Internal Medicine
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Certified-American Board of Internal Medicine

Please complete and return the enclosed forms prior to your appointment. **We must be in receipt of these forms at least 48 hours prior to your scheduled time or we will reschedule your visit.** A self-addressed, stamped envelope has been provided for your convenience.

Insurance co-pays or deductible amounts will be collected at check-in. Patients without insurance may expect a minimum charge of $200.00. Please bring cash or credit card only, for your first visit, as well as your **picture I.D and insurance card**.

Our office also has a "No Show" appointment charge of $100.00 and if you no show your first appointment you will not be allowed to reschedule. 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

Viewmont Internal Medicine
Patient Demographic Form

First Name: _____**Middle:** _____**Last:** _____

Date of Birth: _____ SSN #_____ Sex: _____ Language: _____

Race: _____ Married____ Widowed_____ Single____ Divorced____

Home Phone: _____ Cell: _____ Daytime Phone: _____

Mailing Address: _____

Home Address: (if different from above):_____

Email Address:
_____

Employer: _____ Phone: _____

Primary Insurance: _____ **Secondary:** _____

Emergency Contact Information

Name: _____ Relationship: _____

Home Phone: _____ Daytime: _____ Cell: _____

Secondary Emergency Contact Information

Name: _____ Relationship: _____

Home Phone: _____ Cell: _____ Daytime Phone: _____

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1375 4th Street Drive NW
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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 our office to ask questions about our privacy practices.
By signing 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.

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 appointment, 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 Name	**Relationship to Patient**
_____	_____
_____	_____
_____	_____
_____	_____

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

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

_____ _____
Signature (or patient's representative) **Date of signature**

Viewmont Internal Medicine, PLLC

CONSENT TO OBTAIN MEDICATION HISTORY

As a user of an electronic medical record, we would like to include you medication history in your record. A medication history is a list of prescription medicines that we or other doctors prescribed for you. This list is collected from several sources, including your pharmacy and your health insurance

An accurate medication history is very important to help us treat you and to avoid potentially dangerous drug interactions. By signing this consent form, you give us permission to collect, and give your pharmacy and your health insurance permission to give us information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become part of your electronic medical record, should your provider feel it is important to your medical care.

This medication history is a useful guide, but it may not be complete. Some pharmacies do not make drug history available to us, and the drug history might not include drugs that you purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time to discuss everything you are taking, and for you to tell us about any errors in your medication history

_____**Yes, I give permission for Viewmont Internal Medicine, PLLC, to obtain my medication history from my pharmacy, my health insurance, and my other healthcare providers.**

_____**No, I do not give permission for Viewmont Internal Medicine, PLLC, to obtain my medication history from my pharmacy, my health insurance, nor my other healthcare providers.**

_____ _____

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

_____ _____

Patient Signature (or guardian with relationship) **Date Signed**

Insurance Information

Please attach copy of insurance cards if available.

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

Primary Insurance

- ***If you are unable to send a copy*** **(front and back)** ***of your insurance card*****,** **<u>the portion below must be filled out completely!!</u>**
- **Name of Insurance:** _____
- **Policy #:** _____ **Group #:**_____
- **Co-pay: $**_____ **Deductible: $** _____ **Effective Date:** _____
- **Insurance Co. Contact Phone #:** _____
- **Claims address:** _____
- **Relationship to insured: (circle one) Self Spouse Child Mother Father Guardian**

Primary Card Holder (***<u>if other than patient</u>***)

Name: _____ SS#_____ Birth Date: _____

Relationship to patient: _____ Phone: _____

Secondary Insurance (if applicable)

Insurance Company: _____ Relationship to insured: _____

Policy #: _____ Group #: _____Effective Date: _____

_____

I hereby authorize Viewmont Internal Medicine to release any information acquired during 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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Patient Name: _____ Birth date: _____

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**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient/Guardian Signature: _____ Date: _____

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Patient Name: _____ DOB: _____

Preferred Pharmacy_____

Please list all MEDICATIONS (prescription, non-prescription and vitamin supplements) that you are currently taking. **Please fill out completely and do not attach a medication list from your pharmacy or another medical office as these are often incorrect.**

Medication Name	Dosage	How many times daily

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/Guardian Signature: _____ Date: _____