BRISTOL HEALTH MEDICAL GROUP NEW PATIENT INFORMATION:

____Referring Provider_______________________________________

Primary Care Provider:_________________________________

Patient Name: ____
Last Name First Name Middle Initial

Address: ____
Street Apt City State Zip Code

Home Phone: (____) _____-_______ Cell Phone: (____) ____-_______ Work Phone: (____) ____-______

Date of Birth: _____/_____/______ Age: _______ Marital Status: S M D W O

Email Address: ____@_________________________

Ethnicity: Caucasian Hispanic African American Asian Middle Eastern Pacific Islander Native American

Other: ________________________(circle one)

Race:___________________

Do you have an advance directive (living will)? Yes____ No_____

Do you have a conservator? Yes____ No_____ Name: ____

Sexual Orientation: (circle one) Lesbian Gay Homosexual Straight or heterosexual Bisexual
choose not to disclose or other: ___________________________

Gender Identity: (circle one) Male Female Female-to-Male Male-to-Female Transgender
choose not to disclose or other: ____________________________

Birth Sex: (circle one) Male Female Unknown

Employer Information:

Employer Name/Address: ____

Spouse's Name: ____ Date of Birth: ____/____/_____

Spouse's Employer Name/Address: ____

INSURANCE INFORMATION:

Primary Insurance: __________________________________ Secondary Insurance: _________________________________

Subscriber's Name:___________________DOB:___/___/____Subscriber's Name:__________________DOB: ___/___/____

WHOM MAY WE CONTACT IN CASE OF EMERGENCY? ____
Name Relationship Phone

Signature on File

Please read carefully and sign:

I request that payment of authorized benefits be made to me or on my behalf to Bristol Health Medical Group, Inc. for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to HCFA and its agents, or any other supplier of medical benefits, any information needed to determine those benefits, or the benefits for the related services. If for some reason my insurance company denies my claim, the office/billing department has the right to appeal on my behalf.

I understand that regardless of any insurance coverage I may have, it is my responsibility to pay my bill. I further understand that my insurance is designed to reimburse me for covered expenses. I understand further that not all services are covered by Medicare or other insurance and acknowledge that I am responsible and will pay for those services. I agree to pay all costs of collection, including a reasonable attorney's fee incurred in the collection of any amounts not pain, as required above. **If you fail to give 24 hour notice to cancel an appointment you may be subject to a $30 No-Show Fee.**

____ _______/________/_______

Signature Patient or Responsible Party Date

FINANCIAL RESPONSIBILITY FORM

I am visiting a provider at Bristol Health Medical Group, Inc.

I acknowledge that:

- I will provide a copy of my insurance card today and during each subsequent visit. In addition, I will supply my driver's license and pay any co-pays.
- As a courtesy, the Group will submit demographic, protected health information and billing information to my health plan for the purpose of determining eligibility, covered benefits, payment and for the coordination of care such as authorization for tests, services, home care and hospitalizations.
- Payments available under my plan will be paid directly to the Group, or if payment is denied, the Group may elect to appeal the denial on my behalf.
- Some portions, or all portions, of the bill may be my responsibility including, but not limited to:
    - Office Co-pays
    - Annual Deductibles
    - Cost Sharing Coinsurance
    - Amounts applied to my high deductible health plan (including health savings account (HSA) compatible plans)
    - Amounts not covered by my benefits plan
- Group may request that some portions of the patient responsibility be collected at time of service including:
    - Co-pays as indicated on your insurance card, and
    - Some portion of the amounts that will be applied to a deductible (minimum $100 payment to be applied toward deductible amount).
    - Any outstanding prior BHMG balances are due and payable in full
    - Failure to pay fees at the time of visit will result in a service charge of $15 due to the additional expense of statement processing.
- Group may assign uncollected balances to a credit reporting Collection Agency.

Printed Name: ____

Patient Signature:_______________________________Date: __________

Bristol Health Medical Group (BHMG) is committed to providing you with the highest quality medical care. Our health care providers and staff are dedicated to helping you achieve and maintain your health goals in a safe, respectful and supportive environment. We encourage you to speak openly with your health care providers and to be involved in your health care. We are committed to honoring these patient rights and equally expect responsible behavior from our patients.

PATIENT RIGHTS-YOU HAVE THE RIGHT TO:

- Receive considerate, respectful and compassionate care in a safe setting regardless of age, gender, race, national origin, religion, sexual orientation, gender identity or disability. BHMG does not discriminate, treat differently or exclude treatment to anyone for reasons including and beyond those identified here.
- Be treated with professionalism and courtesy in a clean and safe environment
- Know the names and titles/roles of everyone involved in your care
- Receive the information necessary to actively participate in your health care decisions
- Full information regarding your diagnosis, prognosis, treatment benefits/risks and expected outcomes
- Have access to resources that facilitate effective communication with your healthcare provider
- Informed consent prior to any non-emergency procedure
- Have a chaperone present for intimate/invasive appointments, or as requested
- Refuse treatment as permitted by law and be informed of effect(s) this may have on your health
- Respectful protection of your personal privacy in accordance with HIPAA guidelines, including access to our Notification of Privacy Practices upon request
- Expect all communications and records about your care to be kept confidential and not disclosed unless permitted by law. You also have the right to request and receive a copy of your medical records.
- Receive information regarding charges relative to the care you have received
- Voice your concerns about the care you receive. If you have an issue, concern or complaint, you may discuss it with your healthcare provider or practice management.

PATIENT RESPONSIBILITIES-YOU ARE EXPECTED TO:

- ✔ Treat BHMG staff with respect, courtesy and consideration for the needs and rights of other patients
- ✔ Confirm appointments promptly, arrive on time for your scheduled appointments and notify the office a minimum of the day prior to your appointment should you need to reschedule. Patients with a combination of three (3) or more no shows and/or same day cancellations in a calendar year may be discharged from the practice.
- ✔ Provide complete and accurate demographic and insurance information including relevant phone numbers/emails so we may communicate with you. You are also expected to provide both photo identification and your insurance card at each visit.
- ✔ Provide complete, honest and accurate information about your health and medical history, including present or past medical conditions, medications, and any other details to the best of your ability.
- ✔ Ask questions if you are not sure or do not understand your diagnosis, treatment, prognosis or other instructions
- ✔ Follow directions concerning medications, follow up care, referrals and notify your health care provider if you feel you cannot follow your treatment plan
- ✔ Receive a referral from your primary care physician before specialty care may be obtained, if required by your insurance company
- ✔ Pay for copays or deductibles as arranged at the time of each visit
- ✔ Assume responsibility for any charges billed to you as a result of receiving services within BHMG

Printed Name: ____

Patient Signature: ______________________________ Date: __________

To begin your BHMG electronic medical record, we ask that each patient review ad sign the following:

PRIVACY POLICY:	A Notice of Privacy Practice has been made available in the waiting room. I acknowledge that the policy may change and that I may read updated copies at subsequent visits. I currently have no questions about the policy. A Privacy Officer is available at (860) 585-3223.
MULTIDISCIPLINARY APPROACH:	I understand that BHMG provides a range of services in the Greater Bristol community and that if I access other sites, my BHMG EMR will be made available for my appointments. I acknowledge that the forms signed today will apply to other offices within the network. I understand that I may visit MedHelp Medical Center for an acute illness visit at the cost of the Primary Care Physician visit. My provider will have access to these findings.
HEALTH INFORMATION EXCHANGE:	I consent to BHMG sharing my protected health information (PHI) with providers involved in my care via health information exchange (HIE).
FINANCIAL RESPONSIBILITY:	I have reviewed and signed the BHMG financial responsibility form.
CANCELLATION POLICY:	I agree that I may be charged $30 for either (a) failure to cancel an appointment with a 24 hr notice or (b) missing an appointment.
PATIENT RESPONSIBILITY:	I agree to optimize the delivery of care to me by providing a complete medical history
PRESCRIPTIONS:	**Refills:** I will call my pharmacy to request a routine refill on my prescription and understand that the pharmacy will contact BHMG directly to obtain authorization for continuation. **History:** I authorize the provider office to review my prescription history
REFERRALS:	If I have an appointment with a SPECIALIST, it is my responsibility to contact my insurance company to see if an insurance referral from my Primary Care Physician (PCP) is required.

Printed Name: ____

Patient Signature: ______________________________ Date: __________

HEALTH HISTORY

NAME: ____ Today's Date: _________________________________

Circle all that apply

AIDS	Cancer ________	Gout	Murmur, Heart	Scarlet Fever
Alcoholism	Cataracts	Heart Disease	Measles	Stroke
Anemia	Chicken Pox	Hepatitis	Migraines	Stomach Ulcer
Anorexia	Drug Dependency	Hernia	Mononucleosis	Suicide Attempt
Anxiety Disorder	Depression	Herpes	Multiple Sclerosis	Thyroid problem
Arthritis	Diabetes	High Cholesterol	Osteoporosis	Tuberculosis
Asthma	Diverticulitis	High BP	Pacemaker	Ulcers, stomach
Bleeding Disorders	Emphysema	HIV Positive	Pneumonia	Vaginal Infection
Blood Clots in legs Bronchitis	Glaucoma Goiter	Kidney Disease Kidney Stones	Prostate Problems Psychiatric Care	Venereal Disease Lyme Disease
Bulimia	Gonorrhea	Liver Disease	Rheumatic Fever	Other________

Age: _______ Date of Birth: ___/___/_____ Date of last physical ____/____/_____ by Dr. ________________________

MEDICAL HISTORY:

Circle all conditions that you have or have had in the past or since last Physical Past Surgery:

Cataract	Appendectomy	Bladder Suspension	Tonsils	Gallbladder
Hip Replacement	Knee Replacement	Prostate Surgery	Cardiac Bypass	Hysterectomy
Neck Surgery	Angioplasty	C-Section	Back Surgery	Other

FAMILY HISTORY:

Please fill in all that apply:

	Age, Death,	Age at Cause Age of death	MEDICAL PROBLEMS: **CIRCLE ALL THAT APPLY:**						
Father			Asthma	Diabetes	High BP	High Cholesterol	Stroke	Heart Problem	Cancer
Mother			Asthma	Diabetes	High BP	High Cholesterol	Stroke	Heart Problem	Cancer
Brothers			Asthma	Diabetes	High BP	High Cholesterol	Stroke	Heart Problem	Cancer
			Asthma	Diabetes	High BP	High Cholesterol	Stroke	Heart Problem	Cancer
			Asthma	Diabetes	High BP	High Cholesterol	Stroke	Heart Problem	Cancer
Sister			Asthma	Diabetes	High BP	High Cholesterol	Stroke	Heart Problem	Cancer
			Asthma	Diabetes	High BP	High Cholesterol	Stroke	Heart Problem	Cancer
			Asthma	Diabetes	High BP	High Cholesterol	Stroke	Heart Problem	Cancer

CURRENT MEDICATIONS:

List all prescribed medications including vitamins and dietary supplements. Use back for more medications.

MEDICATION	DOSE (mgs)	Frequency	MEDICATION	DOSE (mgs)	Frequency
ALLERGIES:					

SOCIAL HISTORY:

Do you smoke: Y / N ___Pks ___of Years

Alcohol: Y/N ____ Drinks per week

Drugs: Y/ N

Single Married Divorced Widow(er)

Children: Y/ N How many: (B) ___ (G) ___

Occupation: ____________________________

Printed Name: ____

Patient Signature: ____ Date: _____________

Review of Systems

GENERAL	YES	NO
Good General Health	____	____
Loss of Appetite	____	____
Fatigue	____	____
Fever	____	____
Poor Sleep	____	____
Weight gain/loss in past 4 months	____	____

If yes ___ up ___down how much ____lbs

EYES	YES	NO
Blurred Vision	____	____
Double Vision	____	____
Irritated/dry eyes	____	____
Blind/Dark Spots	____	____
Watery Eyes	____	____
Pain in eyes	____	____

EARS/NOSE/THROAT	YES	NO
Hearing Loss	____	____
Ringing in the Ears	____	____
Frequent Headaches	____	____
Sore Throat	____	____
Voice Change	____	____
Neck Tenderness/Pain	____	____
Sinus pain	___	___

CARDIOVASCULAR	YES	NO
Chest Pain	____	____
Nervousness	____	____
Swelling of the Legs	____	____

RESPIRATORY	YES	NO
Chronic/frequent Coughs	____	____
Wheezing	____	____
Shortness of Breath on activity	____	____

GASTROINTESTINAL	YES	NO
Blood in Stool	____	____
Loss of Appetite	____	____
Nausea/Vomiting	____	____
Difficulty in Swallowing	____	____
Constipation/Diarrhea	____	____
Frequent Bowel Movements	____	____
Abdominal Pain	____	____

GENITOURINARY	YES	NO
Frequent urination	____	____
Burning/painful urination	____	____
Blood in urine	____	____
Urine Incontinence	____	____
Kidney Stones	____	____
Problem with sexual function	____	____
Female-regular menstrual periods	____	____

Pregnancies ____ # live births _____

Age of first period ________ Age of last period ________

MUSCULOSKELETAL	YES	NO
Joint Pain/Swelling	____	____
Pain of Feet	____	___
Muscle Weakness	____	____
Back Pain	____	____
Pain of Legs on Walking	____	____
Muscle Cramps	____	____

DERMATOLOGIC	YES	NO
Poor Wound Healing	____	____
Dry Skin	____	____
Hair Loss	____	____
Skin Rash	____	____
Generalized Itchiness	____	____
Acne	____	____
Dry Skin	____	____
Brittle Hair/Nails	____	____

NEUROLOGICAL	YES	NO
Chronic Sinus Congestion	____	____
Poor Memory	____	____
Dizziness	____	____
Convulsions/Seizures	____	____
Numbness/Tingling Sensations	____	____
Tremors	____	____

PSYCHIATRIC	YES	NO
Palpitations	____	____
Depression	____	____
Irritability	____	____
Anxiety	____	____
Shortness of Breath at rest	____	____

ENDOCRINE	YES	NO
Excessive Thirst	____	____
Heat/Cold Intolerance	____	____
Change in shoe/ring size	____	____
Excessive Sweating	____	____
Decrease in Sex Drive	____	____
Breast Discharge	____	____

HEMATOLOGIC	YES	NO
Bleeding/Bruising Tendency	____	____
Anemia	____	____
Previous Blood Transfusions	____	____

I certify that I have completed and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my clinician, or any other member of his/her staff, responsible for any actions they take or do not take because of errors or omissions that I may have made in the completion of this questionnaire.

Printed Name: ____

Patient Signature: ______________________________ Date: ____________

Bristol Health
Medical Group

HEALTH RISK ASSESSMENT FORM

Patient's Name____ **DOB** ___________________
We at Bristol Health care about you and our community. Please take a moment to answer these questions. Resources may be available.

Living Situation

What is your living situation today?
___ I have a steady place to live
___ I am worried about losing my housing
___ I do not have a steady place to live (temporarily staying with others, in a hotel or shelter, on the street or car, etc)

Think about the place you live. Do you have problems with any of the following? ____ Yes ____ No
___ Smoke detectors missing or not working ___ Oven or stove not working
___ Lack of heat ___ Water leaks

If for any reason you need help with day-to-day activities such as bathing, preparing meals, shopping, managing finances, etc., do you get the help you need?
___ I don't need any help ___ I could use help (please describe) ____

How often do you feel lonely or isolated from those around you?
___ Never ___ Rarely ___ Sometimes ___ Often ___ Always

In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?
___ Yes ___ No

Safety - Because violence & abuse happens to a lot of people & affects their health, we are asking the following:

How often does anyone, including family and friends, threaten harm or physically hurt you?
___ Never ___ Rarely ___ Sometimes ___ Fairly often ___ Frequently

How often does anyone, including family and friends, scream, curse or talk down to you?
___ Never ___ Rarely ___ Sometimes ___ Fairly often ___ Frequently

Financial

How hard is it for you to pay for the very basics like food, housing, medical care, and heating?
___ Not hard at all ___ Somewhat/Very hard (would you like assistance with resources? ___ yes ___ no)

Within the past 12 months, did you worry your food would run out before you got money to buy more?
___ Never ___ Sometimes ___ Often

Do you want help with school or training? For example, job training or getting a high school diploma or GED.
___ Yes ___ No

Do you need or want help finding or keeping work or a job?
___ Yes ___ No

Physical Activity

In the last 30 days, other than the activities you did for work, on average, how many days per week did you engage in moderate exercise (like walking fast, running, jogging, dancing, swimming, biking, or other similar activities)?

___ 0 ___ 1-2 ___ 3-5 ___ 6-7

How many times in the past 12 months have you had 5 or more drinks in a day (males) or 4 or more drinks in a day (females)? One drink is 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of 80-proof spirits.

___ Never ___ Once or Twice ___ Weekly ___ Monthly ___ Daily/Almost Daily

How many times in the past year have you used prescription drugs for non-medical reasons?

___ Never ___ Once or Twice ___ Weekly ___ Monthly ___ Daily/Almost Daily

How many times in the past year have you used illegal drugs?

___ Never ___ Once or Twice ___ Weekly ___ Monthly ___ Daily/Almost Daily

Mental Health

Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things?

___ Not at all ___ Several days ___ More than half the days ___ Nearly every day

Feeling down, depressed, or hopeless?

___ Not at all ___ Several days ___ More than half the days ___ Nearly every day

Stress is when a person feels tense, restless, nervous, or anxious, or is unable to sleep at night because his or her mind is troubled. Do you feel this kind of stress lately?

___ Not at all ___ Several days ___ More than half the days ___ Nearly every day

Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?

___ Yes ___ No

Are you currently being treated for depression, stress and/or anxiety? ____ Yes ____ No

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Thank you for taking the time to complete these questions. We may have resources available to assist you.
If you have needs or concerns, one of our care coordination staff will be in contact to see how we can help.

Would you like someone to contact you for further assistance? ______ Yes ______ No