Patient Information Form			
FIRST:		LAST:	
SEX:		DOB:	AGE:
SSN#		MARITAL STATUS:	

PATIENT HOME ADDRESS:	CITY:	STATE:	ZIP CODE:

RACE:	ALLERGIES:		PREFERRED LANGUAGE:
SPOUSE NAME:		HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:			

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

NAME/FIRST:	MIDDLE:	LAST:
RELATIONSHIP TO PT:	CONTACT NUMBER:	
IS THE ABOVE NAME YOUR POWER OF ATTORNEY (POA)?		

PATIENT INSURANCE INFORMATION

PAYER/INSURANCE COMPANY:	PRIMARY:	TYPE: HMO/PPO/POS/PRIVATE/EPO
START DATE:	END DATE:	
PAYMENT TYPE (COPAY AMT):	FIXED AMOUNT/PAYMENT %:	
EMPLOYER NAME:	EMPLOYER ADDRESS:	
INSURED ID NUMBER:	INSURED GROUP NUMBER:	

PATIENT INSURANCE INFORMATION

PAYER/INSURANCE COMPANY:	PRIMARY:	TYPE: HMO/PPO/POS/PRIVATE/EP
START DATE:		
PAYMENT TYPE (COPAY AMT):	FIXED AMOUNT/PAYMENT %:	

Dr. Martin Janis | 3927 Sunset Ridge Road, Suite 101, Raleigh NC 27607 | Phone (919) 782-7576 | Fax: (919) 782-7573

NEW PATIENT FORM

MEDICATIONS

PLEASE LIST ALL MEDICATIONS YOU USE REGULARLY (INCLUDED NON- PRESCRIPTION DRUGS)

MEDICATION/DRUG	STRENGTH	HOW OFTEN

HOSPITALIZATIONS

PLEASE LIST ALL HOSPITALIZATIONS, STARING WITH THE MOST RECENT

YEAR/DATE	OPERATION/ILLNESS	HOSPITAL NAME/LOCATION

HEALTH MAINTENANCE

HAVE YOU EVER HAD THE FOLLOWING?

PROCEDURE	YES	NO	UNSURE	DATE
Flex Sigmoidoscopy				
Colonoscopy				

PLEASE LIST ALL IMMUNIZATIONS AND DATES

Immunization	Date
Tetanus	
Influenza (Flu Shot)	
Pneumovax (Pneumonia)	
Hepatitis A	
Hepatitis B	
Shingles	

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HAVE YOU EVER BEEN TREATED FOR TUBERCULOSIS?

YES NO

HAVE YOU EVER HAD A POSITIVE TUBERCULOSIS TEST/READING?

YES NO

	YES	**NO**
Do you drink more fluids now than you used to?		
Have you ever used narcotics or other addictive drugs?		
Have you ever used intravenous drugs?		
Do you wear a seatbelt?		
Do you exercise? If yes, how often?		
Have you been regularly exposed to chemicals, toxins, poisons, fumes, smoke or radioactive materials at home or work		
Do you use snuff? If yes, how often?		
Do you smoke? If yes, how often?		
If you have quit smoking, at what age did you quit? How often did you smoke?		
Do you drink alcohol? If yes, what kind, how much and how often?		
Have you ever received a blood transfusion? If so, what year?		
Have you ever had a cholesterol test? If yes, was it elevated?		
Have you ever had a PSA (Prostate Specific Antigen) test? If yes, was it positive?		

FOR WOMEN ONLY

Date of last PAP Smear:	Results:
Date of last Mammogram:	Results:
Age Menstruation ended:	

	Yes	NO
Do you examine your breasts each month?		
Any complications during pregnancies?		
Any unusual vaginal order, discharge or itching?		

OTHER ILLNESS

HAVE YOU EVER HAD THE FOLLOWING?

Condition	Yes	No	Unsure	Comments
AIDS				
Anemia				
Arthritis/Rheumatism/Gout				
Asthma/Hay Fever				
Bowel Disorder/Colitis				
Cancer/Tumors (including benign)				
Diabetes/Sugar				
Epilepsy/Fits/Seizures				
Gallbladder Trouble/Gallstones				
Glaucoma				
Heart Trouble or Heart Murmur				
Hemorrhoids				
High Blood Pressure				
Kidney/Bladder Trouble				
Nervous/Emotional Problems				
Phlebitis/Varicose Veins				
Pneumonia/Pleurisy				
Rheumatic Fever				
Shingles				
Stroke Paralysis				
Thyroid Disease/Goiter				
Tuberculosis				
Ulcer/Stomach Trouble				
Venereal Disease				
Yellow Jaundice/Hepatitis/Liver Cirrhosis				

Please list any other serious illnesses or injuries (fractures or wounds) you have had and the dates:

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____

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Review of Systems

Condition	Yes	No	Unsure	Comments
Unexpected weight changes of more than 10lbs. over the past year				
Any serious problems with your ears or eyes				
Any breast lumps or nipple discharge				
Heart racing of skipping beats				
Pain or tightness in your chest with exertion				
Frequent coughing or wheezing				
Serious difficulty chewing or swallowing				
Frequent or severe stomach or abdominal pain				
Frequent nausea or vomiting				
Frequent or severe constipation or diarrhea				
Blood or mucus in bowel movement				
Blackened bowel movements				
Painful or burning urination				
Blood in urine				
Unusual frequency of urination				
Loss of control of urine				
Kidney Stone or Kidney Colie				
Redness, severe pain or swelling of joints				
Frequent or severe pain				
Unusually frequent or severe headaches				
Sexual Difficulties				
Serious stress from problems at home or work				

Have any family members had one of the following?

Condition	Yes	No	Unsure	Comments
Diabetes				
High Blood Pressure				
Heart Attack				
Cancer				
Alzheimer’s Disease				
Mental Illness				

Do you require assistance in order to perform any of the following activities?

Activity	Yes	No	Unsure	Comments
Walking				
Bathing				
Toileting				
Dressing				
Eating				
Preparing Meals				
Getting In/Out of Bed				
Grocery Shopping				
Cleaning				
Managing Money				
Paying Bills				
Taking Medicine				

FAMILY MEDICAL HISTORY

Is your Mother living?	Yes what is her current age? No age at time of death?
Cause of death? ______________________________	
Is your Father living?	Yes what is his current age? No age at time of death?
Cause of death? ______________________________	
Is your Brother(s) living?	Yes what is his current age? No age at time of death?
Cause of death? ______________________________	
Is your Sister(s) living?	Yes what is her current age? No age at time of death?

EQUIPMENT

Equipment	Yes	No	Sometimes	Comments
Cane				
Walker				
Wheelchair				
Oxygen				

Sleeping Habits:

How many hours do you sleep at night? ______________ During the day? _____________

What time do you wake up? ______________________
What time do you go to bed? ______________________
Are you still tired when you wake up? Yes No
Have there been any significant changes in your sleep patterns recently? Yes No

If so, please explain: ____
____

Are there any concerns about sleep patterns? Yes No
If so, please explain: ____
____

Authorization for Care

I grant permission to the employees of Raleigh Geriatrics, PA to render care for me and to expedite the orders of the staff physician extender.

Release of Information

I authorize Raleigh Geriatrics, PA to release any medical information pertaining to my diagnosis and treatment to Medicare or my secondary Insurance representatives. My records may be released also to any State or Federal agencies in accordance with the law. I further authorize release of this information to other health care providers associated with my care and any person or entitles financially responsible for my care.

Insurance Coverage and Assignment of Benefits

Medicare Benefits: As a Medicare patient, I certify that the information given by me applying for payment title XVII of the Social Security Act is correct. I request payment to authorize benefits be made on my behalf.

Assignment of Insurance Benefits: I request that payment of authorized insurance benefits be made on my behalf to the provider indicated for any services furnished me.

Financial Responsibility

I understand that I am responsible for the total allowable charges for services rendered, regardless of any assigned Insurance benefits. I understand that I am responsible for any deductible and/or co-insurance payment not otherwise covered.

I request that the above acknowledgement be in effect until revoked in writing by myself or my representative

______________________	______________________
SIGNATURE	DATE
______________________	______________________
WITNESS SIGNATURE	DATE

Authorization to Release Medical Records

Patient's Name: ________________________   Date of Birth: ___________________________

Previous Name: _________________________   Social Security #: ________________________

I request and authorize (specify location of records)

____

to release healthcare Information of the patient named to:

Raleigh Geriatrics, PA | Martin Janis, MD
3921 Sunset Ridge Road, Suite 101, Raleigh, NC 27607
Office: 919-782-7576 | Fax: 919-782-7573
Raleigh.geriatrics.office@gmail.com

Practice Hours of Operation
9:00 a.m. – noon and 1:00 – 5:00 p.m.

This request and authorization applies to:

Healthcare Information relating to the following treatment, condition, or dates:
____
____

All Healthcare Information

Other: ____

Important: Patient Information is confidential. Confidential means that the patient, or their guardian, has the statutory right to be the sole determiner of whether any details relative to the patient's treatment or hospitalization may be released to persons outside the medical facility.

Both boxes below must be checked 'yes' in order for request to release Medical records to be valid:

Yes	No	I understand that I may revoke this authorization at any time be written notice except to the extent that Raleigh Geriatrics, PA has already acted in reliance with it. Without my express revocation, this consent will not expire as of the date of my signature. I certify that this authorization is voluntary and without coercion.
Yes	No	I hereby authorize you to release my medical information as listed above. This authorization expires ninety (90) days after the date signed.

Patient's Signature
(or legal representative): _________________________________   Date Signed: ______________________

Witness' Signature: ______________________________________   Date Signed: _______________________

Acknowledgement of Receipt of Privacy Policy

I have been presented with a copy of this provider's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restrictions (s) concerning my personal medical information:

____
____
____

Signed: ________________________________ Date: _________________________________

Assignment of Benefits, Release of Information Authorization, and Financial Policy

I, ____clearly understand and assign to Raleigh Geriatrics, P.A. all insurance benefits, if any, including payments that might otherwise be made payable to me for services rendered. I understand that I am financially responsible for all charges, whether paid by insurance or not paid by insurance. I hereby authorize Raleigh Geriatrics, P.A. to release all information to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand and agree that health and accident insurance policies are an arrangement between an insurance company and myself (and or my dependents). I further agree that any amount authorized to be paid directly to this office will be credited to my account upon receipt. If I should suspend or terminate my care and treatment in this office, any fee(s) for professional services rendered will become due and payable immediately. Any unpaid balance due to this office, may at any point, become subject to a finance charge of 1.5% interest per month. Should it become necessary to initiate any collection proceedings, I will then become responsible for any legal and/or other fees

Signed: ________________________________ Date: _________________________________

Cancellation Policy

All cancellations must be made 24 hours in advance, unless there are mitigating circumstances (weather, accident, or other unforeseen incidents). Patients who repeatedly cancel appointments with less than 24 hours' notice or cancel more than 2 times in a row will be charged a fee of $25.00. This fee will be billed to you and not your Insurance company. this is due to the fact that there are patients that need to be seen and the appointment times are extremely valuable.

Signed: ________________________________ Date: _________________________________

Patient Information

Did you continue your Insurance after Retirement?

Yes or No

If yes, when did you retire? _________________

Was this a work-related injury?

Yes or No

If yes, what was the injury date? _____________

Is this visit the result of a car accident?

Yes or No

If yes, what was the accident date? ___________

Attorney Name: ___________________________

Who can we thank for referring you to us?

____

Are you a veteran?

Yes or No

If yes, do you wish to use your Veteran Benefits

Yes or No

Preferred Pharmacy Name: ____

Preferred Pharmacy Phone Number: ____

Preferred Pharmacy Fax Number: ____

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Signature: _________________________________ Date: ___________________________________