

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 45 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 <input type="checkbox"/> M <input type="checkbox"/> F	AGE	BIRTHDATE	MARITAL STATUS M S D W
MAILING ADDRESS		SOCIAL SECURITY #		DRIVER'S LICENSE #	
CITY	STATE	ZIP	<input type="checkbox"/> EMPLOYED	<input type="checkbox"/> RETIRED	<input type="checkbox"/> DISABLED <input type="checkbox"/> 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)

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)

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

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 _____

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 _____

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	Beech Street	TRICARE
Medicare and most Medicare Plans	First Health	CIGNA
Medicaid Referrals (Specialists Only)		

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