MEMORIAL MEDICAL GROUP, LLC

DEMOGRAPHIC INFORMATION SHEET

PATIENT INFORMATION

First Name: ______________________ MI: ______
Last Name: ______________________
Maiden Name: ______________________
Sex (Please Circle): M F Age: ________
Birth Date: (MM/DD/YYYY): ______________________
Marital Status: □ Single □ Married □ Divorced □ Widowed
SSN#: ______________________
Race: □ White □ Black/African American □ American Indian/Native Alaskan □ Asian □ Hawaiian/Pacific Islander □ Two or more races
Preferred Language: ______________________
Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino
Is patient FULL TIME STUDENT? □ Yes □ No

ADDRESS

Street: ______________________
PO Box / Apt # : ______________________
City/State/Zip: ______________________
E-Mail: ______________________
Home #: ______________________
Work #: ______________________
Cell #: ______________________
Minors: Lives with □ Mother □ Father □ Both

MAILING ADDRESS (if different from above)

Street: ______________________
PO Box / Apt # : ______________________
City/State/Zip: ______________________

PATIENT or LEGAL GUARDIAN EMPLOYER

Employer Name: ______________________
Street: ______________________
PO Box / Suite # : ______________________
City/State/Zip: ______________________
Occupation: ______________________

(If applicable): PARENT / LEGAL GUARDIAN

First Name: ______________________ MI: ______
Last Name: ______________________
Relationship to Patient: ______________________
Home #: ______________________
Work #: ______________________
Cell #: ______________________

EMERGENCY CONTACT (OTHER THAN ABOVE)

First Name: ______________________ MI: ______
Last Name: ______________________
Relationship to Patient: ______________________
Home #: ______________________
Work #: ______________________
Cell #: ______________________

INSURANCE INFORMATION

(PLEASE PRESENT ALL CARDS SO THAT THEY MAY BE COPIED AND SAVED WITH YOUR RECORDS)

Primary Insurance Carrier

Insurance Carrier: ______________________
Insured Name: ______________________
Insured DOB (MM/DD/YYYY): ______________________
Insured SSN #: ______________________

Secondary Insurance Carrier

Insurance Carrier: ______________________
Insured Name: ______________________
Insured DOB (MM/DD/YYYY): ______________________
Insured SSN #: ______________________

Other Insurance Coverage

Is this visit for a Workers Compensation issue?
□ Yes □ No
Is this visit for an Auto Insurance issue?
□ Yes □ No

PHYSICIAN INFORMATION

Referring Physician: ______________________
Phone #: ______________________
Family Physician: ______________________
Phone #: ______________________

I hereby assign directly to Memorial Medical Group, LLC, or any of its subsidiaries, all medical benefits, if any, otherwise payable to me for services rendered. I understand that all services rendered to me (or my dependents) are charged directly to me and I am personally responsible for payment of all charges whether or not paid by insurance. The patient or their responsible legal guardian agrees to pay any and all costs of collection and/or attorney fees required to settle account balance. I authorize the release of all information necessary to my current or valid insurance carrier in order to secure the payment of benefits for services rendered .

____
Patient Signature & Date

____
Legal Guardians Signature & Date

____
Relation to Patient

1. General Information

First Name:________________________Middle Initial ____ Last Name________________

Home Address ____

City_____________________________ State ____________ Zip ______________

Phone (home)______________________ (Other) _____________________________

Date of Birth: _______________ Age___________

Sex: _____Male _____Female

Insurance Carrier ____

Where do you have your laboratory work/medical tests performed ___________________

Physicians:

Primary Care Physician:

Name ____

Address ____

City ____________________________________ State _________ Zip ____________

Phone _________________________________

Other physicians you see on a regular basis (cardiologist, etc)

____

____

____

____

2. Kidney Disease History

Cause(s) of your kidney disease ____

When were you first aware of your kidney disease (year) _____________________________

3. Past Medical History

History of and duration of treatment for any medical conditions (please list):

Medical Condition	Approximate date of diagnosis
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

4. Diabetic history (if not applicable, skip to section 5)

How old were you when first diagnosed with diabetes? ________________________________

Have you been on ________ Insulin ________ Pills or _______ both and for how long?______________

Have you had eye problems as a result of diabetes (retinopathy)? ___Yes ___No

Have you had nerve problems as a result of diabetes(neuropathy)? ___Yes ___No

Have you had stomach or intestinal problems as a result of diabetes(gastroparesis)? ___Yes ___No

Do you have a history of foot ulcers? ___Yes ___No

Do you have a history of amputations? ___Yes ___No

5. Past Surgical History (when and where)

Surgical Procedure	Approximate Date

6. Allergies to Medications (please list agent and reaction)

Agent	Reaction

7. Current medications and dose/frequency (including frequently taken over the counter and herbal products)

______________________________ ______________________________

______________________________ ______________________________

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______________________________ ______________________________

8. Social History

Marital Status: ___Married ___Divorced ___Single Number of children: ___________

Employment: ______ Work full time/part time Occupation___________________________

______ Retired ______Unemployed ______ Disability

Smoking history: ____Currently Smoking ___Former Smoker __________Quite date

____ Packs per day for ____ number of years ____ Never Smoked

Alcohol use: ___None ___Social ___Currently Heavy ___Prior heavy

Illicit drug use: ___Yes ___No

9. Family History: Please list any history of medical disease/illness in immediate family members.

____

____

____

10. Review of Systems

How would you describe your (mark if indicated)

General health: ___ Excellent ___Good ___Poor

Appetite: ___ Excellent ___Good ___Poor

Energy/Activity ___ Excellent ___Good ___Poor

Has your weight been stable? ___Yes ___No Explain____________________________________

Any chest pain? ___Yes ___No

Any shortness of breath? ___Yes ___No Explain_______________________________________

Swelling in legs (edema)? ___None ___Moderate ___ Severe

How far can you walk without difficulty? _______________________________________

Any hip/leg pain with walking or elevation of legs? ___Yes ___No

Any other limitation of mobility? ___Yes ___No Explain _______________________________

____

Any history of numbness, weakness, loss of vision? ___Yes ___No

Explain ____

Any difficulty currently or in the past with urination (prostate problems, bladder Dysfunction, etc.)?

___Yes ___No Explain ____

____

History of kidney stones? ___Yes ___No Explain_____________________________________

History of severe/chronic kidney infections? ___Yes ___No Explain___________________

____

History of any severe infections? ___Yes ___No Explain_______________________________

____

Patient Signature____Date_______________

PATIENT RESPONSIBILITY STATEMENT

HEALTHCARE INFORMATION

- **Provide to nursing a list of all current medications including; prescription, non-prescription, herbal remedies, vitamins and communicate current healthcare concerns.**

- **Expect physician to treat the <u>primary</u> reason for that day's office visit, such as: workmans compensation, sick visit, wellness visit, follow-up visit or routine office visits.**

- **Comply with suggested treatment plans from your physician. Any suggested treatment plan refused by the patient will be documented by the physician in the medical record. <u>This is the responsibility of the patient to re-schedule cancelled office appointments and any scheduled tests.</u>**

- **Update the Code Blue Designation Form as applicable. The office will require that you acknowledge this form annually.**

- **Provide to the office any documents regarding advance directives, living wills, or healthcare power of attorney.**

HEALTHCARE MAINTENANCE

- **Medication refills;**
  - **for refills to a pharmacy, allow 48 hours**
  - **for written prescriptions, you must be specific on the name, strength, dosage, quantity required, and the number of refills needed per each medication requested. Allow 48 hours for pick-up of prescription.**
  - **Do not rely on medication refill requests to be completed after hours or on weekends when the office is closed.**
  - **DO NOT CONTACT THE PHYSICIAN ON CALL TO REFILL MEDICATIONS THAT ARE NON-EMERGENCIES.**
  - **If you have an emergency, go to a hospital's Emergency Room for medical evaluation and treatment.**

I, ______________________________, have read the above patient responsibility statement, received a copy and agree to the terms stated.

Patient's Signature________________________________ Date____________ D.O.B.__________

PATIENT RESPONSIBILITY STATEMENT

As a patient you should expect to provide and discuss the following at each office visit.

HEALTHCARE REGISTRATION

- **Arrive 10 minutes prior to your appointment time to complete appropriate paperwork. If the physician's schedule is extremely behind, you may request to re-schedule your appointment at no charge.**
- **Picture I.D.**
- **Update information regarding current legal name, address, telephone number and employer as applicable.**
- **Verify your insurance coverage by providing current insurance card(s). Provide complete new insurance information if there are changes.**
- **Pay current copay amounts and any outstanding balances payable to the physician.**
- **If you cannot provide current insurance information**
  - **you will be required to pay in full for that day's office visit OR**
  - **a payment plan may be implemented at the discretion of the physician, dependent on the patient's payment history OR**
  - **your office visit may be re-scheduled.**
- **It is your responsibility to know the coverage and requirements of your health plan regarding diagnostic testing, physical exams, physician referrals and other preventative services. Please know that in some cases when your policy pays your wellness care and illness care in the same visit, your insurance company may apply a copay to both even though both were on the same visit.**
- **There could be a charge for the following:**
  - **broken or missed appointments without 24 hour notice**
  - **copies of medical records for any non-physician recipient**
  - **returned checks**

Patient Authorization for Discussion of Personal Health Information

Memorial Medical Group, LLC (MMG) is comprised of many providers from multiple specialties. MMG providers utilize one centralized computer system. In the event you are a current patient or become a patient of another MMG provider, the information you have included on this document will be followed in every MMG office that you are an active patient.

As a patient of MMG, from time to time we may need to contact you regarding your healthcare or to remind you of an upcoming appointment. To preserve your privacy, we would like you to indicate which methods of communication are acceptable for us to use when trying to contact you.

____ Home or Cell telephone

____ Text messaging

____ E-mail message

____ Work telephone

In the event we are unable to make direct contact with you, we will leave a message for you.

The HIPAA Privacy Rule generally requires us to protect the privacy of your health information. We are unable to discuss or share relevant information about you or your healthcare with others without your permission.

Because every patient and family is different, we cannot make assumptions on who may be involved in your care or payment for your care. Please provide us the names of family members or other individuals that you allow us to share information with concerning your health care or treatment received at any MMG provider practice.

Name (First, Last)	Relationship and Phone Number

We ask that you notify us and complete a new form whenever there are any changes you need to make to the information you have provided in this document.

______________________________ PRINT Patient Name

______________________________ Date of Birth

______________________________ Patient or Legal Guardian Signature

______________________________ Today's Date

Memorial Medical Group, LLC (MMG) is comprised of many providers from multiple specialties. MMG providers utilize one centralized computer system. In the event you are a current patient or become a patient of another MMG provider, the information you have included on this document will be followed in every MMG office that you are an active patient.

Consent to Retrieve Medication Prescription History

As a patient of MMG, I give consent to Memorial Medical Group, LLC to retrieve and use my medication history from SureScripts, an electronic prescriptions network. ________________ (initial)

Accessing this information will ensure MMG has the most accurate information on your current prescription medication history, preferred pharmacy and prescription benefits.

Notice of Privacy Practices

Any health care professional, providers, staff and business associates of MMG authorized to enter information into your medical record or who may need access to your information must abide by Memorial's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how we may use or disclose your confidential information. As a patient of MMG, I acknowledge receipt of Memorial's Notice of Privacy Practices. _______________ (initial)

Insurance Authorization and Assignment

I hereby assign directly to Memorial Medical Group, LLC, or any of its subsidiaries, all medical benefits, if any, otherwise payable to me for services rendered. I understand that all services rendered to me (or my dependents) are charged directly to me and I am personally responsible for payment of all charges whether or not paid by insurance. As the patient or the patient's responsible legal guardian, I agree to pay any and all costs of collection and/or attorney fees required to settle account balances. I authorize the release of all information necessary to my current or valid insurance carrier in order to secure the payment of benefits for the services rendered.

I agree to the above:

_______________________________________ ____________________

PRINT Patient Name Date of Birth

_______________________________________ ____________________

Patient Signature Today's Date

_______________________________________ ____________________

Legal Guardian Signature Relationship to Patient

Patient Portal Consent and Guidelines

Memorial Medical Group, LLC (MMG) is comprised of many providers from multiple specialties. MMG providers utilize one centralized computer system. In the event you are a current patient or become a patient of another MMG provider, the information you have included on this document will be followed in every MMG office that you are an active patient.

MMG offers secure viewing and communications as a service to patients who wish to view parts of their medical records and communicate with our provider practices. Some features of the MMG portal, such as online appointment scheduling and secure messaging may not be available initially. However, as MMG continues to develop our portal, these additional features may become available to our patients. MMG recognizes that secure messaging can be a valuable communication tool between our patients and the MMG provider practices, but it does have certain risks. In order to manage these risks we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risk and agree to the conditions.

How the Secure Patient Portal Works:

A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from accessing confidential information they have no right to see. Secure information on the portal can only be read by someone who knows the correct password or pass-phrase to log in to the portal site.

Protecting Your Private Health Information and Risks:

Communication and viewing of information through the secure web portal prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain the electronic security of your information. However, keeping messages secure depends on you as well:

- MMG must have your correct personal e-mail address and;
- Only the correct individual (or someone authorized by that individual) must be able to have access to the message.

Only you can make sure these two factors are present. It is imperative that MMG has your correct personal e-mail address and that you inform us of any changes to your personal e-mail address. You also need to keep track of who has access to your e-mail account so that only you, or someone you authorize, can see the messages you receive from MMG.

You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

Online communications should never be used for emergencies or urgent matters.

Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent and guidelines regarding the MMG patient portal. I understand the risks associated with online communications and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth on the log in screen as well as any other instructions MMG or my physician may impose with regard to the patient portal and online communications. I understand and agree with the information that I have been provided and consent to MMG providing me with the access information to the online MMG Patient Portal utilizing the e-mail address I have provided below. I understand it is my responsibility to log on to the patient portal once I receive the access information from MMG.

____ ____________________

PRINT Patient Name Date of Birth

____ ____________________

Patient Signature Today's Date

____ ________________________

Legal Guardian Signature Relationship to Patient

____

Current personal E-mail address for MMG portal communications