Mooresville PPM, LLC

Outpatient Information / Consent to Treat

PATIENT INFORMATION	Account #:		Medical Record#:	Date:	
Patient Name:			Referring Doctor:		
Billing Address:			City	State	Zip
Physical Address:			City	State	Zip
(H) Phone:	(C) Phone:		Work Phone:	Other:	
Primary Doctor			Employer/School:		
Social Security #:	Date of Birth:	Age	Martial Status:	Sex:	
Emergency Contact:	Relationship:		(H) Phone:	(C) Phone:	
Responsible Party:	Relationship:		DOB:	SS#:	
Email (responsible party if minor/child)					
Responsible Party Address:					
City:	State	Zip	(H) Phone:	(C) Phone:	
INSURANCE INFORMATION					
Primary Insurance:	Employer:		Secondary Insurance:	Employer:	
Insurance ID #:	Insurance Group #:		Insurance ID #:	Insurance Group #:	
Insured Name:			Insured Name:		
Address:			Address:		
City	State	Zip	City	State	Zip
DOB:	Insured Social Security #:		Insured DOB:	Insured Social Security #:	

Financial Responsibility and Assignment of Insurance Benefits:

I guarantee payment to Mooresville PPM, LLC and its affiliates (Mooresville PPM, LLC) of all charges for services provided to the patient. I understand I am personally responsible for all charges not covered by insurance. I authorize payment of surgical and medical benefits, which would otherwise be payable to me, to Mooresville PPM, LLC for services rendered. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Titles V, XVIII and/or XIX of the Social Security Act is correct.

For Staff Use Only

❑ Patient refused to sign after he/she received Joint Notice of Privacy Practices and was informed that signing the form merely acknowledges that the patient actually received the notice.

❑ Patient was initially treated for an emergency condition. Patient either was given the notice after stabilization or will be given the notice after transfer.

(Check one)

Signature of Staff _____ ***Date/Time:*** _____

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

❑ Interpreter Accepted _____ ❑ Interpreter Refused

(Name/Number of Person/Services Chosen/Used

ADULT HISTORY QUESTIONNAIRE

NAME: _____ DOB: _____

FAMILY HISTORY: Please check if any blood relative has had:

_____ Diabetes	_____ Heart Disease	_____ High Blood Pressure
_____ Cancer	_____ Tuberculosis	_____ Kidney Disease
_____ Birth Defects	_____ Blood Disease	_____ Mental Illness
_____ Retardation	_____ Suicide	_____ Glaucoma
_____ Alcoholism	_____ Epilepsy or Convulsions	_____ Stroke
_____ Asthma	_____ Migraines	_____ Allergies
_____ Arthritis	_____ HIV or AIDS	_____ Other Serious Illness

HOSPITALIZATIONS:

	DATE	PLACE	REASON
1)			
2)			
3)			
4)			
5)			

ALLERGIES: Please list allergies of any kind, and include reactions: _____

PRESENT MEDICATIONS: (Please include all prescription and non-prescription medications)

	NAME	DOSE		NAME	DOSE
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

OBSTETRICAL HISTORY:

# of Pregnancies: _____ # of Children: _____ Age at first live birth : _____

Age of Menarche: _____ Age of Menopause: _____

PLEASE CHECK IF YOU HAVE NOW OR HAVE EVER HAD:

_____ Arthritis
_____ Painful or swollen joints
_____ Persistent back or neck pain
_____ Broken bones or fractures
_____ Persistently enlarged glands
_____ Seizure or convulsion
_____ Concussion
_____ Stroke or paralysis
_____ Persistent numbness or tingling
_____ Weakness in arms or legs
_____ Passing out or fainting
_____ Meningitis
_____ Migraines or severe headaches
_____ Nervous breakdown or depression
_____ Dissatisfaction with sex
_____ To wake up at night short of breath
_____ A heart murmur
_____ Whooping cough
_____ Recent change in bowel habits
_____ Appendicitis
_____ Frequent colds or infections
_____ Ulcer
_____ Colitis
_____ Hepatitis or cirrhosis
_____ Blood clot
_____ Heart attack or coronary
_____ Ankle or leg swelling
_____ High blood pressure
_____ Anemia
_____ Jaundice
_____ Pneumonia
_____ Shortness of breath climbing stairs
_____ A black or bloody stool
_____ Frequent vomiting or diarrhea

_____ Difficulty sleeping
_____ Trouble with ears or hearing
_____ Blurred or double vision
_____ Glasses
_____ To get up at night
_____ Kidney stones
_____ Lose urine when you cough
_____ Trouble starting your stream
_____ Persistent pain when urinating
_____ Syphilis or Gonorrhea
_____ A tumor
_____ Urinary infections
_____ Frequent vaginitis
_____ Chest pain
_____ Shortness of breath with exercise
_____ Gall bladder trouble
_____ Trouble tolerating heat or cold
_____ To take tranquilizers
_____ X-rays of your:
  _____ Chest
  _____ Stomach or bowel
  _____ Gall bladder
  _____ Kidneys
  _____ Skull
  _____ Back or neck
_____ A thyroid problem
_____ Diabetes
_____ Trouble with your sinuses
_____ Tuberculosis
_____ Weight change
_____ A transfusion
_____ Heavy sweating at night
_____ Chest pains
_____ Hot flashes

Do you now or have you ever had any problems with substance abuse? Yes No
How often do you drink alcohol? _____
Do you smoke? Yes No Have you ever smoked? Yes No
Do you follow any special diet? Yes No
Do you have any allergies? Yes No
How many cups of coffee do you drink per day? _____
How many hours of sleep per day? _____
What exercise do you do regularly? _____
List all occupations you have had _____
Date of last physical _____ Cholesterol test _____ Mammogram _____
Date of last sigmoidoscopy _____
Would you say that there is excessive stress at work or at home? _____
Date of last tetanus shot _____ Flu Shot _____ Pneumonia _____