PATIENT DEMOGRAPHICS

# ONE STOP WELLNESS CLINIC

PATIENT NAME_____BIRTHDATE_____AGE_____

SEX ___M___F ADDRESS_____

CITY_____STATE_____ZIP_____

HOME#(____)_____ CELL#(____)_____

WORK #(____)_____

May OSMC leave a message on your: Home Phone: __y __n Work: __y __n Cell :__y __n

SS# __ __ __-__ __-__ __ __ __ MARITAL STATUS _____

EMPLOYER_____EMPLOYERS ADDRESS_____

EMERGENCY CONTACT_____ PHONE #_____

E-MAIL _____ REFERRED BY_____

PRIMARY INSURANCE_____ID#_____GROUP#_____

INSURED PERSON'S NAME_____

EMPLOYED BY_____

SS# __ __ __-__ __-__ __ __ __ DATE OF BIRTH___/___/_____

SECONDARY INSURANCE_____ID#_____GROUP#_____

INSURED PERSON'S NAME_____ EMPLOYED BY_____

SS# __ __ __-__ __-__ __ __ __ DATE OF BIRTH___/___/_____

***I authorize release of my health records to any provider who is being advised or consulted with in connection to my current treatment. Initials_____

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitle, including MEDICARE, private insurance and any other health plans to: One Stop Medical Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment. In the event that the patient fails to make payment or there is an outstanding obligation on the account, the patient hereby agrees to be responsible for all court costs and reasonable attorney fees in regards to the collection of this account.

SIGNED_____ DATE _____

Name_____ Date_____

# FEMALE NEW PATIENT HISTORY FORM

**PLEASE LIST YOUR PRIMARY CARE PHYSICIAN**

| NAME | SPECIALTY | CITY, STATE | DATE LAST SEEN |
|---|---|---|---|
| | | | |

**LIST ANY OTHER PHYSICIANS YOU SEE**

| NAME | SPECIALTY | CITY, STATE | DATE LAST SEEN |
|---|---|---|---|
| | OB/GYN | | |
| | | | |
| | | | |
| | | | |

**WHY ARE YOU SEEING US TODAY?** _____

_____

_____

**PREVIOUS SURGERIES** ***(Include C-Sections and Tubal Ligations)***

| YEAR | OPERATION | HOSPITAL | COMMENTS |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**MEDICATION ALLERGIES**

| | NAME | REACTION | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**MEDICAL HISTORY** *Have you or members of your family had any of the following:*

| CONDITION | YOU | FAMILY |
|---|---|---|
| High Cholesterol | | |
| Heart Disease/Attack | | |
| Rheumatic Fever | | |
| High Blood Pressure | | |
| Stroke | | |
| Blood Clots | | |
| Asthma | | |
| Tuberculosis | | |
| Diabetes | | |
| Thyroid Problems | | |
| Liver Disease | | |
| Hepatitis | | |
| Gallstones | | |

| CONDITION | YOU | FAMILY |
|---|---|---|
| Arthritis | | |
| HIV/AIDS | | |
| Kidney/Bladder Problem | | |
| Anemia | | |
| Blood Transfusion | | |
| Bleeding Disorder | | |
| Breast Disease | | |
| Breast Cancer | | |
| Ovarian Cancer | | |
| Colon Cancer | | |
| Birth Defects | | |
| Genetic/Inherited | | |

**OTHER MEDICAL HISTORY**_____

_____

**CURRENT PRESCRIPTION MEDICATIONS**

| NAME | DOSAGE | TIMES PER DAY | HOW LONG? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**CURRENT NON-PRESCRIPTION MEDICINES (Include Herbals and Supplements)**

| NAME | DOSAGE | TIMES PER DAY | HOW LONG? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## SYMPTOM CHECKLIST

**Instructions:** Please note the symptoms in the list that you experience on a regular basis. Place an **"X"** in the column corresponding the **frequency** and **severity** of each symptom.

*If you **rarely** have the symptom, just leave that line **blank.***

**Symptom Frequency**

***1**=A Few days a Month*

***2**=A Few days a Week*

***3**=Almost Every Day*

**Symptom Severity**

***1**=Mildly Noticeable*

***2**=More Bothersome*

***3**=Severe/Debilitating*

| SYMPTOM | 1 | 2 | 3 | | 1 | 2 | 3 |
|---|---|---|---|---|---|---|---|
| Aches & Pains | | | | | | | |
| Fatigue (All-Day) | | | | | | | |
| Fatigue (Morning) | | | | | | | |
| Fatigue (Afternoon) | | | | | | | |
| Fatigue (Evening) | | | | | | | |
| Irritability | | | | | | | |
| Mood Swings | | | | | | | |
| Foggy Mind | | | | | | | |
| Anxiety | | | | | | | |
| Can't Fall Asleep | | | | | | | |
| Interrupted Sleep | | | | | | | |
| Waking Up Unrefreshed | | | | | | | |
| Carb. Cravings | | | | | | | |
| Depression | | | | | | | |
| Heavy Periods | | | | | | | |
| Cyclic PMS Symptoms | | | | | | | |
| Breakthrough Bleeding | | | | | | | |
| Hot Flashes | | | | | | | |
| Breast Tenderness | | | | | | | |
| Headaches | | | | | | | |
| Bloating | | | | | | | |
| Night Sweats | | | | | | | |
| Low Sex Drive | | | | | | | |
| Weight Gain | | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Vaginal Dryness | | | | | | | |
| Hair Loss | | | | | | | |
| Dry,Thinning Skin | | | | | | | |
| Cold Body Temperature | | | | | | | |

## LIFESTYLE QUESTIONS

Do you smoke cigarettes? _____ YES _____ NO If so, how many cigarettes per day? _____

Do you drink alcohol? _____YES _____ NO If so, how many drinks per week? _____

Do you use any street drugs? _____ YES _____ NO *(all answers are confidential)*

How many caffeine-containing drinks do you have a day? _____ *(coffee, tea, sodas, energy drinks)*

What time do you go to bed at night? _____ How long until you fall asleep? _____

How many times do you wake up a night? _____ Do you go to sleep with the TV on? _____

What do you do when you wake up at night? _____

What time do you wake up in the morning on a typical work day? _____

Do you take anything to help you fall asleep? _____

Do you eat after 8PM? _____ YES _____ NO Do you feel refreshed when you wake up? _____

Do you exercise for at least 30 minutes at a time, at least 3 days per week? _____ YES _____ NO

What do you do for exercise? _____

What time of day do you usually exercise? _____

How many meals a day do you eat? _____ Do you snack between meals? ____ YES ____ NO

Do you drink at least 64 ounces of water per day? ____YES _____ NO

What prescription diet pills have you taken in the past? _____

What was your most successful diet? _____ How much did you lose? _____

How much weight would you realistically like to lose in the next year? _____ pounds.

## STRESS QUESTIONS

- *Please **circle** all current stressors in your life (continued on next page).*

MOVED YOUR HOME JOB CHANGE JOB STRESS/LOSS

| | | |
|---|---|---|
| ILL FAMILY MEMBERS | MARITAL PROBLEMS | DIVORCE/SEPARATION |
| DEATH OF SPOUSE/CHILD | FORECLOSURE/BANKRUPTCY | LEGAL PROBLEMS |
| NEW MARRIAGE | RETIREMENT | TROUBLE W/ IN-LAWS |
| PROBLEMS WITH CHILDREN | NEW PERSON LIVING WITH YOU | |

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## Patient Financial Responsibility Disclosure Statement

Your signature below forms a binding agreement between One Stop Medical Center (OSMC) - the provider of medical services) and the Patient who is receiving medical services or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical bills.

All charges for services rendered are due and payable at the time of service.

MEDICAL INSURANCE: We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason.

The person signing on behalf of the Patient as the Responsible Party must:

• Inform OSMC of the current address and phone number for the patient and the responsible party.

• Present all current insurance cards prior to each office visit.

• Verify at each visit that the information is current by signing our data sheet.

• Pay any required copay at the time of the visit.

• Pay any additional amount owing within 30 days of receiving a statement from our office. *(When OSMC receives an explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you).*

Returned Check Policy

If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a $30.00 Service Charge. Once notice is received of the returned check, OSMC will send out a letter to notify the Responsible Party of the returned check. If a response is not made within 15 days from the letter date by the Patient or the Responsible Party, the

account may be turned over to our collection agency and a collection fee of 50% will be added to the outstanding balance – in addition to the $30.00 Check Service Charge.

Non-Payment on Account

Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's Responsible Party, understands that OSMC has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient's Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, interest due at 18% APR, all court costs and Attorney fees, and a collection fee of 50% will be added to the outstanding balance.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient Name (Please Print)
_____

Patient Signature _____ Date
_____

Responsible Party Name (Please Print)_____ Date -
_____

Responsible Party Signature
_____

## NOTICE OF PRIVACY POLICY

Patient Name (Print): _____ Date_____

I _____, have reviewed the One Stop Medical Center Privacy Policy. I agree with all the terms of this policy.

I _____, have reviewed and request a copy of the One Stop Medical Center Privacy Policy. I agree with all the terms of this policy.