minor)

Name:_____ Social Security#:_____/____/_____

Relationship:_____ Birthdate: _____/_____/_____

Street Address:_____ City:_____ State:____ Zip:_____

Home Phone:(____)_____-_____ Cell Phone:(____)_____-_____ Work Phone:(_____)_____-_____

Employer:_____

Employment Status: □ Full-Time □ Part-Time □ Retired □ Unemployed

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Primary Insurance Information ****Please present all insurance cards to the Receptionist****

Insurance Company:_____

Name of Policy Holder/Insured:_____ Insured Date of Birth:____/___/_____

Relationship to Patient:_____ Employment Status: □ Full-Time □ Part-Time □ Retired □ Unemployed

Second Insurance (if applicable)

Insurance Company:_____

Name of Policy Holder/Insured:_____ Insured Date of Birth:____/___/_____

Relationship to Patient:_____ Employment Status: □ Full-Time □ Part-Time □ Retired □ Unemployed

~~Please Read Authorizations and Polices on back~~

I have read and agree to the authorizations and policies of IMC-Eastern Shore Family Practice as documented on this form.

Patient or Responsible Party Signature:_____ Date:_____

FINANCIAL RESPONSIBILITY – I understand that I am responsible for all charges not paid by my insurance plan except those amounts that IMC-ESFP is contractually obligated to write off. I understand that I am responsible for all non-covered services and by signing this form I acknowledge I have been made aware of my obligation prior to receiving such services. I understand that if I do not pay for the charges for which I am responsible for, IMC-ESFP may turn my account over to a collection agency. I understand that should my account be turned over to a collection agency, I may be charged a collection fee, not to exceed 25% of my account, and I accept these fees charged by IMC-ESFP as a legal and lawful debt and agree to pay such fee if charged. Please remember that your insurance policy is a contract between you and your insurance carrier. Patients without insurance are expected to pay at the time the service is rendered. **Initials** _____

Well (Preventive) vs. Sick Visit-A well visit is an appointment in which the patient has no complaints/concerns or medical diagnosis. This is considered a routine preventive visit. A sick visit is when the patient has complaints/concerns, a pre-existing diagnosis, or the physician discovers a medical concern that needs to be addressed that day. If your appointment is for a well exam and there is also a concern addressed that day, you may be charged an office visit in addition to your wellness visit. In this case, your regular co-pay and/or deductible will apply in addition to your wellness co-pay and/or deductible (if applicable). **Initials** _____

Co-pays are due at the time of your service**.**

No Show Appointments and Late Cancelations – I understand when I make an appointment time is reserved for me that cannot be scheduled for someone else. Recognizing this I will, exempting unforeseen emergencies, notify IMC-ESFP no later than the business day before my appointment should I not be able to keep my appointment. If I do not, I understand IMC-ESFP has the right to charge me a no show fee and I acknowledge such a charge would be a legal and lawful debt and agree to pay such fee if charged. **Initials** _____

Returned Check (NSF) - If you present a check that is returned to IMC-Eastern Shore Family Practice for non-sufficient funds, a $30.00 fee will be charged to your account. **Initials** _____

Laboratory Services - Please remember that specimens sent to labs outside the IMC-ESFP laboratory are billed separately from lab performed in our office. You will be billed separately from the laboratory. **Initials** _____

Minors – I understand that I am responsible for this child's account and any agreement otherwise by means of a court decree or other valid agreement is between me and another party. **Initials** _____

Assignment of Benefits –I request that payment of authorized Medicare and/or Medicaid benefits to me or on my behalf for services in or by IMC-ESFP shall be made to IMC-ESFP, and I specifically assign such benefits to the IMC-ESFP. If applicable, I hereby assign and authorize payment directly to IMC-ESFP all medical benefits under any insurance or third party plan payable to me or which I am otherwise entitled. **Initials** _____

Authorization to Treat – I voluntarily consent to medical treatment and diagnostic procedures provided by IMC-ESFP. I/we are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the results of treatments and/or examinations. **Initials** _____

Release of Information-I authorize any holder of medical information about me to release to Medicare, Medicaid, and/or other health insurance or third party plan and their respective agents any information needed to determine these benefits or related services. **Initials** _____

Telephone and Alternative Communication Consent-I understand IMC-ESFP or its agents may use pre-recorded/artificial voice messages and/or auto dialing devices to remind me about appointments or notify me of other information and I expressly consent to IMC-ESFP or its agents use of any number associated with my account, including any wireless number. I also authorize IMC-ESFP or its agents to contact me at any number associated with my account, including wireless numbers, including contact by means of pre-recorded/artificial voice messages and/or automatic dialing devices, for the purposes of collecting on my account. I also authorize IMC-ESFP to communicate with me using any e-mail address I provide to IMC-ESFP. **Initials** _____

Eastern Shore Family Practice
INFIRMARY HEALTH

27961 US Highway 98, Suite 14

Ross H. Bishop, M.D.
Heather Castleberry, M.D.
David A. Johnson, M.D.

Daphne, AL 36526
Phone: 251-626-1175
Fax: 251-625-1507

Amy E. Kayl, D.O.
Andrew A. Smith, M.D.

Please fill out all four (4) pages of this form ***in advance*** of your appointment.

Personal History: Answering all questions will allow us to best serve your health needs. The information provided herein is strictly confidential.

Name: _____ Date of Birth: _____

Preferred Phone: _____ Alternative Phone: _____

Occupation: _____ Employer: _____

Who was your previous Primary Care Physician? _____

Do you currently see any specialists? _____

Have you ever had a colonoscopy? Yes / No When / By whom? _____

Female only:

When was your last PAP Smear? _____ Was it normal? Yes / No

Last Mammogram? _____ Was it normal? Yes / No

Do you currently use birth control? Yes / No if so, which method? _____

Male only:

When was your last Digital rectal examination? _____ PSA? _____

Self and Family Medical History: please place a "x" in the appropriate box that applies to each family member

	Self	**Mother**	**Father**	**Sibling**	**Sibling**	**Child**	**Other**
Allergies							
Anemia							
Anorexia							
ADD/ADHD							
Anxiety							
Arthritis							
Asthma							
Birth Defect							
Bladder Problems							
Blood Disorder							
Blood Clots							
Bulimia							
Bronchitis							

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	Self	Mother	Father	Sibling	Sibling	Child	Other
Cancer/Type:							
CHF							
COPD							
Depression							
Diabetes: I or II							
Drug Abuse							
Early Deaths							
Emphysema							
Epilepsy							
Gallbladder Disease							
GERD							
Glaucoma							
Gout							
Heart Attack							
Heart Murmur							
Hepatitis							
Hypertension							
HIV							
High Cholesterol							
Irregular Heart Beat							
Kidney Disease							
Liver Disease							
Lung Disease							
Lupus							
Mental Illness							
Migraines							
Osteoporosis							
Seizures							
Stroke							
Tuberculosis							
Thyroid Disease							
Ulcers							
Other							

If applicable:

Mothers cause of death/age? _____

Fathers cause of death/age? _____

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Do you suffer from any of the disorders listed below? (please circle)

Frequent Falls	Sleep Apnea	Insomnia	Bleeding disorder
Recurrent Illness	Trouble Urinating	Chest Pain	Blood in urine / bowel mvmt
Chronic Opioid use	Headaches	Nosebleeds	Post –Concussion Syndrome

Surgical History: If you've had any of the following surgeries *please circle* and *write the year* next to it

Appendectomy	Adenoidectomy	Back Surgery	Bladder Repair
Blood Vessel Repair	Breast Surgery	Cataract	C-Section
Gall Bladder	Heart Surgery	Hernia	Hysterectomy
Intestinal	Joint Replacement	Lasik	Pacemaker
Prostate	Renal / Kidney	Sinus	Tubal Ligation

Any additional surgeries not listed above: _____

Social History:

Marital Status: _____ If married, spouses name: _____

Do you have children? Yes / No

Do you exercise? Yes / No If yes, how often? _____

What are your hobbies / enjoyment? _____

Dietary Habits: _____

Do you currently use tobacco? Yes / No if yes, how many packs per day? _____

Type: Cigarettes ___ Pipe/Cigar ___ Snuff ___ Chew ___ E-Sig/Vape ___

Have you ever smoked tobacco? Yes / No if yes, when did you quit? _____

Do you drink alcohol? Yes / No if yes; Beer / alcohol / wine # drinks per week: _____

Do you use illicit drugs or any history of substance use? Yes / No

Are you sexually active? Yes / No

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Allergies:

Drug Allergies: _____

Food Allergies: _____

Which Pharmacy do you use? _____

Medications: please list or attach all medications that you are currently taking

Medication	Dose (mg/mcg/Units)	Frequency	Doctor	Reason

Additional Medications not listed above: _____

For Women Only:

Currently Pregnant Yes / No

Having Menstrual Cycle? Yes / No If yes, last date of menstrual cycle _____

Immunizations: **Date**

Influenza / Flu: Yes / No / Reaction _____

Pneumonia: Yes / No/ Reaction _____

Tetanus: Yes / No / Reaction _____

Shingles: Yes / No / Reaction _____

COVID-19: Yes / No / Reaction _____

We greatly appreciate you taking the time to fill out this form to the best of your ability.
We look forward to helping you with all your health care needs.

IMC-Eastern Shore Family Practice, LLC

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Daphne, AL 36526
251-626-1175 | Fax 251-625-1507

Authorization form – Release of Medical Records
For use and disclosure of Protected Health Information

Patient Name:_____ Date of Birth:_____

By signing this Authorization Form, I understand I am giving authorization to IMC-Eastern Shore Family Practice, LLC +medical record custodian, to release my protected health information including Medical, Psychiatric, Alcohol, HIC, Drug Abuse and/or Financial Information contained in my records. I authorize IMC-Eastern Shore Family Practice to:

[ ] Disclose (release) to: or [ ] Obtain (request) from:

Name of Person or Organization:_____

Address:_____

City:_____State:_____ Zip:_____

Phone:_____ Fax:_____

Please use additional form for additional persons or organizations.

Purpose of release: □ At the request of the individual □ Ongoing medical care
□ Other_____

Personal Health Information to be disclosed/or obtained:

___Lab Reports
___Operative Notes
___Pathology Reports
___Immunization Records
___Emergency Room Report
___Progress Notes
___Radiology Reports
___Other_____
Comments:_____

I understand that I can revoke this authorization at any time except to the extent that any action has been taken in reliance on this authorization. I can revoke this authorization by submitting a written request to IMC-Eastern Shore Family Practice release of information department.

This authorization will expire 1 year from the date of signing below unless specified otherwise. Date of expiration if different:_____

I understand that the stated recipient may not be subject to privacy laws and that my protected health information may be further disclosed without privacy regulation protection.

I understand that I am not required to sign this form in order to receive treatment from IMC-Eastern Shore Family Practice.

_____ _____
Signature of Patient Date

_____ _____ _____
Signature of Authorized Representative Date Relationship

☐ Records given to patient/representative Date:_____ Signature_____

IMC-Eastern Shore Family Practice

Acknowledgement of Receipt of Privacy Practice

You acknowledge that you were offered a copy of our Notice of Privacy Practices. If you would like to receive a paper copy at any time in the future, you may call (251)626-1175.

Patient Name:_____
(please print)

Signature of Patient (if over 14 years of age):_____

Signature of Parent/Guardian (if under 14 years of age):_____

Date:_____

We will only release information with a completed and signed Release of Information. However, you may designate individuals that we may discuss your health care with. Please list those below.

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

☐ I <u>do not</u> wish to have my health care discussed with anyone.