Welcome to Dothan Medical Associates, PC

You have been scheduled for an appointment to see one of our physicians or a nurse practitioner here at Dothan Medical Associates, PC.

Your appointment time is enclosed along with the **forms and information needed for your visit with us.**

You must complete the enclosed paperwork prior to being seen in our office.

IMPORTANT**:** Arrival time is 30 minutes before your scheduled appointment. This will allow our staff ample time to complete all the necessary paperwork.

BRING ALL MEDICATIONS OR A COMPLETE WRITTEN LIST OF CURRENT MEDICATIONS.

If you are a diabetic and have a meter, please bring your meter and log book.

LOCATION: We are located in the **"Doctor's Building"** on the **1st floor** at **Southeast Alabama Medical Center.**

Please feel free to contact us if you have any questions or concerns.

Dothan Medical Associates, P.C.
Patient Registration

FOR OFFICE USE ONLY
ID# ____________

REASON FOR VISIT: ______________________________________ PREFERRED PHARMACY: ________________________________

WHAT DOCTOR REFERRED YOU TO US: ____ DATE ______________________

NAME		SEX ❑ M ❑ F	AGE	BIRTHDATE	MARITAL STATUS M S D W
MAILING ADDRESS		SOCIAL SECURITY #		DRIVER'S LICENSE #	
CITY STATE ZIP		❑ EMPLOYED	❑ RETIRED	❑ DISABLED	❑ STUDENT
EMAIL ADDRESS		EMPLOYER OR SCHOOL		OCCUPATION	
HOME PHONE	CELL	WORK		PRIMARY NUMBER	

WHICH ONE OF THE ABOVE NUMBERS CAN WE USE TO LEAVE MESSAGES REGARDING APPOINTMENT REMINDERS:

SPOUSE OR GUARDIAN INFORMATION:

NAME		RELATIONSHIP TO PATIENT	SSN #	BIRTHDATE
ADDRESS		OCCUPATION		
CITY		EMPLOYER		
HOME PHONE	WORK OR CELL PHONE	CITY	STATE	ZIP

EMERGENCY CONTACT OTHER THAN SPOUSE (REQUIRED):

Name Relationship Phone

FINANCIAL POLICY:

COMMERCIAL INSURANCE:

Payment is expected at the time of service unless we are a provider for your insurance company. We currently have provider contracts with Medicare, BCBS PMD/PPC, Heathsource PPN (formerly Provident PPN), Perdue, Beechstreet, CCN, TriCare, and OneSource MedNet. It is our policy that all co-pays and/or deductible amounts are due and expected at the time of service.

Credit Cards accepted: VISA MASTERCARD

INSURANCE INFORMATION:

Primary ____ Secondary ____

Please present the following information to the Receptionist to make a photocopy for your chart:

All Insurance Cards Your Driver's License

AUTHORIZATIONS:

INSURANCE AND PAYMENT AUTHORIZATIONS:

I authorize **Dothan Medical Associates, P.C.**, to release any medical information requested by my health insurance carrier, Medicare or any other third-party payers. **Dothan Medical Associates, P.C.**, may contact my insurance company or health plan administrator to obtain pertinent financial information concerning coverage and payments under my policy. I hereby authorize payment of insurance benefits be made on my behalf to **Dothan Medical Associates, P.C.**, and assign benefits to the physician indicated on the claim.

I understand that I am responsible for any co-pays or deductibles as defined by my insurance policy, and for any "non-covered" services of my consent if deemed necessary. I accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all costs of collection, attorney fees, and/or court costs; if such be necessary. I waive now and forever my rights of exemption under the laws of the constitution of the State of Alabama and any other state.

I give **Dothan Medical Associates, P.C.**, its employees and/or agents "express prior consent" to contact me at any/all phone numbers, including cell phone numbers (by phone call or text message) for the purpose of treatment, insurance or payment. I authorize **Dothan Medical Associates, P.C.**, to release all information to my referring physician and/or primary care physician.

I hereby give authorization for treatment to my physician(s) at **Dothan Medical Associates, P.C.**, and give permission to disclose my protected health information in order to carry out treatment, payment, and other healthcare operations.

DATE__________________________ **SIGNATURE** ____

(PATIENT OR RESPONSIBLE PARTY)

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DOTHAN MEDICAL ASSOCIATES, P.C.
NEW PATIENT INFORMATION
Please Complete In Full

GW#____________
(office use only)

NAME:____ **Date of Birth**:________________ Sex: ❑ M ❑ F

Occupation: ____Marital Status:________________

Do you smoke? ❑ No ❑Yes, packs per day? ________ ❑ Former smoker-how long?_____________________

Do you drink alcohol? ❑ No ❑ Yes - how much and how often? ___________________________________

Do you drink caffeinated beverages? ❑ No ❑Yes - cups/glasses per day? ______________________________

Do you have a history of illegal drug use? ❑ No ❑Yes If yes, name of drug_____________________________

MEDICAL HISTORY

Have you had or do you have any of the following? (check box if applicable)

❑ Abdominal Aortic Aneurysm
❑ Acid reflux
❑ Allergic Rhinitis
❑ Alzheimer's
❑ Anemia
❑ Anxiety disorder
❑ Arthritis
❑ Arrhythmias
❑ Asthma
❑ Atrial Fibrillation
❑ Bipolar disorder
❑ Cancer: Location _____________________
❑ Carpal Tunnel Syndrome
❑ Cataracts
❑ Cirrhosis
❑ CHF (Congestive Heart Failure)
❑ COPD (Chronic Obstructive Pulmonary Disease)
❑ Coronary Artery Disease
❑ Dementia
❑ Depression
❑ Diabetes ___Type I ____Type II
❑ Diverticulitis
❑ DVT (Blood Clot)
❑ Emphysema
❑ Enlarged prostate
❑ Erectile Dysfunction
❑ Fatty Liver
❑ Fibromyalgia
❑ GERD (Gastro-esophageal Reflux Disorder)
❑ Glaucoma
❑ Goiter
❑ Gout
❑ Heart attack
❑ Hepatitis A___ B____ C___
❑ High blood pressure
❑ High cholesterol
❑ HIV/AIDS
❑ Jaundice
❑ Kidney disease
❑ Kidney stones
❑ Leukemia
❑ Lupus
❑ Menopause
❑ Migraine headaches
❑ Mitral Valve Prolapse
❑ Nervous breakdown
❑ Neuropathy
❑ Osteoporosis
❑ Parkinson's Disease
❑ Pneumonia
❑ Psoriasis
❑ PVD (Peripheral Vascular Disease)
❑ Raynaud's
❑ Rosacea
❑ Schizophrenia
❑ Seizure disorder
❑ Sleep apnea
❑ Stomach ulcers
❑ Stroke
❑ Thyroid abnormality (overactive or underactive)
❑ TIA (Mini Stroke)
❑ Tuberculosis
❑ Other significant illness: (please list)____
____
____
____
____
____

PAST SURGICAL HISTORY

List All Surgeries

Type of Surgery **Year** **Surgeon**

1.____

2.____

3.____

4.____

5.____

6.____

7.____

8.____

Any previous fractures? ❑ No ❑ Yes Describe: ____________________________

Any other serious injuries? ❑ No ❑ Yes Describe: ____________________________

FAMILY MEDICAL 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 ________Ages of each ______________

Health of children: ____

____

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

❑ Cancer ________________ ❑ Heart disease ______________________ ❑ Asthma __________________

❑ Diabetes ______________ ❑ High blood pressure ________________ ❑ Leukemia _________________

❑ Stroke ________________ ❑ Bleeding tendency _________________ ❑ Epilepsy _________________

❑ Psoriasis ______________ ❑ Rheumatic fever __________________ ❑ Goiter ____________________

❑ Colitis_________________ ❑ Tuberculosis ______________________ ❑ Alcoholism ________________

CURRENT MEDICATION LIST

(Include any vitamins or non-prescription medicines)

NAME OF MEDICATION	DOSAGE (ex. mg, mcg)	DIRECTIONS

ALLERGIES: ______________________________

SYSTEMS REVIEW

As you review the following list, please check any of those problems that you are currently having at time of visit.

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 ________________ Date of last foot exam ______________

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
- £ Numbness/Tingling
- £ Tremor

Psychiatric
- ❑ Excessive worries
- ❑ Anxiety
- ❑ Easily losing temper
- ❑ Depression
- ❑ Agitation
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep

Endocrine
- ❑ Excessive thirst
- £ Hot/Cold Intolerance

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 _______

DOTHAN MEDICAL ASSOCIATES, P.C.

PATIENT CONSENT FOR USE / DISCLOSURE OF HEALTH CARE INFORMATION

I, ______________________________________, give permission to my physician(s) at **Dothan Medical Associates, P.C.** to use and disclose my personal health information to carry out treatment, payment, and other health care operations. I understand that **Dothan Medical Associates, P.C.** works hard to protect my privacy and preserve the confidentiality of my personal health information. I realize that employees who work for **Dothan Medical Associates, P.C.** may use and see my information, but they may use it only as permitted in this form.

This information can include spoken or written facts about my health or payment benefits as permitted under the law. It can include copies of records from my health care providers or health plans about my health care. It also gives permission for any listed persons I designate below to have access to my medical information.

This disclosure becomes effective April 14, 2003 and will continue unless it is cancelled, changed or amended by my appointed legal representative, or myself. I realize I may stop or change the names listed below by notifying my doctor in writing that I do not want them to know or share my private information. If I decide to revoke this consent, I understand that **Dothan Medical Associates, P.C.** does not have to provide any further care services to me depending on the circumstances.

I know that my private healthcare information will be protected by **Dothan Medical Associates, P.C.** and every safety precaution will be taken to ensure that my personal health information is kept private and confidential. My signature below indicates that I agree to allow Dothan Medical Associates, P.C. to use and disclose my personal health information to carry out treatment, payment, and health care operations.

______________________________ ______________________ ______________

Signature of Patient or Authorized Person **Date of Birth (Patient)** **DATE**

______________________________ ______________________________

Printed Name of Above **Relation to Patient**

PLEASE CHECK ANY/ALL OF THE FOLLOWING WAYS WE ARE PERMITTED TO LEAVE PATIENT INFORMATION FOR YOU:

- ❑ Information regarding tests results may be left on my_____home phone_____work phone_____other___________
- ❑ Information regarding appointments may be left on my_____home phone_____work phone_____other___________
- ❑ I do not wish for any of my private information to be left on my home phone, work phone, or other phone.

*** The names listed below are permitted to share and know my health information.**

______________________________ RELATION:__________________ PHONE:__________________

______________________________ RELATION:__________________ PHONE:__________________

______________________________ RELATION:__________________ PHONE:__________________

______________________________ RELATION:__________________ PHONE:__________________

______________________________ RELATION:__________________ PHONE:__________________

* **The names given above mean we can discuss results of ordered tests, labs, medication changes, appointments, or other things pertaining to your health care. For example, if your daughter is usually the contact person for you, please be sure to list her.**

Financial Policy

Since the founding of this practice, Dothan Medical Associates, P.C. has always offered the most innovative and best medical care possible. In order to continue to do so, the following Patient Financial Policy was implemented.

Self-Pay Patients / Non-Covered Patients

Payment is expected at the time of service for patients who have no insurance coverage. You will be given an ESTIMATE of the charges before your visit. We will work with you should you have the need for a payment plan, however, this must be arranged prior to your visit.

Insurance Patients

You are required to present your insurance card and a photo ID at each appointment. We will verify your benefits and your financial responsibility with your insurance company prior to your appointment. Also, as a courtesy to you, we will file a claim with your primary and secondary insurance companies.

Health plan coverage varies significantly by carrier, by employer, and/or by contract. We cannot know the benefits and exclusions of each patient's health plan. It is the patient's responsibility to know and understand their plan coverage and benefits.

While our billing professionals will do all they can to help you in communicating with your insurance plan representative, you remain responsible for any issues regarding your coverage, benefits, and/or payment for services provided.

Payment of copay and/or deductible is required at the time of service. We are providers for the following insurance plans:

Blue Cross Blue Shield of Alabama
Medicare and most Medicare Plans
Medicaid Referrals (Specialists Only)
Beech Street
First Health
TRICARE
CIGNA

Balance Due: We will send monthly statements to inform you of any balance due. We will also remind you of a balance due when you call to schedule an appointment and when you arrive to register for your appointment. Payment may be made in our office or mailed in with your statement. In order to make payment easier for you, we accept cash, checks, money orders, Visa, Mastercard, payment by phone or online payment via our website at www.dothanmedical.com.

Any balance on your account that is 60 days old or older will be considered past due. This balance is your responsibility, regardless of whether or not your insurance company has processed or paid your claim. It is our policy to send two statements and a final notice letter before taking further collection action on your account. You will be responsible for all court costs, filing fees, and attorney's fees should your account require litigation.

Returned Checks: There is a $30.00 fee for a check that is returned.

Questions regarding this financial policy should be directed to our billing office at (334) 794-1148 and ask for Patient Accounts.

Please sign that you have read and understand the Financial Policy of Dothan Medical Associates, P.C.

____
Patient or Responsible Party

____
Date

____
Relationship to Patient