Dr. Bernice R. Swain | Family Medicine
2424 Danville RD Suite L
Decatur, AL. 35603
Phone: 256-341-0043
Fax: 256-341-0095

New Patient Inquiry

Name:_____ Date of Birth: _____ SSN:_____

Address:_____ Phone: (___)___-____

Email:_____ How did you hear about us?_____

Current Family Dr._____ Today's Date:_____

Insurance

Primary:_____ Secondary:_____ Tertiary:_____

List any Medications you're currently taking or have been prescribed and the Doctor prescribing them:

_____
_____
_____
_____
_____

Do you have an urgent medical need? Yes / No If yes, what is it?_____
_____
_____

Office Use Only

Dr. Bernice R. Swain Review Date: __/__/____ Accepted: Yes / No

Reasons Denied:_____
Scheduled:_____

Scheduled by:

_____

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Patient Registration (Confidential)			
Patient Name	Marital Status	Date of Birth	
Street Address		City, State, Zip	
Home Phone	Cell Phone	Social Security	
Referred By		Driver's License Number	
Patients Employer		Occupation (Include if Student)	
Employer Address		Employer Phone Number	
Spouse/Parent		Date of Birth	SSN
Employer		Phone Number	Cell Number
Emergency Contact		Relationship	
Address		Home	Cell
Billing information		Payment required at the time of service unless other arrangements have been made.	
Billing Name (If other than Patient)		Relationship	
Billing address		City, State, Zip	
Insurance Information			
Primary Insurance	Phone Number	Effective Date	
Address		Group Number	
Name of Insured		Relationship to Patient	
Additional Insurance		Effective Date	
Name of Insured	Relationship to Patient	Group Number	
Medicare Number:			
Signature:		Date:	

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Patient Consent

Consent for treatment:

I hereby authorize the performance of any medical procedure which may be advised and/or recommended by Dr. Bernice R. Swain while I am under her care.

Authorization for release of medical information:

I authorize Dr. Bernice R. Swain and/or authorized employee to furnish any medical information requested by insurance companies with whom I have coverage or any public agency which may be assisting in payment for my care

Financial Policy:

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees. Financial Policy, or your responsibility. All patients must complete our *"Patient Information form"* Before receiving treatment.

I understand that I will be responsible for all charges incurred during my course of treatment in this office regardless of insurance coverage.

Adult patients: Are responsible for full payment.

Minors Accompanied by an Adult: The adult accompanying a minor, and his/her parents (or Guardian), are responsible for full payment.

Unaccompanied Minors: The parents (or guardians) are responsible for full payment. Non-emergency treatment may be denied unless charges have been pre-authorized to an approved method of payment (cash, or check).

Insurance:

If you have insurance, we will help you receive maximum benefits. If we accept your insurance, you will be responsible for your estimated co-payment amount and any unmet deductible at the time of service.

Insurance is a contract between you and your insurance company.

We are NOT a party to this contract. We file insurance claims as a COURTESY to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual, customary & reasonable" charges, etc. other than to supply factual information as necessary. You are responsible for the timely payment of your account.

Any account that we receive no payment on for 90 days will be turned over to a collection agency for collection. At that time, you will be responsible (or the balance on your account, and an additional charge of 40% of your total balance to cover the collection agency fees. Therefore, please do not let your account reach this point without trying to make satisfactory arrangements with us to keep your account current.

Missed Appointments

If you cannot make your appointment, please call at least two hours in advance to cancel. We reserve the right to charge for any non-cancelled appointment. It is our policy that three consecutive "NO SHOW" for two scheduled appointments, or a total of six cancellations and/or no shows constitute discontinuation of treatment.

Patient (Responsible Party) Signature _____ Date _____

Witness _____ Date _____

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Authorization to Release Medical Information

Dr. Bernice R. Swain is authorized to discuss my medical information or needs with the following individuals:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Patient or Representative Signature:_____ Date:_____

(14 and Over)

By circling yes on this form you authorize Dr. Swain and staff to leave detailed messages regarding personal health care information on your voicemail. (Please Circle One) Yes / No

If yes, please list numbers where you may be contacted:

Cell: (___)_____

Work: (___)_____

Home: (___)_____

Parent or Guardian Signature:_____ Date:_____

(14 and Over)

New Patient Inquiry

Date of first appointment: _____/____/_____ Time of appointment: _____ Birthplace:_____
MONTH DA Y YEAR

Name: _____ Birthdate: _____/_____/_____
LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR

Address: _____ Age: _____ Sex: __ F __ M
STREET APT#

_____Telephone: Home (_____)_____
CITY STATE ZIP Work (_____)_____

MARITAL STATUS: __ Never Married __ Married __ Divorced __ Separated __ Widowed

Spouse/Significant Other: Alive/Age _____ Deceased/Age _____ Major Illnesses_____

EDUCATION (circle highest level attended):

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School _____

Occupation _____ Number of hours worked/average per week _____

Referred here by: (check one) __ Self __ Family __ Friend __ Doctor __ Other Health Professional_____

Patient's Name _____ Date _____Physician Initials _____

MEDICAL HISTORY

As you review the following list, please check any of those problems, which have significantly affected you.

Date of last mammogram _____ Date of last eye exam _____ Date of last chest x–ray _____

Date of last Tuberculosis Test _____ Date of last bone densitometry _____

Constitutional

☐ Recent weight gain
amount _____
☐ Recent weight loss
amount _____
☐ Fatigue
☐ Weakness
☐ Fever

Eyes

☐ Pain
☐ Redness
☐ Loss of vision
☐ Double or blurred vision
☐ Dryness
☐ Feels like something in eye
☐ Itching eyes

Ears–Nose–Mouth–Throat

☐ Ringing in ears
☐ Loss of hearing
☐ Nosebleeds
☐ Loss of smell
☐ Dryness in nose
☐ Runny nose
☐ Sore tongue
☐ Bleeding gums
☐ Sores in mouth
☐ Loss of taste
☐ Dryness of mouth
☐ Frequent sore throats
☐ Hoarseness
☐ Difficulty in swallowing

Cardiovascular

☐ Pain in chest
☐ Irregular heart beat
☐ Sudden changes in heart beat
☐ High blood pressure
☐ Heart murmurs

Respiratory

☐ Shortness of breath
☐ Difficulty in breathing at night
☐ Swollen legs or feet
☐ Cough
☐ Coughing of blood
☐ Wheezing (asthma)

Gastrointestinal

☐ Nausea
☐ Vomiting of blood or coffee ground material
☐ Stomach pain relieved by food or milk
☐ Jaundice
☐ Increasing constipation
☐ Persistent diarrhea
☐ Blood in stools
☐ Black stools
☐ Heartburn

Genitourinary

☐ Difficult urination
☐ Pain or burning on urination
☐ Blood in urine
☐ Cloudy, “smoky” urine
☐ Pus in urine
☐ Discharge from penis/vagina
☐ Getting up at night to pass urine
☐ Vaginal dryness
☐ Rash/ulcers
☐ Sexual difficulties
☐ Prostate trouble

For Women Only:

Age when periods began:_____
Periods regular? ☐ Yes ☐ No
How many days apart? _____
Date of last period? _____
Date of last pap? _____
Bleeding after menopause? ☐ Yes ☐ No
Number of pregnancies? _____
Number of miscarriages? _____

Musculoskeletal

☐ Morning stiffness
Lasting how long?
_____ Minutes _____ Hours
☐ Joint pain
☐ Muscle weakness
☐ Muscle tenderness
☐ Joint swelling
List joints affected in the last 6 mos.
_____
_____
_____
_____
_____

Integumentary (skin and/or breast)

☐ Easy bruising
☐ Redness
☐ Rash
☐ Hives
☐ Sun sensitive (sun allergy)
☐ Tightness
☐ Nodules/bumps
☐ Hair loss
☐ Color changes of hands or feet in the cold

Neurological System

☐ Headaches
☐ Dizziness
☐ Fainting
☐ Muscle spasm
☐ Loss of consciousness
☐ Sensitivity or pain of hands and/or feet
☐ Memory loss
☐ Night sweats

Psychiatric

☐ Excessive worries
☐ Anxiety
☐ Easily losing temper
☐ Depression
☐ Agitation
☐ Difficulty falling asleep
☐ Difficulty staying asleep

Endocrine

☐ Excessive thirst

Hematologic/Lymphatic

☐ Swollen glands
☐ Tender glands
☐ Anemia
☐ Bleeding tendency
☐ Transfusion/when _____

Allergic/Immunologic

☐ Frequent sneezing
☐ Increased susceptibility to infection

Patient’s Name _____ Date _____ Physician Initials _____

SOCIAL HISTORY

Do you drink caffeinated beverages?

Cups/glasses per day? _____

Do you smoke? ☐ Yes ☐ No ☐ Past – How long ago?_____

Do you drink alcohol? ☐ Yes ☐ No Number per week _____

Has anyone ever told you to cut down on your drinking?
☐ Yes ☐ No

Do you use drugs for reasons that are not medical? ☐ Yes ☐ No
If yes, please list: _____

_____

Do you exercise regularly? ☐ Yes ☐ No

Type _____

Amount per week_____

How many hours of sleep do you get at night? _____

Do you get enough sleep at night? ☐ Yes ☐ No

Do you wake up feeling rested? ☐ Yes ☐ No

PAST MEDICAL HISTORY

Do you now or have you ever had: (check if "yes")

☐ Cancer	☐ Heart problems	☐ Asthma
☐ Goiter	☐ Leukemia	☐ Stroke
☐ Cataracts	☐ Diabetes	☐ Epilepsy
☐ Nervous breakdown	☐ Stomach ulcers	☐ Rheumatic fever
☐ Bad headaches	☐ Jaundice	☐ Colitis
☐ Kidney disease	☐ Pneumonia	☐ Psoriasis
☐ Anemia	☐ HIV/AIDS	☐ High Blood Pressure
☐ Emphysema	☐ Glaucoma	☐ Tuberculosis

Other significant illness (please list)

_____

_____

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

_____

_____

_____

Previous Operations

Type	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? ☐ No ☐ Yes Describe:_____

Any other serious injuries? ☐ No ☐ Yes Describe:_____

FAMILY HISTORY:

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of siblings _____ Number living _____ Number deceased _____

Number of children _____ Number living _____ Number deceased _____ List ages of each _____

Health of children: _____

Do you know of any blood relative who has or had: (check and give relationship)

☐ Cancer _____	☐ Heart disease _____	☐ Rheumatic fever_____	☐ Tuberculosis _____
☐ Leukemia _____	☐ High blood pressure _____	☐ Epilepsy_____	☐ Diabetes _____
☐ Stroke _____	☐ Bleeding tendency _____	☐ Asthma _____	☐ Goiter _____
☐ Colitis _____	☐ Alcoholism_____	☐ Psoriasis _____	

Patient's Name _____ Date _____Physician Initials _____

MEDICATIONS

Drug allergies: ☐ No ☐ Yes To what? _____

_____

Type of reaction: _____

PRESENT MEDICATIONS (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: Helped? A Lot	Some	Not At All
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

PAST MEDICATIONS Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, how long you were taking the medication, the results of taking the medication and list any reactions you may have had. Record your comments in the spaces provided.

Drug names/Dosage	Length of time	Please check: Helped? A Lot	Some	Not At All	Reactions
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)					
Check any you have taken in the past					
Ansaid (flurbiprofen)					
Arthrotec (diclofenac + misoprostil)					
Aspirin (including coated aspirin)					
Celebrex (celecoxib)					
Clinoril (sulindac) Daypro (oxaprozin)					
Disalcid (salsalate)					
Dolobid (diflunisal)					
Feldene (piroxicam)					
Indocin (indomethacin)					
Lodine (etodolac)					
Meclomen (meclofenamate)					
Motrin/Rufen (ibuprofen)					
Nalfon (fenoprofen)					
Naprosyn (naproxen)					
Oruvail (ketoprofen)					
Tolectin (tolmetin)					
Trilisate (choline magnesium trisalicylate)					
Vioxx (rofecoxib)					
Voltaren (diclofenac)					
Pain Relievers					
Acetaminophen (Tylenol)					
Codeine (Vicodin, Tylenol 3)					
Propoxyphene (Darvon/Darvocet)					
Other:					
Other:					
Disease Modifying Antirheumatic Drugs (DMARDS)					
Auranofin, gold pills (Ridaura)					

Patient's Name _____ Date _____ Physician Initials _____

Gold shots (Myochrysine or Solganol)					
Hydroxychloroquine (Plaquenil)					
Penicillamine (Cuprimine or Depen)					
Methotrexate (Rheumatrex)					
Azathioprine (Imuran)					
Sulfasalazine (Azulfidine)					
Quinacrine (Atabrine)					
Cyclophosphamide (Cytoxan)					
Cyclosporine A (Sandimmune or Neoral)					
Etanercept (Enbrel)					
Infliximab (Remicade)					
Prosorba Column					
Other:					
Other:					
Osteoporosis Medications					
Estrogen (Premarin, etc.)					
Alendronate (Fosamax)					
Etidronate (Didronel)					
Raloxifene (Evista)					
Fluoride					
Calcitonin injection or nasal (Miacalcin, Calcimar)					
Risedronate (Actonel)					
Other:					
Other:					
Gout Medications					
Probenecid (Benemid)					
Colchicine					
Allopurinol (Zyloprim/Lopurin)					
Other:					
Other:					
Others					
Tamoxifen (Nolvadex)					
Tiludronate (Skelid)					
Cortisone/Prednisone					
Hyalgan/Synvisc injections					
Herbal or Nutritional Supplements					
Please list supplements:					

Have you participated in any clinical trials for new medications? ☐ Yes ☐ No

If yes, list: _____

_____

_____

_____

_____

Patient's Name _____ Date _____ Physician Initials _____

ACTIVITIES OF DAILY LIVING

Do you have stairs to climb? ☐ Yes ☐ No If yes, how many? _____

How many people in household? _____ Relationship and age of each _____

Who does most of the housework? _____ Who does most of the shopping? _____ Who does most of the yard work? _____

On the scale below, check which best describes your situation; Most of the time, I function…

VERY POORLY	POORLY	OK	WELL	VERY WELL

Because of health problems, do you have difficulty:
(Please check the appropriate response for each question.)

	Usually	Sometimes	No
Using your hands to grasp small objects? (buttons, toothbrush, pencil, etc.)			
Walking?			
Climbing stairs			
Descending stairs			
Sitting down			
Getting up from chair			
Touching your feet while seated			
Reaching behind your back			
Reaching behind your head?			
Dressing yourself?			
Going to sleep?			
Staying asleep due to pain?			
Obtaining restful sleep?			
Bathing?			
Eating?			
Working?			
Getting along with family members?			
In your sexual relationship?			
Engaging in leisure time activities?			
With morning stiffness?			
Do you use a ☐ cane, ☐ crutches, as ☐ walker or a ☐ wheelchair?			

What is the hardest thing for you to do? _____

Are you receiving disability? Yes ☐ No ☐

Are you applying for disability? Yes ☐ No ☐

Do you have a medically related lawsuit pending? Yes ☐ No ☐

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Consent for Purposes of Treatment. Payment and Health Care Operations

I, _____, understand that as part of my health care; Dr. Bernice Swain originates and maintains paper and/or electronic records describing my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Dr. Bernice Swain is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Dr. Bernice Swain reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Dr. Bernice R Swain change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to allow the following persons to have access to, use of, or disclosure of my health information:

_____
_____

I wish to have the following restrictions to the use or disclosure of my health information:

_____
_____
_____

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / disclose the terms of this consent.

_____

Patient’s Signature

_____

Date

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Receipt of Notice of Privacy Practices Written Acknowledgement Form

I am patient of Dr. Bernice R. Swain. I hereby acknowledge receipt of Dr. Bernice R. Swain's Notice of privacy Practices.

Name:_____

Signature:_____

Date:_____

or

I am a parent of legal guardian of _____ [Patient Name]. I hereby acknowledge receipt of Dr. Bernice R. Swain's Notice of privacy Practices with respect to the patient.

Name:_____

Relationship to Patient:_____ Parent_____ Legal Guardian_____

Signature:_____

Date:_____