Balance Medical Care

Patient Information: (Please complete using your name as listed on your insurance card. **PRINT CLEARLY)**

First Name:_____ MI: _____ Last Name:_____

Date of Birth:_____ SS#:_____ Sex: M F

Address:_____ Apt:_____ City:_____

State:_____ Zip:_____ Home Phone:_____ Cell Phone:_____

Work Phone:_____

Marital Status: Single Married Divorced Domestic Partner Widow

Employer: _____ Occupation: _____

STUDENTS ONLY: (If over 18 years of age) Part-time student Full-time student

Ethnicity: Race:

Under a new federal law, the following questions are now required:

- ☐ English
- ☐ Spanish
- ☐ Other _____
- ☐ I'd rather not report

- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino
- ☐ I'd rather not report

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic Origin
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other _____
- ☐ I'd rather not report

Email Address: _____

Do you have any impairment? (Please circle): Visual Hearing Speech Learning Physical Language/Cultural NONE

Person Responsible for Payment:

First Name: Initial: Last Name:

Address: Apt: City:

State: Zip: Home Phone: Cell Phone:

Relationship to patient: Date of Birth: SS#:

Insurance Information: (All patients must provide a copy of their insurance card and proper ID at **every** visit.)

Primary Insurance: _____ Policy Holder Name:

Policy ID#: _____ Group#: _____

Relationship to patient: Policy Holder's Date of Birth: Sex: M F

Policy Holder's Employer: _____

Secondary Insurance: _____ Policy Holder Name:

Policy ID#: Group#:

Relationship to patient: Policy Holder's Date of Birth: Sex: M F

Policy Holder's Employer:

Primary Pharmacy Name (and Address): _____ Town/Location:

Patient Name:_____
Date of Birth: / /

To expedite your patient visit, PLEASE REVIEW AND BRING WITH YOU TO YOUR FIRST VISIT

Have you had any of the following conditions in the past?

Asthma	Y	N		Y	N
Coronary Heart Disease	Y	N	Hair loss	Y	N
Depression	Y	N	Hypertension	Y	N
Anxiety	Y	N	Diabetes	Y	N
Allergies	Y	N	Hepatitis/Liver disease	Y	N
Over weight	Y	N	Arthritis	Y	N
Diabetes	Y	N	Headache	Y	N
HIV	Y	N	Sexual dysfunction	Y	N
Fibromyalgia	Y	N	Kidney/Renal disease	Y	N
Anemia	Y	N	GYN problems	Y	N
Fatigue	Y	N	HIV	Y	N
Thyroid disease	Y	N	AIDS	Y	N

Please identify any of the following that a family member may have had:

Diabetes	Y	N	Thyroid disease	Y	N
Blood pressure problem	Y	N	Autoimmune disorders	Y	N
Heart Attack	Y	N	Mental Health including Attention	Y	N

Other:

Do you have a "Living Will" or Advance Directives? Y N

Do you smoke? Y N Packs per day: _____ **Females:** Pregnant or nursing: Y N

Do you drink alcohol? Y N Drinks per day: _____ Trying to get pregnant: Y N

Do you use illegal drugs? Y N Which drugs:_____

Name of current medication: (Including Aspirin, Birth Control, Vitamins Etc.)	**What are you taking this for?**
_____	_____
_____	_____
_____	_____
_____	_____

Drug Allergies: _____

E-PRESCRIBE CONSENT FORM

E-Prescribe is defined by a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribe greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an E-Prescribe program. These include:

- **Formulary and benefit transactions –** gives the prescriber information about which drugs are covered by the drug benefit plan.

- **Medication history transactions** – provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

By signing this consent form you are agreeing that Advanced Medical & Skin Care, LLC can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Advanced Medical & Skin Care, LLC to enroll me in the E-Prescribe program.

Consent Accepted:

Patient Name (Print) _____

Signature: _____ Date: _____

Relationship to Patient: _____