1424 US HWY 331
DeFuniak Springs, FL
32435
P (850)920-1700
F (850)520-5357

DeFuniak ALL-Care Walk In Clinic

**PATIENT'S DEMOGRAPHICS**:

NAME_____DOB_____AGE_____SEX_____

ADDRESS_____CITY_____STATE_____ZIP_____

CELL_____HOME_____WORK_____OTHER_____

EMAIL_____

OK to receive email and text appointment reminders □ YES □ NO

MARITAL STATUS □ Single □ Married □ Divorced □ Separated □ Widowed

RACE □ Caucasian/White □ African American/Black □ Native American □ Asian □ More Than One Race □ Other_____

ETHNICITY □ Hispanic □ non-Hispanic □ Decline to specify

| | INSURANCE | NAME OF POLICY HOLDER | RELATIONSHIP TO PATIENT | GROUP NUMBER | POLICY NUMBER | DATE OF BIRTH POLICY HOLDER |
|---|---|---|---|---|---|---|
| PRIMARY | | | | | | |
| SECONDARY | | | | | | |
| | | | | | | |

**GUARANTOR INFO (IF OTHER THAN PATIENT)**:

FIRST_____MI_____LAST_____RELATIONSHIP_____

SS#_____DOB_____AGE_____SEX □ Female □ Male

ADDRESS_____CITY_____

STATE_____ZIP_____HOME_____CELL_____

**PATIENT'S EMPLOYMENT INFORMATION**:

EMPLOYER'S

NAME_____OCCUPATION_____

ADDRESS_____

CITY_____STATE_____ZIP_____

IS THIS COVERED BY WORKMAN'S COMPENSATION? Yes □ No □

EMERGENCY CONTACT:

NAME_____ RELATIONSHIP: _____ PHONE NUMBER: _____

PRIMARY CARE DOCTOR: _____ PHONE: _____

**PREFERRED PHARMACY** _____

I hereby authorize the performance of any medical or surgical treatment rendered under the general and special instruction of my physician. I authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage. Any pre certification required by the insurance company is the patient's responsibility; however, we will gladly assist you with this. For your convenience we will file up to two (2) insurances for you.

I hereby authorize the below listed additional individuals to have access to my medical information:

Name: _____Phone: _____ Relationship: _____

Name: _____Phone: _____ Relationship: _____

_____

Signature (Patient/Responsible Party) Date

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Name: _____ DOB: _____

Reason for Visit: _____

| Operations: | Year | Operations: | Year | Self and Family Cancer History: |
|---|---|---|---|---|
| Tonsils | | Heart Stenting / Bypass | | Breast ‘ Colon ‘ Thyroid ‘ |
| Bariatric | | Hysterectomy | | |
| Appendix | | Vasectomy | | Other Cancers: |
| Gallbladder | | Breast Augmentation/Mastectomy R / L | | |
| Knee R / L Hip R / L | | Neck/Back | | |

Other Operations: Year Performed

Hospital Stays Other Than Above: Reason and Year

Current Medication: Name and Dosage:

Habits: Start / Quit year

‘ Cigarettes: _____ _____

‘ Oral tobacco: _____ _____

‘ Vape: _____ _____

Caffeine: Cups per day: _____

Alcohol: Drinks per day: _____

Other Drugs: _____

Your Living Situation and Who Lives There:

Allergies to Medications or Other Substances:

| | Self | Father | Mother | Brother | Sister |
|---|---|---|---|---|---|
| Headaches/Migraines | | | | | |
| Stroke / CVA / TIA | | | | | |
| Kidney Disease | | | | | |
| Thyroid HYPER / HYPO | | | | | |
| High Blood Pressure | | | | | |
| High Cholesterol | | | | | |
| Heart Attack | | | | | |
| CHF | | | | | |
| Heart Disease | | | | | |
| Epilepsy | | | | | |
| Asthma | | | | | |
| COPD | | | | | |
| Liver/Hepatitis | | | | | |
| Diabetes | | | | | |
| Reflux / Other GI | | | | | |
| Mental Illness: ADHD, Bipolar, Anxiety | | | | | |
| Clotting Disorders | | | | | |
| Peripheral Artery Disease | | | | | |
| | | | | | |

Occupation/Retired:

Any additional information you would like the provider to know:

Do you have an advanced directive or living will?

Do you have a POA?

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

**_____Privacy Policy Notice**

We are committed to preserving the privacy of certain confidential health care information. The law requires us to protect the privacy of your medical information and to abide by the terms of the notice. This notice describes how medical information about you may be used and released and how you can get access to this information. We may use and release your medical information for: payment, treatment, healthcare operations, business associates, appointment reminders, treatment alternative education, health related benefits or services, as required by law to state/federal agencies, family or friends involved in your care, entities assisting in disaster relief. We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. You have the right to receive a copy of our most current Privacy Policy.

**_____Assignment of Insurance and Financial Responsibility**

I do, hereby, authorize payment of all insurance benefits, basic and major medical, for the services I receive, to be made directly to Defuniak All-Care. I understand that I am ultimately responsible for any unpaid balance or non-covered service. I agree to pay all cost of collecting, securing, or attempting to collect or secure payment, including reasonable attorney's fees or collection agency fees.

**_____ePrescribing Consent**

ePrescribing is a federally mandated initiative that requires all physicians to prescribe in this manner. ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, utilizing secure technology to protect the privacy of your personal information. ePrescribing software also allows our providers to see important information, such as drug interactions and your prescriptions history.

**_____Audio Consent**

I do, hereby, grant permission to Defuniak All-Care, and its providers to record audio for charting purposes.

**_____Consent for Lab Services**

Defuniak All-Care uses 2 laboratories to process labs. It is my responsibility to ensure that these labs services are in network with my insurance company. If the lab is out of network, I will notify Defuniak All-Care in advance. I am responsible for any out of network fees associated with lab processing if I have not made arrangements in advance with Defuniak All-Care.

**_____Consent for Radiologist Report**

Defuniak All-Care sends all x-ray imaging to South Alabama Diagnostic Imaging. It is my responsibility to ensure that these services are in network with my insurance company. If this is out of network or I am a self-pay patient, I will be responsible for all fees associated with these services.

**_____Clinic Policies**

Defuniak All-Care Clinic IS NOT a pain management clinic; therefore, we DO NOT dispense narcotics or any other controlled medications.

Proper identification and proof of current insurance must be provided at time of service.

Payments and Copayments are due at time of service.

CANCELLATION POLICY: We kindly request at least a 24-hour cancellation notice to give another patient an opportunity to be seen.

_____ _____

**Date** **Signature (Patient/Personal Representative)** **Print Patient Name**

_____ _____

**Date** **Witness** **Print Authorized Individual/Relationship**