

**American Family Care
PATIENT PROFILE**

PATIENT INFORMATION

Name: _____
Address: _____
City, State & Zip: _____
Phone: _____ [] Home [] Work [] Cell
Phone: _____ [] Home [] Work [] Cell

Sex: [] Male [] Female
Date of Birth _____
Social Security #: _____
Marital Status: [] Single [] Married [] Divorced
Driver Licence: _____ Exp: _____
Primary MD: _____ Referring MD: _____

PATIENT EMPLOYMENT

[] Employed [] Unemployed [] Retired [] Other

Phone: _____
Employer: _____

*AFC has permission to discuss my medical info and billing info with the following persons:

_____ [] Spouse [] Other
_____ [] Relative [] Other

RESPONSIBLE PARTY/GUARANTOR INFORMATION

[] Same as patient

Name: _____
Address: _____
City, State & Zip: _____

Employer: _____
Phone: _____ [] Home [] Work [] Cell
Phone: _____ [] Home [] Work [] Cell
Social Security # _____
Date of Birth: _____

PRIMARY INSURANCE

[] Same as patient [] Same as Guarantor [] Other

Insured Party _____
Insured Phone: _____ [] Home [] Work [] Cell
Insured date of birth: _____
Name of Insurance _____
Insurance Mailing Address _____

Patient Relationship to Insured:
[] Self [] Spouse [] Child [] Other
Social Security # _____
Insured Phone: _____ [] Home [] Work [] Cell
Insurance ID # _____
Insurance Group #: _____
Co-Pay: \$ _____

SECONDARY INSURANCE

[] Same as patient [] Same as Guarantor [] Other

Insured Party _____
Insured Phone: _____ [] Home [] Work [] Cell
Insured date of birth: _____
Name of Insurance _____
Insurance Mailing Address _____

Patient Relationship to Insured:
[] Self [] Spouse [] Child [] Other
Social Security # _____
Insured Phone: _____ [] Home [] Work [] Cell
Insurance ID # _____
Insurance Group #: _____
Co-Pay: \$ _____

PATIENT/GUARANTOR SIGNATURE:

Date: _____



MEDICAL/FAMILY/SOCIAL HISTORY

(PAGE 1 OF 2)

Name: _____ Date: _____

SS#: _____ Date of Birth: _____

Chief Complaint

Why are you seeing the doctor today?

Current problem is the result of

Illness Work Accident Car Accident Injury Other _____

When did you first notice the symptoms _____

Past Medical History

Surgeries/Hospitalization	Year	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical Problems:

Please list all medical problems/illnesses for which you are currently being treated:

Medications	Dose	How Long?	Side Effects
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies: _____ Medications: _____
Food/Environmental: _____
Other: _____



Name: _____

SS#: _____

MEDICAL/FAMILY/SOCIAL HISTORY

(PAGE 2 of 2)

Review of Systems

Are you currently having or have you had problems with: (If yes, please describe)

Eyes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Ears, Nose, Throat	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Respiratory (Lung/Breathing)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Gastrointestinal	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Cardiovascular (Heart)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Urological Problems (Bladder)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
High Blood Pressure	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Endocrine (Thyroid)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Hematologic (Bleeding)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Numbness/tingling	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Psychological Problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Neurological Problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Psychiatric Problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Allergic/Immunologic	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Musculoskeletal	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Integumentary (Skin)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____

Family History

Has any one in your immediate family been diagnosed with the following disease (If yes, please indicate family member)

Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Heart Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
High Blood Pressure	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Bleeding disorders	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____

Social History

Please check:

<input type="checkbox"/> Employed (occupation) _____
<input type="checkbox"/> Work in the home
<input type="checkbox"/> Student
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
<input type="checkbox"/> Children <input type="checkbox"/> Yes <input type="checkbox"/> No Ages _____

Exercise:

Daily Weekly Monthly Rarely Never

What type of exercise? _____

Are you on a special diet? No Yes Describe: _____

History of substance abuse? No Yes What: _____

Smoke currently? No Yes Packs per day _____ for _____ years.

Previously smoked? No Yes

Drink Alcohol? No Yes Frequency _____ Type _____

Reviewed by: _____ MD Date: _____

American Family Care

YOUR HIPAA RIGHTS:

We are required by law to maintain the privacy of, and provide individuals with, a notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the form you received, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number: 205-403-8902.

Your signature below is only acknowledgement that you received a Notice of our Privacy Practices:

Print Name _____ **Signature** _____ **Date** _____

PHONE MESSAGES:

American Family Care has my permission to leave messages on my answering machine or voice mail which may pertain to follow up visits, test results, scheduled appointments, or calls regarding balances on my account. **Yes** **No** _____ **Initial**

GUARANTEE OF ACCOUNT

The Guarantor is responsible for payment of all charges hereafter incurred by the Guarantor and the Guarantor's family. If insurance is filed by American Family Care the Guarantor is responsible for the insurance payment and any remaining balances. If we do not file insurance, Guarantor is responsible for payment of charges at time of service. Any balance over 30 days past due will be charged an annual fee of 18%. Any charges not paid within 90 days will be turned over to our Collection Agency. Should American Family Care find it necessary to place my account with an outside agency for collection, I understand that the collection agency may add collection costs up to 33 1/3% to the account. Any cost incurred by American Family Care through legal action taken for collection of charges, including a reasonable fee, will be the responsibility of the Guarantor and the Guarantor will hereby waive the rights of exemption under the law of the state of Alabama and any other state. Any services rendered after an account has been turned over to our collection agency will be on a cash basis only. I agree to keep American Family Care advised on any change of address or any other change in the information furnished. I authorize the release of any credit information, including but not limited to, verification of employment and income as needed by American Family Care or its agents.

Authorization:

I, or we, hereby authorize American Family Care and the Medical Staff to perform such Medical and Surgical procedures as are necessary and to release records as needed in compliance with HIPAA regulations for received treatment. I acknowledge that no guarantees have been made as to the effect of such treatment.

Signature of Patient or Legal Guardian _____ **Date** _____

INSURANCE DISCLAIMER/PCP WAIVER:

American Family Care is committed to providing the very best in healthcare to all our patients. In addition, we are striving to assist our patients by filing their insurance. However, we need the help of each patient in recognizing whether they have an assigned PCP (Primary Care Physician) that is on staff in our facility.

If you are in need of medical care and your assigned PCP is not available, you have the option of seeing the physician on duty or changing your PCP to the physician on duty. You can change your PCP by placing a call to your insurance company at the number on your insurance card. If you choose to see the physician on duty, your insurance carrier may charge you a deductible, or may not pay any amount on your claim.

We will bill your insurance company within ten days of your visit to our clinic. Your claim should be processed and paid within 45 days, however, if payment of your claim is delayed or denied by your insurance carrier, you may be billed for services rendered. If you feel that your insurance made an error in not paying your claims promptly, you must call our billing office immediately and let us know why payment is delayed.

_____ **Initial**