NEW PATIENT FORMS

PRINT NAME: **D.O.B.** **TODAY'S DATE:**

REASON(S) FOR VISIT TODAY?

___

MEDICATIONS (Please write additional medications on the back of this page) ❒ **Check this box if listed on the back**

Local Pharmacy: (NAME)_______________________________________**(LOCATION/ROAD)**_____________________

Mail Order Pharmacy:____

NAME	DOSAGE	FREQUENCY	REASON FOR MED

DRUG ALLERGIES ⬜ NONE ***Please list your reaction with each allergy***

_______________:_________________ _______________:_________________ _____________:_______________

_______________:_________________ _______________:_________________ _____________:_______________

SOCIAL HISTORY

Exercise Level

- ⬜ None
- ⬜ Occasional
- ⬜ Moderate
- ⬜ Heavy

Caffeine

- ⬜ None
- ⬜ Occasionally
- ⬜ Moderate
- ⬜ Heavy

Tobacco: Cigarettes, Vape, or Chewing Tobacco

- ⬜ None
- ⬜ Former? How many packs per year? ________
- ⬜ Quit Date: ____________
- ⬜ Current: Tobacco Years ______ Year Started _____ Age ____

Typical Alcohol Intake

- ⬜ None
- ⬜ 1-2 drinks/day
- ⬜ 3-4 drinks/day
- ⬜ 5 or more drinks/day

Illicit/Recreational Drugs

- ⬜ Marijuana
- ⬜ Cocaine
- ⬜ Other: _______

Sexually Active

- ⬜ Yes
- ⬜ No

Marital Status:_________

FAMILY HISTORY

Please Specify: Brother or Sister / Maternal or Paternal?

	MOTHER	FATHER	SIBLING	GRANDMOTHER	GRANDFATHER
Autoimmune	⬜	⬜	⬜	⬜	⬜
Bleeding Disorders	⬜	⬜	⬜	⬜	⬜
Blood Clots	⬜	⬜	⬜	⬜	⬜
Breast Cancer	⬜	⬜	⬜	⬜	⬜
Colon Cancer	⬜	⬜	⬜	⬜	⬜
Lung Cancer	⬜	⬜	⬜	⬜	⬜
Ovarian Cancer	⬜	⬜	⬜	⬜	⬜
Pancreatic Cancer	⬜	⬜	⬜	⬜	⬜
Prostate Cancer	⬜	⬜	⬜	⬜	⬜
Skin Cancer	⬜	⬜	⬜	⬜	⬜
Other Cancer: ____________	⬜	⬜	⬜	⬜	⬜
Dementia	⬜	⬜	⬜	⬜	⬜
Diabetes	⬜	⬜	⬜	⬜	⬜
Heart Disease	⬜	⬜	⬜	⬜	⬜
Hypertension	⬜	⬜	⬜	⬜	⬜
Stroke	⬜	⬜	⬜	⬜	⬜
Thyroid	⬜	⬜	⬜	⬜	⬜

SURGICAL HISTORY

	DATE
⬜ Appendectomy	______
⬜ Bowel	______
Specify:______________________	
⬜ Gallbladder	______
⬜ Joint Replacement	______
⬜ Left:______________________	
⬜ Right:______________________	
⬜ Heart Surgery	______
Specify:______________________	
⬜ Hysterectomy	______

	DATE
⬜ Sinus Surgery	______
⬜ Skin Cancer / Lesion removal	______
Location: __________________________	
⬜ Tonsillectomy	______
⬜ Vein Surgery	______
⬜ Wisdom Teeth	______
⬜ Back Procedure	______
⬜ Breast Augmentation	______

⬜ Total (no uterus or cervix) ⬜ Partial (no uterus, but still have cervix) ⬜ Radical (no cervix, uterus, or ovaries)

Reason for hysterectomy: ____

HEALTH MAINTENANCE

Previous Primary Care ____

Please list dates below

Last Blood Work ________/________/___________ Fasting today?_______________________

Last Physical ________/________/___________

Last Colonoscopy ________/________/___________ Repeat due:_________________________

Last Eye Exam ________/________/___________

FEMALE

Last Mammogram _______/________/____________ GYN: _________________________________

Last Pap Smear _______/________/____________

Last Bone Density Scan _______/________/____________

Last Menstrual Period _______/________/____________ Type of birth control:______________________

MALE

Last PSA _____/________/_____________

IMMUNIZATIONS / VACCINES

COVID ___/___/_____ ___/___/_____ ___/___/_____ **Circle**: Moderna, Pfizer, J&J

Flu Vaccine _______/_________/___________

Pneumonia Vaccine _______/_________/___________

Shingles _______/_________/___________

Tetanus _______/_________/___________

SPECIALISTS:

DOCTORS NAME: ____ **SPECIALTY:**

____

____

____

____

____

____

____

REGISTRATION

Patient Name: ____DOB: _____/____/______
Gender: Male Female Other: __________ Gender Assigned at Birth: Male Female Other:_________
Street Address: __________________________________City: _________ State: _____ Zip: ______
Home Phone: ___________________________ Cell Phone: ________________________________
Email: ____
Marital Status: Single Married Divorced Widowed Separated
Sexual Orientation: Heterosexual/Straight Gay Lesbian Bisexual Other: ____________
Race: Asian Hispanic Black/African American Native Hawaiian/Other Pacific Islander
White/Caucasian Other: __________________________________ Decline
Ethnicity: Hispanic/Latin American Non-Hispanic/Latin American Decline

Guardian, if the patient is 18 years of age or younger, please sign below as the responsible party:
Name:____DOB:___/_____/_____
Phone #:_________________________Relationship to Patient: ______________________

Emergency Contact (This person is authorized to access your medical information)
Name:_____________________Relationship to Patient:_________________Phone:_______________

Next of Kin (This person is authorized to access your medical information)
Name:_____________________Relationship to Patient:_______________Phone:_________________

Power of Attorney (Medical) *Please provide documentation.
Name:_____________________Relationship to Patient:_______________Phone:_________________

CONSENTS

PLEASE CHECK ALL BOXES AND SIGN BELOW

LATE ARRIVAL

If a patient is more than **5 minutes** late for an appointment, the appointment will likely need to be rescheduled. This is to ensure that the patients who arrive on time do not wait longer than necessary to see the physician or nurse practitioner.

New patients who did not complete the portal are encouraged to arrive at the office **30 minutes** prior to scheduled appointment and to bring in completed new patient paperwork to their first appointment. The staff at Tempus Primary Care truly appreciate your compliance and understanding of this policy.

❒ **ACCEPT**

CONTROLLED SUBSTANCE

Opioid Medications for Pain

At Tempus Primary Care, we will not be prescribing opioid medications for a duration longer than 2 weeks. If a patient requires long-term use of opioids for pain, we will refer to a specialist for further evaluation and management.

Benzodiazepines

Due to the many risks associated with long-term benzodiazepine use, we will not prescribe these medications for chronic use. For patients who have been on these medications long term, we will help establish a regimen to wean off the medication over the period of several weeks to months or refer to a specialist for further evaluation and management.

Amphetamines for Attention Deficit Disorder (ADD)

Amphetamines are controlled substances that can be appropriately prescribed for ADD and ADHD. At Tempus Primary Care, we require that a patient have a professional psychiatric or psychological evaluation every 5 years in order to prescribe or initiate long-term amphetamine treatment.

❒ **ACCEPT**

CALL OR TEXT

Tempus Primary Care staff can contact me in regard to any matter. This may include phone calls, text messages, or email. I understand that I change/cancel this at any time.

❒ **ACCEPT**

MEDICAL PHOTOGRAPHY

Medical imaging (photo, video, and or audio) may be used in my medical records ONLY.

Ex: rash, wounds, skin disorders, etc.

❒ **ACCEPT**

Signature____Date:_______

HIPAA

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change. If so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time, at which time all disclosures will cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, text you to confirm your appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed with their telephone numbers and relationship to patient:

____

____

____

This consent was signed by: ____

(PRINT NAME PLEASE)

Signature: ____ Date: ___/___/_____

Payment Policy

Thank you for choosing TPC as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance:** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Copayments and deductibles:** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your copayment at each visit.

3. **Non-covered services:** Please be aware that some – and perhaps all – of the services you receive may be non covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit or within 90 days of visit.

4. **Proof of insurance**: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **Claims submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. **Coverage change**s: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. **Nonpayment**: If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency, and you and your immediate family members may be discharged from the practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will be able to treat you only on an emergency basis.

8. **Missed appointments:** Our policy is to charge $30 for missed appointments if the office is not notified at least 24 hours prior to scheduled appointment time. These charges will be your responsibility and billed directly to you.

Please help us to serve you better by keeping your regularly scheduled appointments. Our practice is committed to providing the best care possible for our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

In signing I certify that I have read and understand the payment policy and agree to abide by its guidelines:

Signature of patient or responsible party: ____ Date: ___________________

Medical Records Release

Please completely read this page before starting your release form

Name: ____ D.O.B. _________________

If you would like our office to obtain medical records from physicians, specialists, hospitals, etc. please only fill out the **highlighted fields** on the medical records release form on the next page. Our medical team will complete the rest of the information.

Please list below whom you'd like the office to obtain medical records from for our files.

EX: ***Name / Doctor / Speciality:*** *Tempus Primary Care / Dr.Nall / Family Doctor*

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____

continue to the next page

Medical Records Release

By signing this form, I authorize you to release my confidential health information by releasing a copy of my medical records to Tempus Primary Care.

By signing this form, I authorize Tempus Primary Care to keep documentation of a signed release in my file for future use.

Patient Name____Date of Birth _______________

Request Records From:

____
Medical Facility Name

____
Address

____ ____________________________________
Phone # Fax #

The information you may release subject to this signed release form is as follows:

_______ Complete Records (last year)
_______ Most recent office visit note
_______ Most recent mammogram
_______ Most recent colonoscopy
_______ Most recent pap smear
_______ Other: _______________________________
_______ Other: _______________________________
________ Most recent labs
________ Vaccine records

Please release/fax my protected health information to:

Tempus Primary Care
4101 Balmoral Drive SW, Suite B
Huntsville, AL 35801
(256) 808-2929 phone
(833) 929-3517 fax

____ ____
Patient Name Printed Name of Representative

____ ____
Patient Signature Patient Representative Signature

____ ____
Date Description of Representative's Authority