CRANMORE HEALTH PARTNERS
Primary, Pain, and Urgent Care

(PLEASE PRINT INFORMATION)

PRN: _____ Primary Care ☐ Urgent Care Walk In: ☐

Patient Demographics:

Last Name: _____ First Name: _____ Middle Name/MI: _____

DOB: / / Sex: F ☐ M ☐ Marital Status: _____ Employment Status: _____

Primary Care Provider: _____

Preferred Language: _____ Race: _____ Ethnicity: _____

Advance Directive: Yes ☐ No ☐ Advance Reviewed: / /

Pharmacy: _____ Address: _____

Patient Contact Information:

Mailing Address: _____ Physical Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone _____

Work Phone: _____ Email: _____

Employment Information:

Employer Name: _____ Employer Phone: _____

Address: _____ Employer City: _____

State: _____ Zip: _____

Emergency Contact:

Contact Name: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Patient Signature: _____ Date: _____

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PATIENT HEALTH HISTORY FORM

Reason for Visit: _____

History of Present Illness(**What happened and when**?):

_____

_____

Past Medical History(any current or past medical problems, accidents or injuries)(circle):

Diabetes	High Blood Pressure	Ulcers
Cancer	Stroke	Heart Disease
Bleeding Problems	Seizure	Kidney Problems
COPD/Emphysema	Arthritis	Headaches
High Cholesterol	Asthma	Heart Failure

Other: _____

Past Surgical History:

Type of Surgery	Date	Type of Surgery	Date

Family History(Please tell us about the health of your immediate family):

	Father	Mother	Sister	Brother	Children	Other
Age at Death						
Heart Disease/Stroke						
Diabetes						
Asthma/COPD						
Blood Disease						
Cancer(type)						
High Blood Pressure						
High Cholesterol						
Other:						

Patient Signature: _____ Date: _____

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PATIENT HEALTH HISTORY FORM

Social History(Do you now or have you in the past):

Marital Status:	Single	Significant Other	Married	Divorced	Widowed

Living Situation:	Alone	Spouse/Significant Other	Children/Family	Other

Females: Are you Pregnant?	Yes / No	Hysterectomy	Menopause	Tubal Ligation

Smoking History:	Smoker	Former Smoker	Never Smoked	Current every day smoker	Current some day smoker
Tobacco Use:	Yes / No	Cigarette	Cigars	Chew	Other

Allergies:

Medication(s)	Reaction	Allergen	Reaction

Medication List:

Name	Dosage	Frequency

Patient Signature: _____ Date: / /

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PRIMARY INSURANCE

Patient Type/Source of Payment:(MU): _____

Insurance Co: _____ Insurance Name: _____ Capitation: _____

Primary Insured: _____ Last Name: _____ First Name: _____ Mi: _____

Patient Relationship to Primary Insured: _____

Subscriber ID: _____ Group No.: _____ Plan Name: _____

Insured Authorization: _____ Deductible: _____ Visit Co-payment: _____

Release of Information: _____ Signature on File: _____ Signature Date: / /

Co-pays are due at the time of service. Full payment will be due at the time of service if the patient does not present insurance information. We accept cash or credit cards (Visa, MasterCard, and Discover.)

Our office will kindly bill your insurance company. We participate in a number of medical insurance plans that we may contact to verify eligibility and benefits. Please realize that you have the ultimate responsibility of verifying the coverage with your insurance. You acknowledge that we may be an out of network provider with your insurance . You are also aware that in some circumstances your insurer will send payment directly to you. You agree to endorse the insurance check and forward funds to the appropriate entity within 30 days of receipt. You will be responsible for any balance not or denied by your insurance carrier. Patients who do supply accurate insurance information will be responsible for the balance. You must inform our office of any changes your insurance, as you are the policyholder and it is your responsibility.

If your plan requires referral from your primary care provider, it is your responsibility to obtain this prior to seeking treatment from our office. If a claim is denied due to lack of referral, you will be responsible for the charges. You understand that you are financially responsible for claims denied of not covered by your insurance carrier if referral is not obtained.

If you are unable to keep your appointment, you must notify the office at least 24 hours prior to your scheduled appointment as a courtesy to the provider, staff, and other patients. If you cancel or :no show" without sufficient notice, you may be subject to a fee, payable by you, not your insurance company.

The above information is thorough and accurate to the best of my knowledge. Any changes to the above information will be communicated with the office. I consent to evaluation and treatment by this clinic. I hereby authorize the release of medical information that is necessary for treatment. I have read and agree to the above policy. I understand that payment is expected at the time services are rendered and that I am responsible for any balance.

Patient / Parent and or/legal guardian's Name: _____

Parent and/or legal guardian's signature (required if participant under 18 years of age.): _____ Date: / /

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GENERAL CONSENT AND ACKNOWLEDGMENT FORM

By signing below, I authorize the health care providers at Cranmore Health Partners (CHP), to conduct examination, diagnostic tests and procedure to assess my health care conditions, and to provide care, services or therapies to effectively diagnoses and treat me.

I have received/reviewed a copy of this office's notice of privacy practices. I have received/reviewed the patient rights and responsibilities.

Signature of patient or legally authorized representative: _____ Date: / /

Authorized representative, please state legal authority to act on behalf of patient. Authority/relationship to patient: _____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our notice of privacy practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (please specify)_____

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

this is to acknowledge that I have received, understand, and have been given the opportunity discuss further with privacy contact person the Cranmore Health Partners Notice of Privacy Practices.

_____ _____

Signature of Patient Date Signed

If patient refuses to sign, listed below are the efforts made to get the patient to sign: