



PATIENT INFORMATION

Preferred Provider: Dr. _____ Preferred Pharmacy: _____

Patient Name: _____
Last First Middle "Nickname"

DOB: _____ Sex: _____ SSN: _____ Marital Status: _____ Drivers Lic #: _____

Ethnicity (circle one): African American American Indian Asian Primary Language: _____
Caucasian/White Hawaiian Hispanic/Latino Other

Address: _____
Street Apt # City State Zip Code County

Phone #: _____
Home Work Cell/Other Primary

Email Address: _____

Emergency Contact: _____
Name Relationship DOB Phone #

Insurance Information: Insurance Company Name: _____

Insurance ID #: _____ Group #: _____

Insurance Claim Address: _____

Policy Holder: _____
Last First Middle DOB

Address: _____
Street Apt # City State Zip Code SAME? ☐ (check here)

Phone #: _____
Home Work Cell/Other

SSN: _____ Employer: _____

How did you hear about us?
☐ Word of Mouth ☐ Yelp ☐ Web Search
☐ Facebook ☐ Health Grades ☐ Community Newsletter
☐ Insurance Company ☐ Radio ☐ Other: _____

Preferred Method of Communication: ☐ Mail - ☐ Fax - ☐ Patient Portal - ☐ Cellphone - ☐ Home Phone - ☐ Work Phone

PATIENT AGREEMENT

Payment is due at time services are rendered. By signing below, you agree to and understand the following policies:

HIPAA – Privacy Notice

I am aware that I may review Creekmore Clinic HIPAA privacy notice at any time and understand that I may request a copy.

Initials

PFP Medical Care Agreement

I authorize the physicians of Creekmore Clinic to administer medical treatment as deemed necessary. I understand that there will be a \$25.00 charge for appointments not cancelled 24 hours in advance. I understand that the primary insured is financially responsible for any balance not covered by my insurance, including co-pay, deductible/ co-insurance, and any services excluded by my policy. I also understand that Creekmore Clinic will not verify insurance coverage. I also understand the primary insured will be held responsible for any and all charges incurred by myself or covered dependents should there be no coverage on the date of service. Furthermore, I hereby authorize release of medical information necessary to file a claim with my insurance and assign benefits to otherwise payable to me to Creekmore Clinic.

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Initials

Signature: _____

Date: _____



In order to help you clearly understand our policies and services, please read the following statements, and sign the bottom indicating you accept these rules:

- I understand there can be a fee for controlled substance prescriptions written without an appointment.
- I understand there may be a fee for missed appointments or appointments not cancelled within 24 hours. Please notify us as soon as possible if you cannot make your scheduled appointment.
- I understand there is a \$35 fee for bounced checks and an additional \$20 processing fee for balances that go in to collections.
- I understand a fee may be assessed for any paperwork or forms to be completed without an appointment and that it may take up to 10 days to be completed.
- I understand prescription renewals are to be processed through the requested pharmacy. If the prescription is mail order and requires a written prescription, it may take 3-4 business days to be processed.
- I understand that labs, x-ray reports, and other test results need to be reviewed and it may take between 3-4 business days to be reviewed by the physician/PA. A staff member will contact you sooner if the results are urgent; otherwise, you will be contacted by phone, mail or via our secure patient web portal with the results.

Fees for Services:

\$12 Controlled substance prescriptions without an appointment
\$35 Attending physician statement
\$50 Physician dictated letter
\$75 Physician narrative

Thank you for your cooperation.

Patient Name (please print): _____

DOB: _____

Patient Signature: _____

Date: _____



CONSENT FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

Cell Phone#: _____ Email: _____

Please check the sections that apply, then sign at the bottom of the page:

_____ **I do not give Creekmore Clinic permission** to release my information to anyone other than myself.

or

_____ **I give Creekmore Clinic permission** to release my information that includes:

_____ Entire Medical Record

_____ Blood Tests

_____ X-rays

_____ Cultures, including throat, urine and genital

_____ Appointment Details

_____ Billing Information

with

_____ My spouse or significant other (Name _____)

_____ Other family member (Name _____)

_____ On home answering machine or cell phone # _____

_____ On office/work voice mail # _____

I also give permission to receive all information by mail to address:

Signature: _____ Date: _____
(A signature is required for this form to be considered valid)



Patient Auto-Payment Agreement

For your convenience we are offering a patient balance payment option. This option is designed to help you pay your bill on time every time. You are not required to fill this form out if you do not wish to participate in our Auto-Payment program.

If after a claim has been submitted to my insurance company:

- 1) the claim is denied as a non-covered service; or
- 2) the charges deemed a patient responsibility by your insurance company Creekmore Clinic has my permission to charge my credit card/ debit card on file for services provided to me or my dependent.

I understand that in the event my credit card or debit card has been charged for medical services, and then my insurance company makes payment to Creekmore Clinic for those charges, the office will issue a refund or credit to my credit or debit card in the amount received from my insurance company.

I hereby authorize Creekmore Clinic and its designated payment system to charge my credit or debit card the full amount of charges for medical services provided. The amount charged will be reflected on my credit / debit card statement

If payment is denied by my payment card company or bank, I agree to pay the entire amount promptly via another form of payment

Patient Name: _____

Patient Date of Birth: _____

Dependent Name: _____

Dependent Date of Birth: _____

Signature: _____

Date: _____

(you will receive an electronic receipt via text or email for any transactions processed, provided we have your contact information)

Your Family. Our Team. Good Health.



MALE HEALTH HISTORY FORM

Name: _____ Today's Date: _____
Previous Primary Care Physician: _____ DOB: _____
Other physicians (specialists) involved in your care: _____
Preferred pharmacy: _____

MEDICAL HISTORY:

Have you been diagnosed with any of the following?

Alcoholism ☐ Yes ☐ No
Allergies ☐ Yes ☐ No
Anemia ☐ Yes ☐ No
Anxiety ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No
Asthma ☐ Yes ☐ No
Back pain ☐ Yes ☐ No
Blood clots ☐ Yes ☐ No

If yes: where? _____

Cancer ☐ Yes ☐ No

If yes: what type? _____

Chrohn's / Ulcerative colitis ☐ Yes ☐ No
Depression ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No

If yes: what type? ☐ 1 ☐ 2

Emphysema / Lung disease ☐ Yes ☐ No
Eye disease ☐ Yes ☐ No

If yes: what type? _____

Fractures ☐ Yes ☐ No

If yes: where? _____

Gout ☐ Yes ☐ No
Migraines ☐ Yes ☐ No
Hearing loss / Ear problems ☐ Yes ☐ No
Heart attack ☐ Yes ☐ No
Heart disease ☐ Yes ☐ No

If yes: what type? _____

Hepatitis ☐ Yes ☐ No

If yes: what type? (A, B, C) _____

Hernia ☐ Yes ☐ No

If yes: what type? _____

High blood pressure ☐ Yes ☐ No
High Cholesterol ☐ Yes ☐ No
HIV ☐ Yes ☐ No
HPV infection ☐ Yes ☐ No
Incontinence ☐ Yes ☐ No
Insomnia ☐ Yes ☐ No
Kidney disease ☐ Yes ☐ No
Kidney stones ☐ Yes ☐ No

Osteoporosis ☐ Yes ☐ No
Prostate enlargement ☐ Yes ☐ No
Stomach Reflux ☐ Yes ☐ No
Seizures ☐ Yes ☐ No
Sleep apnea ☐ Yes ☐ No
STDs ☐ Yes ☐ No
Stroke ☐ Yes ☐ No
Stomach ulcers ☐ Yes ☐ No
Thyroid disease ☐ Yes ☐ No

If yes: what type? _____

Testicular torsion ☐ Yes ☐ No
Tuberculosis ☐ Yes ☐ No
Urinary tract infections ☐ Yes ☐ No

SURGICAL HISTORY:

Have you had any of the following?

Abdominal surgery ☐ Yes ☐ No
Appendectomy ☐ Yes ☐ No
Brain surgery ☐ Yes ☐ No
Back surgery ☐ Yes ☐ No

If yes: what type? _____

Bladder surgery ☐ Yes ☐ No
Cosmetic surgery ☐ Yes ☐ No

If yes: what type? _____

Eye surgery ☐ Yes ☐ No

If yes: what type? _____

Gallbladder removal ☐ Yes ☐ No
Heart surgery ☐ Yes ☐ No

If yes: what type? _____

Hernia repair ☐ Yes ☐ No

If yes: what type? _____

Prostate surgery ☐ Yes ☐ No
Thyroid surgery ☐ Yes ☐ No

If yes: what type? _____

Vasectomy ☐ Yes ☐ No

Other surgical history? _____

ALLERGIES:

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list the name(s) and type of reaction

NAME	REACTION

MEDICATIONS:Do you currently take any prescription medications: ☐ Yes ☐ No

MEDICATION NAME	STRENGTH & DOSE	FREQUENCY
		<input type="checkbox"/> Daily <input type="checkbox"/> 2xdaily <input type="checkbox"/> 3xdaily <input type="checkbox"/> 4xdaily <input type="checkbox"/> As needed
		<input type="checkbox"/> Daily <input type="checkbox"/> 2xdaily <input type="checkbox"/> 3xdaily <input type="checkbox"/> 4xdaily <input type="checkbox"/> As needed
		<input type="checkbox"/> Daily <input type="checkbox"/> 2xdaily <input type="checkbox"/> 3xdaily <input type="checkbox"/> 4xdaily <input type="checkbox"/> As needed
		<input type="checkbox"/> Daily <input type="checkbox"/> 2xdaily <input type="checkbox"/> 3xdaily <input type="checkbox"/> 4xdaily <input type="checkbox"/> As needed
		<input type="checkbox"/> Daily <input type="checkbox"/> 2xdaily <input type="checkbox"/> 3xdaily <input type="checkbox"/> 4xdaily <input type="checkbox"/> As needed
		<input type="checkbox"/> Daily <input type="checkbox"/> 2xdaily <input type="checkbox"/> 3xdaily <input type="checkbox"/> 4xdaily <input type="checkbox"/> As needed

Do you take any over-the-counter supplements? (Calcium, multivitamins, sleep aids, other supplements)
☐ No ☐ Yes - _____**FAMILY HISTORY:**☐ Unknown / Adopted

Family Member	Alcoholism	Breast Cancer	Bleeding Problems	Colon cancer	COPD	Crohn's/ Ulc Colitis	Diabetes	Glaucoma	Heart attack	Heart failure	High cholesterol	High blood pressure	Kidney disease	Lung cancer	Lupus	Mental illness	Ovarian cancer	Pancreatic cancer	Prostate cancer	Rheum. arthritis	Stroke	Thyroid disease	Tuberculosis
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maternal grandfather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mat. grandmother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paternal grandfather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pat. grandmother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aunt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uncle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other relatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SOCIAL HISTORY:

Marital status: _____

Occupation: _____

Current tobacco use ☐ Yes ☐ No☐ Previously but quit: (date) _____

Packs per day _____

Years of use: _____ yrs

Type: ☐ Cigarettes ☐ Cigars ☐ Chewing☐ Dip ☐ Pipe ☐ E-cigarettesExposure to second hand smoke? ☐ Yes ☐ NoAlcohol use ☐ Yes ☐ No

If yes: # drinks / week _____

Type of alcohol _____

Are you or others concerned about your drinking? ☐ Yes ☐ NoDrug use ☐ Yes ☐ No

If yes: type _____

Do you practice any religion ☐ Yes ☐ No

If yes, which one? _____

Do you exercise? ☐ Yes ☐ No

How often? _____ times/week

What type of exercise? _____

Are you currently sexually active? ☐ Yes ☐ NoPartner (s): ☐ Male ☐ Female ☐ BothDo you use protection? ☐ Yes ☐ No**HEALTH MAINTENANCE:**

If you've had any of the following please specify date last performed:

Prostate exam _____/_____/_____

PSA _____/_____/_____

Colonoscopy _____/_____/_____

- Result: ☐ Normal ☐ Polyps ☐ Diverticula☐ Hemorrhoids ☐ Other: _____

Aortic aneurysm screening _____/_____/_____

CT for lung cancer screening _____/_____/_____

Dental exam _____/_____/_____

Eye exam _____/_____/_____

Tetanus shot _____/_____/_____

HPV series (3) _____/_____/_____

Flu shot _____/_____/_____

Pneumonia shot: Pneumovax _____/_____/_____

- Prevnar 13 _____/_____/_____

Shingles vaccine _____/_____/_____

Hepatitis A vaccine _____/_____/_____

Hepatitis B vaccine series _____/_____/_____

Meningitis vaccine _____/_____/_____



PATIENTS AGE 18 OR OLDER

**CONSENT FOR DISCLOSURE TO FAMILY MEMBER
AND/OR PERSONAL REPRESENTATIVE**

Patients Name: _____ Birthdate: _____

I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for _____ and his/her staff to disclose my personal medical information to the following individual(s):

Name: _____ Relationship to Patient: _____ Phone# _____

Name: _____ Relationship to Patient: _____ Phone# _____

Name: _____ Relationship to Patient: _____ Phone# _____

Conditions for Disclosure (Check the item(s) that apply):

- ☐ Creekmore Clinic may disclose my medical information to the individual(s) above when I am not physically present, including disclosures by telephone, facsimile, e-mail or regular mail.

Please note:

Creekmore Clinic will not disclose confidential information without a specific release. See release below:

I authorize the release of information relating to:

- ☐ Alcohol / Drug Abuse Evaluation/Treatment
- ☐ HIV / AIDs / STD Evaluation/Treatment
- ☐ Psychiatric / Mental Health Evaluation/Treatment
- ☐ Pregnancy Evaluation/Treatment

Authorization:

- I authorize Creekmore Clinic to release the information marked above.
- I understand that when the health information is released, the information could be redisclosed by the recipient and may no longer be protected by federal or state privacy laws.
- I understand that my health care and payment for health care will not be affected if I do not sign this form.

I understand that this consent may be revoked by me at any time by written notice to the practice.

Patient Signature: _____

Date of Signature: _____

Insurance Information:

Insurance Company Name: _____

Insurance ID #: _____ Group #: _____

Insurance Claim Address _____

Policy Holder (Last, First, Middle) _____ DOB _____

Address: SAME?

Street _____ Apt # _____ City _____ State _____ Zip Code _____

Phone #: _____ Home Work Cell/Other _____

SSN _____ Employer _____

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Signature: _____ Date: _____

Electronic Communication

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach & messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, missed appointment, overdue wellness visit, or any other reasonable healthcare related communication. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information regarding healthcare events, unpaid balances, missed appointments, and to leave a reminder message on my voice mail or answering system if I am unavailable at the number provided by me.

Signature: _____ Date: _____

How did you hear about us?

Word of Mouth ☐ Yelp ☐ Web Search ☐ Facebook ☐ Health Grades ☐ Community Newsletter ☐

Insurance Company ☐ _____ Other _____

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Signature: _____

Date: _____