Fayette Physicians
http://www.heartofwvphysicianclinics.com
Dr. Erika Beckett, MD
New Patient Information Sheet

Patient Name (Last)__________________(First)______________________(MI)_______

Home Phone#__________________Work#___________________Cell#_______________

Mailing Address ____

Date of Birth______________Age____________Social Security #____________________

Male_____Female____Marital Status____________Email Address____________________

Pharmacy______________________________ Pharmacy number____________________

Employed______ Name of Employer ____

Retired _________ Address ____

Spouse Name ______________________________ Spouse date of birth ______________

If child, parents names ____

Next of kin (not living in household) ________________________ Relationship__________

Phone # ___________________________

Guarantor Information (if different from patient)

Name(Last)______________________(First)________________________(MI)________

Address____

Phone#____________________Cell#_____________________Work#________________

Relationship to Patient ____

Date of Birth ______________________ Social Security # ___________________________

Employed ____________ Employer ____

Do You Have A Living Will or Power of Attorney? _________________

I hereby authorize the release of any information including the diagnosis and the records of any treatments or examinations rendered to my insurance and any treating physicians. This release is solely for the purpose of facilitating the billing and reimbursement, directly to the physician of benefits under which I am entitled. I also authorize the faxed transmission of medical records on my behalf to my insurance company or any of my physicians.

Signature ______________________________________ Date ________________________

NAME: ______________________________

DATE OF BIRTH: ______________________________

RELEASE OF INFORMATION/HIPAA

- I hereby give authorization to release my medical information to the following people that I have listed
- If I choose not to list any one person, NO information will be given out for any reason

*Please list ALL people you wish information to be given to if the situation arises that your medical history may need to be discussed with someone other than yourself. (Example: spouse, children, significant other, parents, siblings)

- ______________________________
- ______________________________
- ______________________________
- ______________________________

________ **PLEASE CHECK HERE IF YOU DO NOT WANT ANY INFORMATION GIVEN TO ANY ONE PERSON.**

SIGNATURE: ______________________________ **DATE:** ____________________

RECEIPT OF NOTICE OF PATIENT RIGHTS AND NOTICE OF PATIENT PRIVACY

- I have received a copy of the Notice of Patient Rights and the Notice of Patient Privacy (the stated documents are available at any given time in our office lobby) at Surgical Care of Southern WV.

x ____

Patient Name and Signature Date

If patient is unable to sign or under the age of 18, notice is given to:

x ____

Name and Signature/ Relationship to patient Date

NOTICE TO PATIENTS WITH SMARTPHONES!!

If you have provided us with a cell phone number, at some point after your visit, you will automatically receive a TEXT from our office which will appear to be from UCARE or CareNotify. The text will ask you to click on a link which will take you to your Summary of Care for your visit. It will give you the opportunity to review your visit along with your current plan of care. You will have the option to view it or not view it. IF YOU CHOOSE NOT TO VIEW THE MESSAGE, REPLY "NO" and it will opt you out of this service. This is a secure message and once you have read your message, it will be deleted from your phone. We want to assure you, once again, that this is a SECURE message you DO have the option to opt of this service. We hope you take advantage of this service as we strive to give you the best of care!

- Please list any allergies to medications and their reactions:

Medications	Reactions

- Please list CURRENT medication (also include over the counter medications)

Drug name	Dose	How often?	Drug name	Dose	How often?

- Please list date of each vaccine:

Vaccine	Date
Influenza	
Pneumovax	
Prevnar	
Zostavax (Shingles)	
TDaP (Tetanus)	

- Family History (Please specify Maternal (Mother's side) or Paternal (Father's side)

Breast Cancer Yes No Relationship ____________________

Colon Cancer Yes No Relationship ____________________

Diabetes Yes No Relationship ____________________

Heart Disease Yes No Relationship ____________________

High Blood Pressure Yes No Relationship ____________________

High Cholesterol Yes No Relationship ____________________

Lung Cancer Yes No Relationship ____________________

Prostate Cancer Yes No Relationship ____________________

Skin Cancer Yes No Relationship ____________________

Stroke Yes No Relationship ____________________

Other (please specify) Relationship ____________________

Assignment and Release:

- I hereby assign my insurance benefits to be paid directly to the physician.
- I understand that I am financially responsible for all non- covered services, copays, deductibles, and coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.
- I authorize the physician to release any medical information required to process this claim.
- I authorize my provider's office to contact me by telephone to remind me of my appointments.
- I consent to my provider to submit electronic prescription.
- I consent to medical treatment that is given by my doctor.

I certify that the above information is correct to the best of my knowledge. I will not hold the doctor or staff members responsible for any errors or omissions that I may have made in the completion of this form.

____________________ ____________________

Signature of Patient Date

Health History　　　　Patient Name:____________________

Please check if you had any of the following:

	Abnormal Heart Rhythm		Heart Disease		Stomach Ulcers
	Seasonal Allergies		Heart Failure		Stroke
	Anemia		Heartburn (GERD)		Substance Abuse
	Asthma		Heart Murmur		Alcohol
	Arthritis		Hepatitis		Drugs
	Atrial Fibrillation		High Blood Pressure		Thyroid Disorder
	Blood Clots		High Cholesterol		
~	Leg: Lung:		HIV/AIDS		Other: List
	Bronchitis/Emphysema		Irritable Bowel Disease		
	Cancer		Irritable Bowel Syndrome		
~	Type:		Kidney Stones		
	COPD		Liver Disease		
	Chronic Kidney Disease		Mental Illness		
	Depression		Osteoporosis		
	Diabetes		Vascular Disease		
	Gout		Seizures		
	Heart Attack		Sleep Apnea		

Social History

Patient Name ______________________________

Smoking status: ______________________________

Smoking - how much: ______________________________

Tobacco-years of use: ______________________________

Occupation: ______________________________

Marital status: ______________________________

Diet: ______________________________

Exercise level: ______________________________

General stress level: (please circle) High Medium Low

Has smoked since age: ______________________________

Chewing tobacco: (please circle) None Occasional Moderate Heavy

Alcohol intake: (please circle) None Occasional Moderate Heavy

Caffeine intake: (please circle) None Occasional Moderate Heavy

Illicit drugs: (please circle) None Occasional Moderate Heavy

Live alone or with others: ______________________________

Are you currently employed: ______________________________

Number of children: ______________________________

Please list any surgeries with approximate dates:

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	Date	Test Location	Result
Colonoscopy			
Mammogram			
PAP/Pelvic			
Lung CT Screening			
Bone Density (DEXA)			