STONE RUN
FAMILY MEDICINE
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www.StoneRunFamilyMedicine.com

Date:_____

Hello to those new to Stone Run Family Medicine:

In an effort to more fully understand your medical problems and your risks of medical problems, please fill out this form. Keep this form to review with the nurse or provider at your visit.

**Name**:_____ **DOB**: _____/_____/_____

**1. My Medical Problems** **Year Diagnosed**

| | |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

**2. Medical Procedures and hospitalizations.** **Year**

| | |
|---|---|
| | |
| | |
| | |
| | |

**3. Medical problems of my family members:**

| | |
|---|---|
| *Father* | |
| *Mother* | |
| *Brothers* | |
| *Sisters* | |
| *Sons* | |
| *Daughters* | |

**4. Do you use tobacco?**

_____ **Yes** → What form?_____ How much? _____

_____ **No** → Have you ever used tobacco? ___ Yes ___ No When did you quit? _____

**5. How many alcoholic beverages do you ingest in an average week?**_____

**6. When was your last:**

| | |
|---|---|
| **Eye Exam** | Where? |
| **Colonoscopy** | Where? |
| **Mammogram** | Where? |
| **Pap Smear** | Where? |
| **Wellness visit** | |

**7. List your medications, including prescriptions, inhalers, over-the-counter products, skin products, vitamins, herbs, and supplements (or bring the bottles to your visit):**

| **Medication** | **Dose** | **How often?** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**8. Your Pharmacy:** _____

**9. Allergies to medications:** _____

## Consent to Share Medical Information

Is there anyone that you would like to be able to discuss or have access to your protected medical information (ie, husband, wife, children)? If so, please list them here and sign below:

| Contact First and Last Name | Relationship to you | Phone |
|---|---|---|
| Contact First and Last Name | Relationship to you | Phone |
| Contact First and Last Name | Relationship to you | Phone |
| Contact First and Last Name | Relationship to you | Phone |

*In addition to the allowable disclosure described in the "Notice of Privacy Practices," I hereby specifically consent to the disclosure of my protected health information (PHI) including financial information to the person(s) indicated above who are involved in my care. I acknowledge that this consent will remain in place until my written notification requesting a change has been received and processed.*

Your Signature Date

## Demographics

1. **Race:**

| | |
|---|---|
| Asian | Native Hawaiian |
| American Indian/Alaska Native | Other Pacific Islander |
| Black/African American | White |
| Hispanic or Latino | Declined to report |

2. **Are you** (circle one):

   Hispanic  Non-Hispanic

3. **Preferred Language** (circle one):

   English  Other: _____

4. **Maiden Name** (if applicable): _____

5. **Email Address:** _____
   *(This is for an invitation to our patient portal, where you can see your records online, request refills, appointments, etc.)*

6. **How would you like to be notified of important things (like test results)? Please choose one.**

   _____ Email

   _____ Home/Work/Cell phone _____

   _____ Letter

**Name**:_____ **DOB**: _____/_____/_____



**Social Needs: Patient Questionnaire**

Health starts where we work, play, learn, eat, and sleep. Problems in any of these areas can affect your health. We may be able to provide assistance, so we hope you will answer the following questions. You do not have to answer any questions you do not want to. Anything you write will be kept confidential in your medical record.
Please circle your answers.

| | |
|---|---|
| 1. Is it difficult to get transportation to or from your medical appointment? | Yes No |
| 2. Are there enough people you feel close to and can rely on when you have problems? | Yes No |
| 3. In the past month, did poor physical or mental health keep you from doing your usual activities, like work, school, or a hobby? | Yes No |
| 4. In the last 12 months, did you have enough food to eat and money to buy more? | Yes No |
| 5. In the past year, was there a time when you needed to see a doctor but could not because of cost or lack of health insurance? | Yes No |
| 6. In the last 12 months, did you ever feel stressed about making ends meet?<br>Check the box for anything you have trouble paying for:<br>☐ Food ☐ Rent/mortgage ☐ Medical care ☐ Prescriptions<br>☐ Insurance ☐ Gas/Electricity ☐ Childcare ☐ Household supplies ☐<br>Other_____<br><br>Do you need assistance with any of these needs? | Yes No<br><br>Yes No |
| 7. Do you have any problems with your housing, such as unsafe/unclean conditions, temporary living, or no place to live?<br>Check the box for any housing problems that you are having:<br>☐ Unsafe conditions ☐ Unclean conditions ☐ Temporary housing<br>☐ Staying in shelter ☐ No place to live or living on street<br>☐ Other _____ | Yes No |
| 8. Does a partner, or anyone at home, hurt, hit, or threaten you? | Yes No |
| 9. How confident are you filling out forms by yourself? | Not at all<br>Somewhat<br>Extremely |
| 10. How confident are you that you can control and manage most of your health problems?<br>(Select a number from 1 to 10; 1 = not at all confident, 10 = very confident.) | 1 2 3 4 5 6 7 8 9 10 |

*Office use only:* ☐ **No concerns** _____

*Provider signature*

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# Request for Release of Medical Records

## 1 Patient Information:

Name: _____

DOB: _____ SSN: ****-**-_____

## 2 I request that the following medical records be released from:

_____
Doctor/Facility Name

_____
Address City State Zip

_____
Phone Fax

## 3 Purpose of Disclosure:

- ☐ Changing Physicians
- ☐ Legal
- ☐ Continuing Care/Specialist Appointment
- ☐ Workers Comp
- ☐ Other (Please specify: _____)

## 4 Dates Requested:

- ✓ Previous 2 years of visits and test results
- ✓ Immunizations
- ✓ Medication list
- ✓ Medical history list
- ✓ Most recent colon cancer screening

I understand that this authorization will be valid for one year. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it. I understand that if my record contains information related to substance abuse, HIV related information, and/or mental health information, that information will be released with my medical record.

## 5

_____ _____
**Signature of Patient/Legal Guardian/Personal Representative** **Date**

If signed by anyone other than the patient, state the relationship and/or reason and legal authority to do so:

# Our Policies & Procedures

**Appointments**

We have a 15- minute late policy; if you arrive 15 minutes or later after your scheduled time, you will have to reschedule. Please call 24-hours in advance to reschedule an appointment.

If you do not come to your scheduled appointment without calling to cancel it for a total of 3 times, we may have no alternative than to direct you to another physician and/or clinic to medical care. If you find it difficult to keep your appointment (for example: not having transportation), please call us and ask to speak with a care manager. They may be able to provide the help you need. New patients who miss their appointment without notifying us will not be able to reschedule their appointment.

We typically have same-day availability for sick visits for established patients.

**Payment**

Your copay is collected at the start of your visit. We cannot bill you for your copay. For self-pay patients, we collect an initial fee up front, and the cost for any additional services provided is collected at check out. We accept Visa, Mastercard, Discover card, as well as cash and checks for payments. We do offer payment plans and reduced fees for those in financial need. If you have any concerns about paying for your visit, please come ahead of your appointment time to speak with Doris, the office manager.

**Medications**

All requests for prescription refills will be available at the time of request on the next business day. To get a refill on a prescription, leave a message on the nurse's line or request through the patient portal. Prescriptions for controlled substances must be picked up at our office by the patient.

**Tests**

We are able to do some diagnostic tests in our office, including EKGs, pulmonary function tests (PFTs), and urine analysis. For labs, you can use the LabCorp draw site available in our office, or any other facility you prefer. The draw site is open Monday through Friday, 7:30am – 3:30pm (closed 12:30-1:00pm for lunch).

**Referrals and Pre-Authorizations**

Referrals must be requested at least 2-3 days prior to your appointment, and must be picked up at our office. To request a referral, please schedule your appointment first, and then call our office with your appointment information. Pre-authorizations for medical procedures must be requested at least 5 business days prior.

**Forms and Paperwork**

Any form that is required to be filled out that is not the sole purpose of an office visit will be charged a $15 form fee. Anyone requesting a dictated or typed letter will be charged a $15 fee. If you need paperwork filled out by the provider during a visit, please bring the paperwork with your portion filled out (name, address, etc.). Many commonly used forms are available on our website.

**For more information about our practice, please visit our website at**
**www.StoneRunFamilyMedicine.com.**