CONFIDENTIAL PATIENT INFORMATION

PATIENT DEMOGRAPHICS

Prefix
○ Mr. ○ Mrs. ○ Miss ○ Ms.

Last Name _____ First Name _____ Middle Initial _____

Preferred Name to be called _____

Social Security ___-___-___

Birth Date ___/___/_____

Gender (select one) ○ Male ○ Female

Mailing Address _____

City / State _____

Appt/Lot/Space # _____

Zip Code _____

Race (Select one or more)
○ White
○ Hispanic or Latino
○ Black or African American
○ Asian
○ American Indian / Alaska Native
○ Native Hawaiian or Other Pacific Islander
○ Unknown / Not reported

Ethnicity
○ Hispanic or Latino
○ Not Hispanic or Latino
○ Unknown / Not Reported

Preferred Language _____

May we leave you a phone message? Y / N

Preferred Method of Contact (Indicate One below)
○ Cell ○ Home ○ Work

Marital Status (Select One) ○ Married ○ Partner ○ Separated ○ Divorced ○ Single ○ Widow

Primary Care Physician (First and Last Name) _____

Referring Physician (First and Last Name) _____

Your Home Telephone # _____ Your Work Telephone # _____

Your Cell Telephone # _____ Your E-Mail Address _____

Employment Status (Select One) ○ **Part-time** ○ **Full-time** ○ **Retired** ○ **Other**

Employer Name _____ Employer Telephone # _____ Job Title _____

Name of your Emergency Contact _____ Relationship _____ Telephone # _____

INSURANCE POLICY INFORMATION

Primary Insurance _____ Policy Holder's Name _____

Policy Holder's Date of Birth ___/___/_____ Name as it appears on card _____

Policy # _____ Group # _____ Effective Date _____

Secondary Insurance _____ Policy Holder's Name _____

Policy Holder's Date of Birth ___/___/_____ Name as it appears on card _____

Policy # _____ Group # _____ Effective Date _____

CONFIDENTIAL PATIENT INFORMATION

PHARMACY INFORMATION

May we have your consent to prescribe Electronically? ○ Yes ○No

Pharmacy Name _____ Location _____

ADVANCE DIRECTIVE *Do you have one? if yes complete information below if no check box* □

□ Do Not Resuscitate (DNR) □ Surrogate Decision Maker *(heath care provider)* □ Non Surrogate Decision Maker

GENERAL CONSENT

The information presented here enables you to consent for needed medical care services, as well as for the release of information from your medical records for medical and administrative purposes.

HIPAA ACKNOWLEDGEMENT:

I hereby acknowledge that I have been offered a copy of the Boise Osteopathic Medical Clinic Notice of Privacy Practices on this date or on a previous date. **Initial** _____

ASSIGNMENT OF BENEFITS

ASSIGNMENT OF BENEFITS/PAYMENT AGREEMENT: All accounts are due and payable at the time of service unless other prior arrangements have been made. I understand that I am responsible for any and all balances owing. I hereby authorize payment directly to Boise Osteopathic Medical Clinic of all healthcare benefits, not to exceed charges, to which I would otherwise be entitled for these services. I understand and agree regardless of my personal ability to pay, that I am financially responsible to Boise Osteopathic Medical Clinic for charges not covered by my insurance carrier.

IT IS YOUR RESPONSIBILITY TO TELL US IN ADVANCE IF THERE ARE ANY SPECIAL REQUIREMENTS FOR YOUR INSURANCE/THIRD PARTY PAYER, e.g., PRE-AUTHORIZAION PROCEDURES
I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS FORM AND DO VOLUNTARILY AGREE TO ITS PROVISIONS.

_____ _____
Patient Signature Date

_____ _____
Responsible Person & Relationship Witness

AUTHORIZATION TO SHARE ACCOUNT RELATED INFORMATION

I hereby authorize BOISE OSTEOPATHIC MEDICAL CLINIC to disclose specific information described below, only for the purposes and parties also described below.

Description of the specific information to be discussed: ◯ Medical Record
◯ Financial Information

Information to be given to:

Name: _____

Relationship: _____

This authorization shall remain in effect from the date signed below and until (please check one):

◯ _____ (specific expiration date or event)

◯ NO EXPIRATION DATE

_____ _____
Signature (& relationship to patient) Date

Medical History Form (Date _____)

Name_____**DOB:**____/____/_____**Gender**_____
Age:_____ **Current Weight:**_____ **Current Height:**_____

Date of last physical examination:_____**Physician:**_____

Please list out **medications / supplements** below – indicate dose / strength and reason for use.

Name	Dose	Prescribing Doctor	Reason for use
Allergies		**Reaction**	

Entered / Scanned Date_____ by:_____

Social History

Marital Status:_____Single _____Married _____Divorced _____Partner _____Widowed _____Other
Name of Spouse / Partner:
Who lives at home with you: #_____Adults #_____Children
Do you have any religious/medical restrictions? If yes, please list:
Caffeine intake:_____ None_____Coffee/Tea_____Cups / day_____Soda_____Cups / Day
Diet: _____Good_____Fair_____Poor How many meals per week outside of home:_____
Alcohol (drinks per week)_____Type: _____Beer_____Wine_____Liquor_____Mixed
Smoking: _____Pipe_____Cigarettes_____Chewing Tobacco_____Vaping_____
_____Former Smoker_____Year Quit_____Amount smoked / used per day: _____ _____NON Smoker
Recreational Drug Use: Type:_____Frequency:_____ Used in the Past?_____Last year used:_____

Current Family Health Status

Member	Current Disease	Health Status (Good/Fair/Poor)	D.O.B	Deceased	Cause of Death
Father					
Mother					
Paternal Grandmother					
Paternal Grandfather					
Maternal Grandmother					
Maternal Grandfather					
Brother(s)					
Sister(s)					
Spouse/Partner					

FAMILY Medial History

Please indicate(x) all family members* medical history (Mother/Father/Brother/etc)

		Relationship			Relationship
	Heart Disease			Blood Disorder	
	High Blood Pressure			Stomach Disorder	
	Diabetes			Obesity	
	High Cholesterol			Drug/Alcohol Abuse	
	Stroke			Mental Illness	
	Cancer (type)			Thyroid Disorder	

PAST MEDICAL HISTORY *(Do you have and of the following?)*

	Stroke		**Diabetes**		**Arthritis**		**Psychiatric Disorder**
	Phelbitis		**Liver Disease**		**Gout**		**Alzheimer's**
	Anemia		**Hepatitis**		**Osteoperosis**		**Headache**
	High Blood Pressure		**Thyroid Problem**		**Rheumatic Fever**		**Glaucoma**
	Poor Circulation		**Kidney Disease**		**Lyme Disease**		**Hearing/Ear Disorder**
	Vascular Disease		**Lung Disease**		**Nerve Disorder**		**Keloid/Thick Scar**
	Heart Attack		**Sleep Apnea**		**Sciatica**		**Cancer – Type:**
	Heart Condidtion		**Tuberculosis**		**Epilepsy**		**Smoker**
			Asthma				**Previous Smoker / Year Quit_____**

Previous Surgeries	Year Performed	Place Performed

Last Colonoscopy:	**Normal/Abnormal:**	**Place:**
Last Mammogram:	**Normal/Abnormal:**	**Place:**
Last PSA (Men):	**Normal/Abnormal:**	
Last Pap (Women):	**Normal/Abnormal**	
Influenza Vaccine:	**When:**	**Place:**
Covid Vaccine:	**When & which one:**	**Booster, when & which one:**
Shingles Vaccine:	**When:**	**Place:**
Dexa (Bone Density Scan:	**When:**	**Place:**

REVIEW OF SYSTEMS (*Please check if you've ever had any of the following)*

CONSTITUTIONAL
Fever
Weight Loss
Lethargy

GENITOURINARY
Frequent Urination

NEUROLOGICAL
Headache
Fainting
Dizziness
Depression
Convulsion/Seizure
Numbness

ENDOCRINE
Night Sweats
Thyroid Disease
Frequent Thirst
Heat / Cold Intolerance

MUSCULOSKELTAL
Pain
Muscles Neck
Back Hips
Knees Ankles
Feet
Limited ROM
Limited Strength

CARDIOVASCULAR
Shortness of Breath
Chest Pain (Angina)
Heart Palpitations
Cold Extremities
Poor Circulation

SKIN
Rash
Itching
Dry Skin
Toe/fingernail changes
Sores / Skin Lesions

GASTROINTESTINAL
Diarrhea
Nausea
Vomiting
Constipation
Bloody/Dark Stool
Heartburn/GERD
Loss of Appetite

HEMATOLOGICAL
Blood Thinners
Blood Abnormalities
Lymph node enlargement

Any Problem not listed:_____

Signature:_____ **Date**_____

WELCOME TO OUR PRACTICE

We would like to take this opportunity to welcome you as a patient of Boise Osteopathic Medical Clinic, Dr. Higginbotham, Brittany Aitchison, FNP-C, and Don MacDonagh, NCTMB.
The providers and staff of Boise Osteopathic Medical Clinic would like to thank you for entrusting us to partner with you on your healthcare needs. Our Mission is to work together with our patients to accomplish a common goal of excellence in healthcare and service.
In order to accomplish this mission, we have established policies and procedures to keep you well informed, actively involved with our staff members and help you come prepared for your appointment.

OFFICE HOURS: Our clinic is open Monday thru Thursday from 8:00am to 5:00pm. We begin receiving your phone calls at 9:00am. We close for lunch between 12:00 – 1:45pm.

AFTER HOURS CARE: If you have a medical emergency while the office is closed, please call 911 or go to your nearest urgent care center or hospital emergency room. Our providers operate a clinic only, but have arranged for hospital physicians at both St. Alphonsus and St. Luke's to admit and care for our patients when necessary.

PRESCRIPTION REFILLS: We ask that you call your pharmacist to initiate a refill of your medication. Most pharmacies appreciate a 72 hour notification. This gives the pharmacist time to prepare your prescription accurately and contact your healthcare provider with any questions they may have. Please make sure we have a current record of your preferred pharmacy and insurance coverage. There are also standards of care that we follow regarding prescription refills and lab tests. At a minimum, when you are being prescribed a medication long term, it is important to have annual lab tests to confirm the medication is still effective and you are not experiencing side effects from the medication. Some medications require more frequent testing.

APPOINTMENTS: You may schedule an appointment by calling the office and speaking with any one of our support staff. You may also schedule a follow-up appointment while you are checking out after seeing one of our providers. Diagnosis and treatment plans cannot be appropriately made over the telephone or by emailing, therefore we ask that you schedule an appointment for an office visit and bring all questions with you to your appointment. As a courtesy to other patients as well as our providers, we ask that you give our staff a 24 hour notice if you must cancel or reschedule an appointment. Any appointment not kept without cancelling is considered a No Show. If a patient accumulates 3 No Shows within a year, we must ask you to make other arrangements for your healthcare

PREVENTATIVE CARE: Most insurance plans carry wellness and preventative care benefits. We suggest you become familiar with the coverage of your wellness plan and even print a copy of the benefits that are covered and bring them with you to your appointment. Then we can help you receive the benefits of the plan without incurring unexpected costs for tests not covered. Unfortunately, we can never guarantee coverage from your insurer, but will be happy to provide necessary documentation required from your provider.

*Initials*_____ *Date*_____

BILLING AND INSURANCE

We have provider contracts with several insurance carriers. If you are insured through a carrier that we are in network with, we will bill on your behalf. We ask that you please pay your copay and coinsurance at the time of service. If we are not a network provider for your insurance carrier, we will be happy to bill your insurer. We ask that you pay for your services at the time of service, with the understanding that you will be reimbursed for covered services directly from your insurance company.
As a new patient, if your deductible hasn't been met and extensive lab is necessary, we require a deposit of up to $250 toward diagnostic testing. Any balance can be paid over a 60 day period.

We recognize that at times people experience financial hardships. Our billing manager is here to work with you on a financial agreement for making monthly payments if the need arises. It is important to stay in contact with our staff and keep your account current. Good communication helps you remain informed on any balances and allows our billing staff to work with you more efficiently.

Unfortunately, there are times when we must turn delinquent accounts over to a third party collection service. Once that happens, we can no longer honor any financial agreements that have been made and we find it necessary to release the patient from our care.

CASH PAY: Because not all patients carry health insurance, we ask that you inform our front office staff when you will be paying cash and there will be no insurance billing involved. We can provide you with information on saving money if paying at the time of service.

We hope that communicating our office policies with you will allow us to maintain a vibrant provider / patient relationship.

SIGNATURE:_____ ***DATE:***_____