

ADULT PATIENT INFORMATION

PERSONAL INFORMATION

Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email: _____
Social Security Number: _____
Date of Birth: _____
Sex: M F
Marital Status: Married Single Divorced Widowed
Is Patient Address same as Billing Address? Yes No
If No, write actual billing address/recipient here:

PRIMARY CARE PHYSICIAN

Dr. Cochran Dr. Goldman Dr. Pirozzi

EMPLOYMENT INFORMATION

Employer: _____
Address: _____
City, State, Zip: _____
Occupation: _____

FAMILY INFORMATION

Spouse/Significant Other Name: _____
Date of Birth: _____
Child #1 Name: _____
Date of Birth: _____
Child #2 Name: _____
Date of Birth: _____
Child #3 Name: _____
Date of Birth: _____

EMERGENCY CONTACT INFORMATION

Name: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Relationship to patient: _____

REFERRAL INFORMATION

How were you referred to Ghent Family Practice?
 Website Friend
 Another Physician Existing Patient

INSURANCE INFORMATION

PRIMARY INSURANCE

Company Name: _____
ID/Policy #: _____
Group #: _____
Cardholder Name: _____
Relationship: _____
Social Security Number: _____
Date of Birth: _____
Employer: _____

Send Claims to:

Address: _____
City, State, Zip: _____

SECONDARY INSURANCE

Company Name: _____
ID/Policy #: _____
Group #: _____
Cardholder Name: _____
Relationship: _____
Social Security Number: _____
Date of Birth: _____
Employer: _____

Send Claims to:

Address: _____
City, State, Zip: _____

Assignment of Benefits: I hereby assign all medical and/or surgical benefits to which I am entitled including major medical, Medicare, private insurance, and any other health plans to Ghent Family Practice. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be valid as the original. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of any and all information necessary to secure the payment.

PAYMENT IS EXPECTED AT TIME OF SERVICE

Signed: _____
Date: _____

Ghent Family Practice, Inc.
3535 Granger Road
Akron, OH 44333
www.ghentfamilypractice.com
Phone: 330-666-3400 Fax: 330-665-5133

Updated By: _____ Date: _____

**GHENT FAMILY PRACTICE
COMPREHENSIVE CARE DATA BASE—ADULT**

Name: _____ Date of Birth: _____ Age: _____
Last First MI

Address: _____ City: _____ Zip: _____

Phone:(____) _____ Employer: _____

Please describe your occupation: _____

1. Please list any medication to which you are *allergic* or which you are unable to take for any reason.

2. Please list any medication, either prescription or over the counter (birth control pills, aspirin, etc) that you are taking on a regular basis.

3. Please list all your surgeries (tonsillectomy, appendectomy, etc.)

Year	Surgery	Reason	Surgeon

4. Please list any serious illnesses that you have had in the past or have now (diabetes, blood pressure trouble, etc)

Year of Onset	Illness	Condition at Present

Preventive Health Care Information

1. Date of most recent Chest X-ray _____ EKG _____ PAP Test _____

BMD _____ Complete Physical _____ Mammogram _____ Sigmoidoscopy _____

Were they all normal? Yes No Explain _____

2. Date of most recent tetanus immunization: _____

3. Did you ever receive immunization for Pneumonia (Pneumovax)? Yes No What year? _____

Personal History

1. Marital Status: Single Yes No Year Married _____ Year Divorced _____ Year Widowed _____

Have you been married more than once? Yes No

Name/Age of children from this marriage (if any) _____

Name/Age of children from previous marriage (if any) _____

2. Education (highest grade or degree achieved)? _____

**GHENT FAMILY PRACTICE
COMPREHENSIVE CARE -- ADULT**

FAMILY HISTORY

Mark those diseases you have had. If you know other members of the family with these diseases please mark this also.

**X=Patient, M=Mother, F=Father, R=Blood Relative,
B/S=Brother or Sister, SP=Spouse**

X	M	F	R	B/S	SP	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coronary Heart Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Heart Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder Trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gout
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Retardation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Tendency
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Joint Problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer

Family	Birth Year	Health Status		Deaths	
		Good	Poor	Cause	Age
Father					
Mother					
Brothers/ Sisters:					
Spouse					
Children:					

RISK ASSESSMENT

1. Exposure

Mark those to which you have frequently been exposed:

- Chemicals, cleaning fluids, oils
- Loud noise
- Asbestos or cement dust
- X-rays or radio active materials
- Tobacco smoke
- X-ray treatment to head/neck

2. Smoking History

- Never use tobacco
- Cigarettes, packs per day _____
- Smoke cigars or pipe
- Other tobacco products

3. Caffeine Use

Cups of coffee, tea or Coke per day _____

4. Alcohol and Drugs

Have you ever had a drinking problem?

- Yes No

How much do you drink? _____

When did you last have a drink? _____

Have you ever had a drug problem?

- Yes No

When did you last take drugs? _____

CAGE Questionnaire

Have you ever felt you should cut down on your drinking?

- Yes No

Have people ever annoyed you by criticizing your drinking?

- Yes No

Have you ever felt bad or guilty about drinking?

- Yes No

Have you ever had a drink first thing in the morning to get rid of a hangover?

- Yes No

Signature

Date

HEALTH MAINTENANCE QUESTIONNAIRE

The following list of questions is meant to help with maintaining good health.

1. Do you get adequate calcium in your diet? (2-3 servings/day*)? Yes ___ No ___
If not, do you take calcium supplements Yes ___ No ___ (Recommendations are for men to take 1000mg a day and postmenopausal women to take 1500 mg a day)
*Dairy servings= 8 oz. milk, one cup of cottage cheese or yogurt, 4 oz. cheese.
2. Do you take vitamin D? Yes ___ No ___ (Recommendations are 400 units a day). (Milk is fortified with vitamin D.)
3. Do you do self-breast or testicular exams? (For men under 30 yrs. of age) Yes ___ No ___ If you do not, and you need instruction, please let the nurse know so that the doctor can help you with this.
4. If you have guns at home, are you aware of gun safety i.e. to keep them locked and unloaded and away from children?
Yes ___ No ___
Do not have guns _____
5. Do you smoke? Yes ___ No ___ Do you need help quitting? Yes ___ No ___
6. Do you drink alcohol? Yes ___ No ___
How much alcohol do you drink in a day? _____. A week? _____
Have you ever felt you should cut down on your drinking? Yes ___ No ___
Have people ever annoyed you by criticizing your drinking? Yes ___ No ___
Have you ever felt guilty about drinking? Yes ___ No ___
Have you ever had a first drink in the morning as an eye opener? Yes ___ No ___
Do you use any drugs such as marijuana, cocaine, etc? Yes ___ No ___
7. Do you exercise regularly? (Recommendations are 30 minutes 3-5 times a week). Yes ___ No ___ Exercise but not at the recommended amount? Yes ___ No ___
8. Do you know to wear a helmet for bicycling and motorcycling? Yes ___ No ___
9. Do you use seat belts regularly? Yes ___ No ___
10. Do you know to avoid sun exposure, use at least 15 SPF, avoid sun between the hours of 11am and 3pm and to use a hat outdoors? Yes ___ No ___
11. Do you regularly use sunglasses in strong sunlight? Yes ___ No ___
12. Do you know how to prevent sexually transmitted diseases? Yes ___ No ___
13. Do you have questions regarding risk factors for sexually transmitted diseases? Yes ___ No ___

Reviewed By: _____ Date: _____
Name _____ Date _____

GHENT FAMILY PRACTICE, INC.
3535 Granger Road
Akron, OH 44333
Billing and Insurance Policies

Ghent Family Practice, Inc. welcomes you as a patient. We will make every effort to work with you and your insurer to maximize your healthcare benefits. Please notify us immediately of any changes in your insurance coverage. To avoid any problems and to expedite the services you may require, please be aware of the following:

- 1.** Payment in full is expected at the time of the office visit **unless** you have an insurance plan with which we are contracted, then **your copay is due at the time of the visit.** **If you do not pay your copay at the time of the visit, it is subject to a \$5.00 service charge.** Review your insurance contract closely. You may be responsible for multiple copay/co-insurance payments dependant upon services rendered.
- 2.** The parent or child accompanying a minor child is responsible for payment of the child's care, unless other arrangements have been made with our office **prior** to the visit.
- 3.** If you are billed for charges your insurance company should pay and didn't, please contact your insurance company to find out the status of the claim. We cannot intercede for you except to supply reasonable medical documentation.
- 4.** Some insurance plans do not cover screening or preventative procedures or health assessment physicals. If you desire to proceed with these exams, you will be responsible for the costs. We will, of course, provide you with an estimate of that cost. If this practice provides services not covered by your insurance plan, you will be billed directly for those services.
- 5.** We contract with many insurance plans including HMO's and PPO's. They often have restrictions on what is covered. They may require authorization for referrals to specialists and emergency room visits, as well as specifying where testing is done. We cannot know all the restrictions that may apply to your policy. We therefore suggest you take responsibility to understand your insurance plan. We have found that they will not pay if you do not follow their rules to the letter.
- 6.** Notify us immediately of any changes to your insurance coverage. This ensures that your claims are paid in a timely manner. Since a copy of your insurance card is kept in your chart and referred to as necessary, please make sure we have a copy of the newest card.
- 7.** Notify our Referral Department ***at least one week in advance*** of any appointments you have to see specialists or receive testing. This allows us time to complete a referral for you should one be required. If we are not notified you may end up financially responsible for those services. Calling us the day of your appointment could result in a denial from our physician to complete a referral. This office is prohibited from issuing ***retroactive*** referrals. We are not permitted by your insurance company to write a referral for a specialist visit after that visit has occurred.
- 8.** If you are having financial difficulties, a budget payment plan can be arranged with our Billing Department. Please call to set this up as soon as you know you have a problem, thus avoiding unnecessary collection procedures. Ignoring billing statements leads us to believe that you don't appreciate our service, or don't intend to pay.
- 9.** If you have any concerns or complaints about the healthcare benefits provided by your insurance company, we encourage you to contact your employer's Human Resources Department.
- 10.** If you are experiencing any difficulties with your insurance benefits, you have access to the Consumer Services Division of the Ohio Department of Insurance. You can contact Consumer Services with complaints or concerns at 1-800-686-1526.

Managed Care has added much more overhead expense to our practice due to ever increasing constraints on payment, paperwork and getting medical care authorized. For these reasons we have instituted the above policies.

I have read, understand and agree with the above policies regarding billing and insurance for Ghent Family Practice, Inc.

Patient Signature

Date