PATIENT INFORMATION- PLEASE PRINT CLEARLY AND LEGIBLY

Patient Name _____ Date of Birth _____
Last First MI

Social Security # _____ Sex (M/F) _____ Martial Status _____

Permanent Address (Main Residence/Physical)

Street Address _____ Apt # _____ City _____

State _____ Zip _____ Tele #( )_____ Work # _____ Cell #_____

Extended Address (Other/ Mailing/ PO Box/ Local)

Street Address _____ Apt # _____ City _____

State _____ Zip _____ Telephone # _____ Work # _____ Cell # _____

If Patient Is a Child

Parents Name _____ Date of Birth _____ Social Security # _____

Street Address _____ City _____

State _____ Zip _____ Telephone # if different than listed above ( ) _____

EMPLOYER INFORMATION:

Employer Name _____ Telephone # ( ) _____

Street Address _____ City _____ State ____ Zip _____

PAYMENT IS EXPECTED AT TIME OF SERVICE. INSURANCE WILL BE BILLED AS A COURTESY. PLEASE PRESENT ANY INSURANCE INFORMATION ALONG WITH THIS FORM.

INSURANCE INFORMATION:

Primary Insurance _____ Social Security # _____

Group # _____ Effective Date _____ Insured Name _____ Date of Birth _____

Secondary Insurance _____ Social Security # _____

Group # _____ Effective Date _____ Insured Name _____ Date of Birth _____

Release of Information:

I authorize the release of any medical or other information necessary in order of Alessi Family Care to process any insurance claims as result of treatment.

_____ Date: _____
Patient or Authorized Person's Signature

Assignment of Benefits:

I authorize payment of medical benefits to Alessi Family Care for any services provided while a patient at Alessi Family Care.

_____ Date: _____
Patient of Authorized Person's Signature

ALESSI FAMILY CARE
PATIENT INFORMATION

Patient Name_____ Date of Birth _____
Occupation_____ () Retired ()Male ()Female
Marital Status_____ Contact in case of Emergency_____
Emergency Contact's Phone Number_____

Living Will: Y/N

Reason for visit today: _____

FAMILY HEALTH HISTORY

Please check if adopted ()

	Living	Deceased
Father medical illnesses_____	()	()
Mother medical illnesses_____	()	()
Brother / Sister illnesses _____	()	()
_____	()	()
_____	()	()
_____	()	()
Children's medical illnesses _____	()	()
_____	()	()

IMMUNIZATIONS (include date)

Pneumonia ____
Influenza (flu) ____
Tetanus _____

HOSPITALIZATIONS

_____
_____
_____
_____

MEDICATION (include aspirin, birth control)

_____
_____
_____
_____
_____
_____
_____
_____

MEDICATION ALLERGIES

_____
_____

SOCIAL HISTORY Y /N

tobacco	() ()
alcohol	() ()
exercise	() ()
caffeine	() ()

MEDICAL DATA (include date)

Physical Exam_____
Chest X-Ray _____
Colonscopy/Sigmoidoscopy _____
EKG_____
Bone Density/ DEXA _____
PAP (females) _____
Mammogram _____
Prostate Exam/PSA _____
Bloodwork _____

SURGERIES

_____
_____
_____
_____
_____
_____
_____
_____
_____

MEDICAL HISTORY

() anemia	() aneurysm	() arthritis	() blood transfusion
() cancer, tumor	() depression	() diabetes	() drug abuse
() epilepsy, seizure	() eye problems	() heart attack, MI	() heart disease
() hemorrhoids	() high blood pressure	() high cholesterol	() liver disease, hepatitis
() lung disease	() night sweats	() osteoporosis	() rectal bleeding
() seasonal allergies	() stroke,CVA,TIA	() suicide	() ulcer,reflux, GERD
() venereal disease	() weight change	() other _____	

ALESSI FAMILY CARE

Thank you for choosing Alessi Famiy Care as your primary care provider. We are committed to providing you with the best possible health care. In order to better serve you, we have adopted the following payment policy.

1. **INSURANCE.** We participate in most insurance plans. If you are insured by a plan that we are NOT in network with, payment will be expected at the time of service. If you are insured by a plan we ARE in network with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage or benefits.

2. **CO-PAYMENTS.** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments from patients can be considered fraud.

3. **SELF-PAY ACCOUNTS.** Self-pay patients are expected to pay in full at the time of service. A $7.00 processing fee may be applied to your account if the payment is not made at the time of service.

4. **PROOF OF INSURANCE.** All patients must complete and sign our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information, you may be responsible for the balance of a claim.

5. **CLAIMS SUBMISSION.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract. We cannot guarantee coverage of a specific test or procedure. Again, it is your responsibility to check benefits with your insurance company to see if a particular test or procedure is covered under your plan provisions.

6. **COVERAGE CHANGES.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim within 60 days, the balance will automatically be billed to you and payment will be expected.

7. **NON-PAYMENT.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise agreed upon. Please be aware that if a balance remains unpaid, we will refer your account to a collection agency and you and your immediate family members may be discharged from this practice.

8. **MISSED APPOINTMENTS.** If you fail to show up for a scheduled appointment with less than 24 hours notice, you may be charged a fee of $25 ($50 for a physical). As a courtesy, a reminder call is made by our staff a day prior to your appointment. If is your responsibility to update contact numbers with our office.

9. **PAYMENTS ACCEPTED.** Cash, Check, American Express, Discover, Master Card, and Debt card all accepted forms of payment. If your check is returned for insufficient funds, we reserve the right to add a penalty charge of $35 to your account.

Our practice is committed to providing the best care and treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**