

PATIENT DEMOGRAPHICS

ONE STOP WELLNESS CLINIC (Male form)

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 \_\_\_\_\_

## MALE 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

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 (continued on next page).

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							
Poor Stamina							
Decreased Muscle Mass							
Rapid Aging							
Hot Flashes							
Loss of Initiative/Drive							
Headaches							
Bloating							
Night Sweats							
Low Sex Drive							
Weight Gain							

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.