CARRICO CONGLETON FAMILY PRACTICE
2811 New Hartford Road, Suite B
Owensboro, KY 42303

Demographic Information

First Name: _____ M.I._____ Last Name: _____

Social Security #:_____ Date of Birth: _____

Gender: Male Female

Marital Status (Circle One): Married Single Divorced Widowed Legally Separated

Communication Preference: Letter Cell Home Work

Primary Language: _____ Ethnicity: _____

Race (Circle One): Caucasian (White) African American Hispanic Asian American Other

Mailing Address: _____ City: _____

State: _____ Zip Code: _____

Primary Phone: (_____) _____ Secondary Phone: (_____) _____

Email Address: _____

Employer: _____

Work Phone: (____) _____

Emergency Contact with another Phone Number/Outside of the Home

Name: _____

Phone #_____

Pharmacy (Location):_____

Mail Order Pharmacy: _____

Patient Signature: _____ Date: _____

Carrico Congleton Family Practice

FINANCIAL POLICY

Thank you got choosing us as your provider. We are committed to making healthcare less stressful and more effective by clarifying financial responsibilities in advance. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment.

FULL PAYMENTS DUE AT THE TIME OF SERVICE

REGARDING INSURANCE

For all plans in which your physician is non-participating, we will provide you with a complete insurance form at the time of service for your submittal. However, you must provide us with your insurance information. The medical fees are your responsibility. Your insurance policy is a contract between you and your insurance company, as we are not a part of your insurance contract. In the event we are a participating provider for you insurance, we will process your claims, however all deductibles and co-pays are due at the time of service. Please be aware of some and perhaps all the services provided may be "not-covered" services and not considered reasonable and necessary under the Medicare Program and/or other medical insurances.

UCR(USUAL AND CUSTOMARY RATES)

Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. You are responsible for payment in full regardless of any insurance company's arbitrary/determination of usual or customary rates for which your physician is a non-participating provider. We will be happy to work with you as needed.

I have read the Financial Policy (above). I understand and agree to the Financial Policy.

Patient Signature: _____ Date: _____

Parent or Guardian Signature (if applicable): _____

Carrico Congleton Family Practice

INSURANCE INFORMATION

****PLEASE READ, INITIAL AND SIGN****

_____ I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize Carrico Congleton Family Practice to release to the Social Security Administration or its intermediaries of carriers any information needed for this or related Medicare, Medicaid, or any secondary claims. I request that payment of assigned benefits be made in my behalf to my provider at Carrico Congleton Family Practice and that this office may submit claims for all medical services rendered to me. My signature below represents authority for all claims made in my behalf with signing each claim.

_____ I, undersigned, certify that I have coverage with the insurance carrier whose name provided to the office, Carrico Congleton Family Practice. I authorize Carrico Congelton Family Practice to submit all claims for services on my behalf without signing each claim and to accept assigned benefits for services. I understand that I am financially responsible for all charges that are not covered by insurer and that I am responsible for services when applicable.

Signature _____

Date _____

**Carrico Congleton Family Practice contracts with an independent lab to provide services as a convenience to our patients. We cannot be responsible for any outstanding balances with the may occur.

I, _____ UNDERSTAND CARRICO CONGLETON FAMILY PRACTICE CANNOT GUARANTEE INSURANCE COVERAGE OF ANY LAB WORK DONE. I UNDERSTAND I MUST CONTACT MY INSURANCE COMPANY TO VERIFY THIS COVERAGE. IF THIS IS NOT DONE PRIOR TO THE LAB DRAW, I WILL BE RESPONISBLE FOR ANY OUTSTANDING BALANCE THAT I AM RESPONSIBLE FOR AND CARRICO CONGLETON FAMILY PRACTICE DOES NOT BILL FOR LAB SERVICES AND IS NOT RESPONSIBLE FOR THE CHARGES.

Signature _____ Date _____

Witness _____

Carrico Congleton Family Practice
Privacy Consent
(HIPAA Policy)

NAME: _____ DOB: _____

PERSONAL REPRESENTATIVE

I authorize Carrico Congleton Family Practice, LLC to give my personal representative(s), as listed below, protected health information on my behalf.

Name & Relationship	Telephone number
_____	_____
_____	_____
_____	_____

Please check all that apply:
I wish to be contacted about my protected health information by:

___ Home Telephone_____
___ Cell Phone_____
___ Work Phone_____
___ Mail
___ Other_____

___YES ___NO: Personal health information & test results may be left on voicemail.

I acknowledge that I have received a copy of the Notice of Privacy from Carrico Congleton Family Practice, LLC.

CONSENT: I HEREBY CONSENT TO Carrico Congleton Family Practice, LLC using or disclosing my protected health information (PHI) for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out health care operations. I authorize examination and any other medical service deemed necessary by health care providers or my insurance company, unless specifically requested in writing by me. This protected health information includes any personal or confidential information of a sensitive nature such as psychological, psychiatric records, substance abuse, drug or alcohol treatment or information or information pertaining to communicable diseases (including HIV status, hepatitis's, venereal disease). I understand and agree to these conditions as a patient at Carrico Congleton Family Practice, LLC.

I also understand that no test(s) will be done without my knowledge and that I must come into the office to receive HIV test results, and that the test results will be kept confidential, the extent permitted by law.

PRINT PATIENT NAME _____

PATIENT SIGNATURE _____

PERSONAL REPRESENTATIVE (if applicable) _____

WITNESS_____DATE:_____

Carrico Congleton Family Practice
Health History Update

Name: _____ DOB: _____

Current prescribed medications (with dose and frequency): _____

_____

_____

Non-prescribed medications (with dose and frequency): _____

_____

Allergies: _____

Medical providers/specialist you have seen in the past 12 months: _____

_____

Immunization Update: Check box if yes and put date receive

Flu Shot☐ Date: _____ Tetanus ☐ Date: _____ Shingles ☐ Date: _____
Pneumonia Vaccines (Pneumovax/Prevnar) ☐ Date: _____
Covid ☐ Pfzier ☐ Moderna ☐ J&J Date: _____

Pertinent Past Medical History: _____

_____

Surgical History: _____

_____

Hospitalization History (date and reason): _____

_____

TOP 2 CONCERNS TO DISCUSS AT VISIT:

1. _____

_____

2. _____

_____

Comments: _____

_____

Family History: _____

_____

_____

Health and Lifestyle:

Do you smoke? ☐ Yes ☐ No If yes, how many a day? _____ Age Started: _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many days per week or month do you drink alcohol? _____

How many drinks will you have in one sitting? _____

How often will you have more than 6 drinks in one setting? _____

Are you concerned about your own alcohol use? _____

Last Eye Exam? _____

Do you exercise? _____ If yes, type and frequency of exercise? _____

Do you use a seatbelt at least 90% of the time? _____ Do you use sunscreen? _____

Sexual History:

Have you been sexually active? _____ Are you currently sexually active? _____

Complete the following questions if you are sexually active:

Are you currently having sexual relations with one partner or multiple partners? _____

Number of partners in the last year? _____

Are/Is your sexual partner(s): ☐ Men ☐ Women ☐ Both

Do you and your partner use contraceptive and/or protective methods? _____

Have you ever had a sexually transmitted illness: (STD: (i.e. HPV, Herpes, Chlamydia, Gonorrhea or other))?

List: _____ Treated: ☐ Yes ☐ No

Gynecologic History (**WOMEN ONLY**):

Do you have a cervix? _____ Do you have a period every month? _____ Number of days of flow: _____

Menstrua cramps (circle one): Mild Moderate Severe None

Date of last PAP smear? _____ Last PAP smear results: _____

Have you ever had an abnormal PAP smear(s)? _____

If yes, explain history (including test location, date, what was done) for any abnormal PAP _____

_____

Number of pregnancies? _____ Are you presently trying to become pregnant or will be trying soon? _____

Gynecologic symptoms (circle if present):

abnormal menstrual bleeding	missed period	mood changes associated with period
hot flashes	vaginal dryness	history of prescription hormone use
insomnia	night sweats	

Have you ever had a mammogram? _____

Date and results of your last mammogram? _____

_____