Viewmont Internal Medicine
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1375 4th Street Drive NW
Hickory, NC 28601
828-322-1213
Certified-American Board of Internal Medicine

Please complete and return attached forms prior to your appointment. **We must be in receipt of these forms at least 48 hours prior to your scheduled time or we may have to reschedule your visit.** Insurance co-pays or deductible amounts will be collected at check-in, and self pay patients may expect a minimum charge of $200.00. Please bring cash or credit card only, for your first time visit. Our office also has a No Show appointment charge of $50.00. Please call at least 24 hours prior if you need to reschedule.

We are looking forward to meeting you!

The Office Staff of Viewmont Internal Medicine

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Patient Name: _____ Birth date: _____

Social Security#: _____ Phone#: _____

Emergency Contact: _____ Phone: _____

Please list chronic medical problems and date of onset.
(Example: hypertension, diabetes, cholesterol.)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list all previous surgeries and hospitalizations. Include an approximate date.

Date: Surgery or Hospitalization	**Date: Surgery or Hospitalization**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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Please list all MEDICATIONS that you are currently taking, and any nonprescription drugs including vitamin supplements. Include current dosages. Please attach an additional sheet if necessary.

Medication	Dosage	How many times daily

Preferred Pharmacy_____

_____

Please list any medications, materials, or foods that you need to avoid due to ADVERSE REACTION OR ALLERGY. Use a word to describe the reaction you had.

Allergy	Reaction

Patient signature: _____ **Date:**_____

Insurance Information

Please attached copy of insurance cards if available

Patient Name: (first) _____(last)_____(dob)_____

Primary Insurance

Name of Insurance Company:_____

Policy #: _____ Group #: _____

Co-pay Amount: $_____ Deductible: $ _____ Effective Date: _____

Relationship to insured: (circle one) **Self Spouse Child Mother Father Guardian**

- **Portion below <u>must</u> be filled out completely if you are unable to send a copy (front and back) of your insurance card!!**
- **Insurance Co. Contact Phone #:** _____
- **Claims address:** _____

Primary card holder (if other than patient)

Name: _____ SS#_____ Birth Date: _____

Relationship to patient: _____ Phone: _____

Address: _____

Secondary Insurance (if applicable)

Name of Insurance Company: _____

Policy #: _____ Group #: _____

Co-pay Amount: $_____ Deductible: $ _____ Effective Date: _____

Relationship to insured:(circle one) Self Spouse Child Mother Father Guardian

_____

I hereby authorize Viewmont Internal Medicine to release any information acquired in the course of my examination or treatment to any insurance carrier. I understand that I am financially responsible to Viewmont Internal Medicine for my charges and that the filing of my insurance does not relieve me of this obligation.

Patient/Guardian Signature:_____ Date: _____

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Acknowledgment of Receipt of Privacy Practices and Consent
Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. It also provides information about your rights as a patient of our practice and whom you may contact at out office to ask question about our privacy practices.
By signing this form this form, I hereby acknowledge that I have had the opportunity to read the Notice of Privacy Practices of Viewmont Internal Medicine and understand that in compliance with the Notice, this office is allowed to use or disclose my individually identifiable health information for purposes of treatment, payment, and health care operations. I further understand that the Notice of Privacy Practices provides a more complete explanation of the use or disclosure of my individually identifiable health information.

I have received a copy of Notice of Privacy Practices for Viewmont Internal Medicine.

_____ _____
Patient Name (please print) **Date of Birth**

_____ _____
Patient Signature (or patients representative) **Date**

Contact Authorization

I hereby authorize Viewmont Internal Medicine to contact me and **leave messages** at my home, cell phone, work place, or with **listed family members when necessary to inform me of an appt, appointment changes, billing concerns, or messages to contact the office. If inquiring person's name is not on this list, no information will be given.**

Member/relationship **Member/ relationship**

_____ _____

_____ _____

_____ _____

_____ _____

The above authorization may be revoked in writing at any time except to the extent that action has already been taken.

Viewmont Internal Medicine
Patient Demographic Form

First Name: _____Middle: _____Last:_____

Date of Birth: _____ SSN #_____ Sex: ___ Language: _____ Race: ____

Home Phone: _____ Cell: _____ Daytime Phone: _____

Mailing Address: _____

Home Address: (if different from above):_____

Email Address: _____

Occupation: _____ Primary Dental Provider: _____

Employer: _____ Phone: _____

Primary Insurance:_____ Secondary: _____

Emergency Contact Information

Name: _____ Relationship: _____

Home Phone: _____ Cell: _____ Daytime: _____

Secondary Emergency Contact Information

Name: _____Relationship: _____

Home Phone: _____ Cell: _____ Daytime: _____

Patient Signature: _____ **Date:** _____