Rose Family Medicine, PLLC

New Patient Information

Patient Name:				SSN#
Sex: Male Female Transgender	Date of birth:		Other names used:	
Address:				
City:		State:		Zip code:
Home Phone:		Work Phone:		
Mobile phone:		Email:		
Employment status: Full time Part time Not employed Student				
Employer Name:				
Emergency contact Name:			Relationship to patient:	
Home phone:	Work phone:		Mobile:	
Guarantor Information – *Only complete if different from patient*				
Guarantor relation to patient:		Guarantor name:		
SSN#	Male Female Transgender		Date of birth:	
Address:				
City:		State:		Zip code:
Home Phone:		Work Phone:		
Employer Name:				
Primary Coverage Information				
Subscriber name:	*Date of birth:*		*SSN#*	
Address:				
City:	*State:*		*Zip code:*	
Home phone:	*Mobile phone:*			
Insurance name: *Insurance billing address:*	*Insurance phone:*			
Subscriber ID #	*Group #*		*Group name:*	
Patient relation to subscriber:				
Employment status: *Full time* *Part time* *Not employed* *Student*				
Secondary Coverage Information				
Subscriber name:	*Date of birth:*		*SSN#*	
Address:				
City:	*State:*		*Zip code:*	
Home phone:	*Mobile phone:*			
Insurance name: *Insurance billing address:*	*Insurance phone:*			
Subscriber ID #	*Group #*		*Group name:*	
Patient relation to subscriber:				
Employment status: *Full time* *Part time* *Not employed* *Student*				

3rd Party Coverage Information (such as MVA, Worker Comp)		
Subscriber name:	*Date of birth:*	*SSN#*
Address:		
City:	*State:*	*Zip code:*
Home phone:	*Mobile phone:*	
Insurance company name: *Insurance billing address:*	*Insurance company phone:*	
Date of Injury:		
Claim Number:		
Subscriber ID #	*Group #*	*Group name:*
Patient relation to subscriber:		
Employment status: *Full time* *Part time* *Not employed* *Student*		
If MVA, name of the person who was driving the vehicle that hit you:		

Rose Family Medicine, PLLC Medical Billing Consent

Medical Consent

- I consent to provisions of health care services at Rose Family Medicine, PLLC and request my health care provider to provide any care they think is necessary and consistent with my instructions.
- I understand this care may include tests, examinations, image captures, medical and surgical treatment and related anesthesia. I acknowledge that no guarantee has been made to me as to the results that may be obtained from this care.
- I understand if special procedures or operations are needed, my health care provider will discuss this with me and my additional consent will be required.

Financial Agreement

- I agree to pay for services rendered according to Rose Family Medicine, PLLC rates and terms.
- I understand Rose Family Medicine, PLLC will make inquiries regarding insurance coverage and my financial responsibility from third party payors and financial references. I consent to any related asset credit checks, including inquiries with any credit reporting agencies.
- I understand that I am responsible for charges not covered by my insurance or other agency, which may include a deductible and coinsurance. If insurance payment is not received after 30 days, the balance in full becomes my responsibility. Accounts are payable in full at time of billing.
- If this account is referred to an agency or attorney for collections, I agree to pay attorney's fees and costs as may be allowed by law, whether or not a lawsuit is filed.

Assignment of Benefits: I authorize payment from all insurance or health plan benefits to go directly to Rose Family Medicine, PLLC. I assign the benefits payable for physician services to the physician furnishing the services or authorize them to submit a claim to Medicare for payment for me.

Financial Certification: I certify the information given by me is correct and I have read and consent to the terms of the financial agreement. I certify that I am the patient or am otherwise authorized to execute this document and accept its terms on behalf of the patient. I assume individually all financial responsibility by signing this form.

By signing below, I (Patient or Authorized Consenter) herby acknowledge I have read and fully understand the above information. I have asked questions about anything not clear to me, and am satisfied with the answers I have received. I understand that I may revoke my consent or authorization at any time except to the extent that actions has been taken in reliance on such consent or authorization.

Patient or Legal Representative Relationship: Signed by:

Signature:_____ Signed Date:_____

Rose Family Medicine, PLLC

Adult Health History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name:					Date:
DOB	Male	Female	Transgender	Birthplace:	
Marital status: single	married	separated	divorced	widowed	domestic partner
Occupation:			Date of last exam:		
Do you have an Advance Directive or Living Will? Yes No					

Allergies	Reaction

Food Allergies? Yes No List:

Medications

Please list all medication that you are taking, including over-the-counter drugs, vitamins and nutritional supplements. Please attach a separate sheet if necessary.

Name	Strength	How often do you take?	Start Date (month/Year)

Medical History

	No	Yes, have now	Yes, in the past	When:
Abnormal Pap				
Allergies				
Anxiety				
Arthritis				
Asthma				
Blood Transfusions				
Cancer/Oncology				
Cataracts				
Congestive heart failure				
Bowel disorder				
Clotting disorder				
Chronic obstructive pulmonary disease				
Depression				
Diabetes				
Emphysema				
GERD				

	No	Yes, have now	Yes, in the past	When:
Glaucoma				
Gout				
Headaches				
Hearing loss				
Heart murmur				
Hepatitis				
High blood pressure				
High cholesterol				
Human Immunodeficiency virus/AIDS				
Jaundice				
Kidney disease				
Kidney stones				
Liver disease				
Meningitis				
Osteoporosis				
Prostate problems				
Seizures				
Sexually transmitted disease				
Shingles				
Sickle cell				
Skin problems				
Stroke				
Substance abuse				
Thyroid disease				
Tuberculosis				
Ulcers				
Urinary problems				
Other medical history (list):				

Surgical History

	No	Yes/Date		No	Yes/Date
Amputation			Tonsillectomy		
Appendectomy			Tubal ligation		
Brain surgery			Valve replacement		
Breast surgery			Vasectomy		
Heart surgery			Prostate surgery		
Hernia repair			Sinus surgery		
Hysterectomy			Spine surgery		
Joint replacement			Thyroid surgery		
Cataract			C-section		
Gallbladder			Heart bypass		
Cosmetic surgery			Cardiac stent		
Fracture surgery			other		

Family History (please circle all that apply)	
Mother (alive, deceased)arthritis, asthma, birth defects, cancer, depression, diabetes, early death, hearing loss, heart disease, high blood pressure, high cholesterol, kidney disease, mental retardation, obesity, osteoporosis, thyroid disease, stroke, substance abuse, vision loss, other	
Father (alive, deceased)arthritis, asthma, birth defects, cancer, depression, diabetes, early death, hearing loss, heart disease, high blood pressure, high cholesterol, kidney disease, mental retardation, obesity, osteoporosis, thyroid disease, stroke, substance abuse, vision loss, other	
Sister(s) (alive, deceased)arthritis, asthma, birth defects, cancer, depression, diabetes, early death, hearing loss, heart disease, high blood pressure, high cholesterol, kidney disease, mental retardation, obesity, osteoporosis, thyroid disease, stroke, substance abuse, vision loss, other	
Brother(s) (alive, deceased)arthritis, asthma, birth defects, cancer, depression, diabetes, early death, hearing loss, heart disease, high blood pressure, high cholesterol, kidney disease, mental retardation, obesity, osteoporosis, thyroid disease, stroke, substance abuse, vision loss, other	
Maternal Grandmother (alive, deceased)arthritis, asthma, birth defects, cancer, depression, diabetes, early death, hearing loss, heart disease, high blood pressure, high cholesterol, kidney disease, mental retardation, obesity, osteoporosis, thyroid disease, stroke, substance abuse, vision loss, other	
Maternal Grandfather (alive, deceased)arthritis, asthma, birth defects, cancer, depression, diabetes, early death, hearing loss, heart disease, high blood pressure, high cholesterol, kidney disease, mental retardation, obesity, osteoporosis, thyroid disease, stroke, substance abuse, vision loss, other	
Paternal Grandmother (alive, deceased)arthritis, asthma, birth defects, cancer, depression, diabetes, early death, hearing loss, heart disease, high blood pressure, high cholesterol, kidney disease, mental retardation, obesity, osteoporosis, thyroid disease, stroke, substance abuse, vision loss, other	
Paternal Grandfather (alive, deceased)arthritis, asthma, birth defects, cancer, depression, diabetes, early death, hearing loss, heart disease, high blood pressure, high cholesterol, kidney disease, mental retardation, obesity, osteoporosis, thyroid disease, stroke, substance abuse, vision loss, other	
Social History (please circle all the apply)	
Tobacco	Yes No Quit Passive Cigarette (pks/day) _____ Duration _____ Yrs Date quit_____ Cigar (#/day) _____ Duration _____ Yrs Date quit_____ Pipe (#/day) _____ Duration _____ Yrs Date quit_____ Chew (#/day) _____ Duration _____ Yrs Date quit_____ Snuff (#/day) _____ Duration _____ Yrs Date quit_____
Social	Hobbies_____ Number of children:_____Military Experience:_____
Alcohol	Wine (glasses/week) _____ Duration _____ Yrs Date quit_____ Beer (cans/week) _____ Duration _____ Yrs Date quit_____ Liquor (shots/week) _____ Duration _____ Yrs Date quit_____
Drugs Use	Yes No Used within the last two years_____ Types: Marijuana Cocaine Methamphetamines Heroin Other_____
Sexually Active	Yes No Not Currently Comment:_____ Birth Control/Protection: Abstinence Implant Birth control pills Spermicide Coitus Interruptus Injection Patch Sponge Condom Inserts Post-menopausal Surgical Diaphragm IUD Rhythm Other

Immunizations History		
Vaccinations		Date Administered
	Flu	
	Pneumovax	
	Tetanus Td	
	Tetanus TDAP	
	Hepatitis A	
	Hepatitis B	
	HPV	
	MMR	
	Zostavax	
Specialty Services		
Care Teams	Are you currently seeing a specialist? Yes No Physician Name Specialty Last Seen Phone number	

Rose Family Medicine, PLLC

Patient Health Questionnaire (PHQ-9)

Nine symptoms Depression Checklist

Name_____Date_____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Please circle your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself-or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Add columns: _____ _____ _____

Total score: _____

10. If you circled any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people? (Please circle our answer)	Not difficult at all Somewhat difficult Very difficult Extremely difficult