NEW PATIENT INFORMATION

Thank you for choosing Anderson Medical Center to fulfill your medical needs! Please take a moment to tell us about yourself and your insurance. We want your experience of Anderson Medical Center to be a positive one. Therefore, through continuous focus on patient-centered compassionate care and cost-effective operations, we will work to ensure that our care of you and/or your loved ones is the highest clinical quality, efficient and effective.

PATIENT IDENTIFYING INFORMATION

Social Security Number: _____

Last Name: _____

First Name: _____ Middle Initial: _____

Birth Date: _____
MM/DD/YEAR

Address: _____
Street Apartment Number

_____
City State Zip Code

Home Phone Number: _____

Cell Phone Number: _____

MAY WE LEAVE A MESSAGE AT THESE PHONE NUMBERS FOR MEDICAL PURPOSES? ❑ YES ❑ NO

Sex: ❑ Male ❑ Female

E-Mail Address: _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widow/Widower

Relationship to Guarantor: ❑ Self ❑ Spouse ❑ Child ❑ Other _____
(Guarantor is responsible for payment)

PATIENT TYPE

IS THE PATIENT A MINOR?	❑ Yes	❑ No
IS THIS A CAR ACCIDENT INJURY?	❑ Yes	❑ No
IS THIS A WORK-RELATED INJURY?	❑ Yes	❑ No

EMERGENCY CONTACT INFORMATION

Last Name: _____ First Name: _____ ❑ Male ❑ Female

Address: _____
Street Apartment Number

_____
City State Zip Code

Phone Number: _____

DO YOU AUTHORIZE THIS PERSON TO RECEIVE YOUR MEDICAL INFORMATION OR TO SPEAK WITH US ON YOUR BEHALF? ❑ YES ❑ NO

SUBSCRIBER INFORMATION

(Subscriber is the owner of the insurance policy)

Last Name: _____ First Name: _____

Address: _____
Street Apartment Number

_____
City State Zip Code

Sex: ❑ Male ❑ Female Birth Date: _____
MM/DD/YEAR

My relationship to the subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Phone Number: _____

INSURANCE INFORMATION

Primary Insurance: _____

Policy Holder's Name: _____

Relationship to the subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Policy Holder's Birth Date: _____
MM/DD/YEAR

Secondary Insurance: _____

Policy Holder's Name: _____

Relationship to the subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Policy Holder's Birth Date: _____
MM/DD/YEAR

I hereby request that payment of authorized Medicare and all other insurance benefits be made on my behalf to Anderson Medical Center for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services.

I hereby understand in the event that the reason for my visit today is related to a motor vehicle accident and/or a personal injury accident, I will be responsible to pay as a SELF-PAY patient all charges incurred.

I agree to pay all applicable charges, which are not paid in full by my insurance. I also agree to be responsible for collection fees and accrued interest if the account falls in default. I also agree to pay any additional fees for charges incurred by Anderson Medical Center in the event a check would be returned from my financial institution

I hereby acknowledge that I have read and had an opportunity to ask questions concerning Anderson Medical Center's Financial Policy.

Patient's Signature	Date
Responsible Party	Relationship to Patient

PATIENT RIGHTS AND RESPONSIBILITIES

As a patient you have the right to:

1. Exercise your rights without being subjected to discrimination or reprisal. Be free from all forms of abuse or harassment. Be fully informed about your diagnosis, treatment, or procedure and the expected outcome before the procedure is performed.
2. Receive medical treatment and accommodations regardless of race, creed, sex, national origin, religion, handicap, or disability. Personal privacy and confidentiality of records and communication. Except as required by law, you have the right to approve or refuse the release of records.
3. Participate in decisions involving your health care, unless contradicted by concerns for your health.
4. Make decisions about medical care, including the right to accept or refuse medical treatment and the right to leave the facility even against medical advice of your physician. Receive discharge instructions (verbally and/or written) following any and all treatment or procedure prior to leaving the facility.
5. Receive instructions for provisions for emergency care after discharge from the facility should it become necessary.
6. Be informed if your physician is the owner of the facility. Know the identity and the professional status of the individuals performing medical treatment for you. Receive information concerning the facility's policy regarding advance directives.

If a patient is adjudicated incompetent under applicable state health and safety laws by the court of proper jurisdiction, the rights of the patient are exercised by the person appointed under state law to act on the patient's behalf. If a state court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with state law may exercise the patient's rights to the extent allowed by the state.

As a patient, you have the responsibility for:

1. Providing, to the best of your knowledge, accurate and complete information about your present health status and past medical history and reporting any unexpected changes to the appropriate primary care physicians or providers about your health status and past medical history, including suspected or known allergies, current medications, and herbs or supplements you may be taking.
2. Following the treatment plan recommended by the primary care physicians or providers involved in your care, including the instructions of other health professionals as they carry out physician or provider orders.
3. Indicating whether you understand a contemplated course of action and what is expected of you.
4. Your actions, if you refuse treatment, leave the facility against the advice of the physician or provider, and/or do not follow the physician or provider instructions relating to your care.
5. ***Assuring that the financial obligations of your healthcare are fulfilled as expediently as possible by providing accurate insurance and/or credit information. In addition, you understand that Anderson Medical Center will not accept any responsibility on third-party liability billing and that you are responsible for all expenses incurred in the event that no payment is received from your health plan.***
6. Following the facility policies and procedures affecting patient care and conduct.

Grievance and/or complaints can be filed directly to the facility (HIPAA Compliance Officer) or to the health department.

Patient signature below indicates the Patient Rights and Responsibilities have been read and any questions regarding this information have been discussed with the facility's personnel.

Patient's Printed Name	Date

Patient's Signature

ANDERSON
MEDICAL CENTER

To help us treat you, please complete the following:

Patient's Name: _____ Date: _____

Sex: ❑ Male ❑ Female Occupation: _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widow/Widower

Primary Care Physician: _____

Preferred Pharmacy: _____

List Allergies to Medications: _____

List Current Medications:	Dose:	Name of Prescribing Physician:

Past Medical History (Check if applicable):

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder/Kidney Disorder
- ☐ Blood Disorder
- ☐ Breast Disorder
- ☐ Cancer
  Type: _____
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Elevated Cholesterol
- ☐ Fibromyalgia
- ☐ Gastro Esophageal Reflux
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Lung Disorder
- ☐ Migraine Headaches
- ☐ Peptic Ulcer
- ☐ Prostate Problems
- ☐ Seizure Disorder
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Other: _____

List any surgeries you have had:

Surgery: _____ Year: _____

Surgery: _____ Year: _____

Females

Date of first day of last Menstrual Period: _____ Birth Control Method: _____

Date of last Pap Test: _____ Was it Normal or Abnormal? _____

Have you received the Gardasil Vaccine? ❑ Yes ❑ No Date of last Mammogram: _____

Patient's Name: _____ Date: _____

Exercise

Activity: _____ Days per week: _____ Duration: _____

Activity: _____ Days per week: _____ Duration: _____

Tobacco Use

Have you ever smoked or chewed tobacco? ❑ Yes ❑ No

If yes: Average number of packs/day: _____ Number of years smoked: _____

Year quit: _____ Are you planning to quit? ❑ Now ❑ Sometime ❑ Never

Alcohol Use

Number of drinks per day: _____ or per week: _____ Have you ever felt you should cut down? _____

Have you ever felt guilty about your drinking? ❑ Yes ❑ No

Recreational Drug Use: (Check if applicable)

❑ Marijuana	❑ Amphetamine	❑ Ecstasy	❑ Hallucinogens
❑ Oxycodone	❑ Norco	❑ Vicodin	

Health Maintenance

	Date Last Performed		Date Last Performed
Tetanus Vaccine		Pneumovax Vaccine	
Eye Exam		Bone Density Scan	
Dental Exam		Colonoscopy	

Family Medical History (Check if applicable)

Disease	Family Member Affected
❑ Asthma	
❑ Alcohol Abuse	
❑ Cancer	
❑ Diabetes	
❑ Heart Disease	
❑ High Cholesterol	
❑ Hypertension	
❑ Mental Health Disorder	
❑ Thyroid Disease	
❑ Other: _____	