

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Name _____
Preferred Name _____ Maiden Name _____ Preferred Pharmacy & Address _____
Date of Birth _____ Social Security # _____ Primary Language _____ English _____ Spanish _____
Marital Status: _____ Driver's License State _____ # _____

Race: African American American Indian Asian Caucasian Hispanic Other

Religion: Catholic Protestant Hindu Islam Jewish Buddhist Other

Address: _____ ZIP _____ City _____ State _____
Primary Phone: _____ Work Phone _____ Cell Phone _____
Fax Number _____ Pager Number _____ E-mail _____
Employer: _____ Full Time Part Time
Phone Or Ext _____ Hire Date _____ Occupation _____

PARENT OR SPOUSE (Circle One) INSURED INFO:

Last Name _____ First Name _____ Middle Name _____
Preferred Name _____ Maiden Name _____
Date of Birth _____ Social Security # _____ Primary Language _____ English _____ Spanish _____
Marital Status: _____ Driver's License State _____ # _____

Address: _____ ZIP _____ City _____ State _____
Primary Phone: _____ Work Phone _____ Cell Phone _____
Fax Number _____ Pager Number _____ E-mail _____
Employer: _____ Full Time Part Time
Phone Or Ext _____ Hire Date _____ Occupation _____

EMERGENCY CONTACT:

Last Name _____ First Name _____ Middle Name _____
Preferred Name _____ Maiden Name _____ Date of Birth & Relationship _____
Address: _____ ZIP _____ City _____ State _____
Primary Phone: _____ Work Phone _____ Cell Phone _____

PATIENT MEDICAL HISTORY - Please attach additional pages if necessary

Name: _____

Current & Past Medical Diagnosis

Please list all medical conditions you have or have had diagnosed.

Description	Date or Age Diagnosed	Current / Past
		___ Current ___ Past
		___ Current ___ Past
		___ Current ___ Past
		___ Current ___ Past
		___ Current ___ Past
		___ Current ___ Past
		___ Current ___ Past
		___ Current ___ Past
		___ Current ___ Past

Have you ever smoked? ___ Yes ___ No
 If yes, are you currently smoking? ___ Yes ___ No
 Amount smoked per day _____

Do you drink alcohol? ___ Yes ___ Never ___ Occasionally
 If yes, number of drinks per week/month (circle one) _____

Have you ever used recreational/street drugs? ___ Yes ___ No
 If yes, what kind? _____

Family History

Please list any medical conditions of immediate family members

Mother		
Father		
Grandmother (Maternal)		
Grandfather (Maternal)		
Grandmother (Paternal)		
Grandfather (Paternal)		
Aunts		
Uncles		
Brothers		
Sisters		

Patient Name: _____

Patient HIPAA Questionnaire

1. Please list anyone whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations).

Name	Phone #	Relationship to Patient
_____	_____	_____
_____	_____	_____

2. Please print the address you want your billing statements and/or correspondence from our office to be sent if other than your home.

3. We routinely leave messages (i.e. appointment reminders or requests to call our office back) on telephone answering machines or voicemail? If you do not want these messages handled in this fashion, indicate otherwise.

Patient Signature (Guardian if under 18) _____

Date _____

IF THE PATIENT IS UNDER 18, AND NOT PREGNANT, A PARENT OR GUARDIAN MUST COMPLETE THE CONSENT TO TREAT BELOW:

I am the parent/legal guardian of _____ who is a minor.
I give my permission for Dr. Libson to provide complete medical care for her.

Signed _____ Date _____

Patient Financial Policy

INSURANCE AUTHORIZATION AND ASSIGNMENT (Please read and Sign)

I hereby authorize Dr. David S. Libson to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. If I fail to provide the correct insurance or Medicaid/Medicare information to the office, I understand I will be responsible for any amount not paid or recouped by third party carriers.

Signature _____

Date _____

NEW POLICY ACKNOWLEDGEMENT

Effective October 15, 2018, there will be a charge to patient (not paid or recouped by third party carriers) of \$40.00 for a no show to your appointment and a \$20.00 for same day cancellations.

Signature _____

Date _____