raffee medical group

PATIENT INFORMATION SHEET

Patient Information

First Name:	Last Name:	Preferred Name:	Date:
Gender:	Date of Birth:	Address:	
City:	State:	Zip Code:	Marital Status:
Email:	Cell Phone:	Home Phone:	Social Security Number:

Emergency Contact

Full Name:	Relationship:	Contact Number:
Full Name:	Relationship:	Contact Number:

Insurance Information

Insurance Carrier:	Subscriber Name:	Relationship to subscriber:
Policy Number:	Group Number:	

Secondary Insurance Information

Insurance Carrier:	Subscriber Name:	Relationship to subscriber:
Policy Number:	Group Number:	

Employment Information

Employed: ○ Self Employed ○ Unemployed ○

Occupation:	Industry:		Company Name:
Address:	City:	State:	Zip:

Previous Healthcare Information

Previous Primary Care Physician:		
Address:		Phone:
City:	State:	Zip Code:
Reason for Leaving:		

Medical History	Y / N		Y / N		Y / N	
AIDS/HIV	O	O	Ear problems	O O	Psychiatric problems	O O
Anemia	O	O	Epilepsy	O O	Radiation Treatment	O O
Angina	O	O	Fainting	O O	Rash	O O
Arthritis	O	O	Foot ulcer	O O	Respiratory disease	O O
Artificial joints	O	O	Gout	O O	Shortness of breath	O O
Back problems	O	O	Headaches	O O	Sinus problems	O O
Bleeding	O	O	Heart problems	O O	Stroke	O O
Cancer	O	O	Hemophilia	O O	Swelling in ankles	O O
Chemical dependency	O	O	High blood pressure	O O	Tuberculosis	O O
Chest pain	O	O	Kidney problems	O O	Ulcers, Stomach/Bowel issues	O O
Chronic Diarrhea	O	O	Liver disease	O O	Varicose veins	O O
Circulatory problems	O	O	Nervous system problems	O O	Venereal Disease	O O
Diabetes Type I or Type II	O	O	Phlebitis	O O	Weight loss - Unexplained	O O

Medications (List all including supplements)

Medication Allergies & Your Reaction	Surgeries

Substance Use

Tobacco Use: Packs per Day: Since what age:

Chewing Tobacco:

Nicotine Vaping:

Cannabis Use:

Alcohol use per week:

Consent to Treat

- By signing below, I voluntarily consent to and authorize the clinicians and staff of the Raffee Medical Group to provide medical care, examinations, diagnostic procedures, laboratory tests, and medical treatments that are deemed necessary in their professional judgment.
- I understand that no guarantees have been made to me regarding the results of any examination or treatment. I acknowledge that I have the right to discuss my treatment plan with my provider and to refuse any proposed procedures or treatments at any time.

Financial Responsibility & Assignment of Benefits

- I understand and agree that I am ultimately responsible for all financial balances incurred for services rendered at the Raffee Medical Group, regardless of my insurance coverage.
- Insurance Billing: As a courtesy, the practice will bill my insurance company. However, I am responsible for providing accurate and updated insurance information.
- Payment is expected at the time of service for co-pays, deductibles and non-covered services. We accept most major credit cards. If we are required to send a second statement you will be charged a $5 billing fee from the 2nd statement and each one thereafter.
- We expect a 24 hours notice for all cancellations. We reserve the right to charge a cancellation or no show fee for appointments cancelled less than 24 hours in advance.
- Co-pays & Deductibles: I agree to pay all applicable co-payments, co-insurance, and deductibles at the time of service.
- Non-Covered Services: If my insurance company denies payment because a service is deemed not covered, out-of-network, or medically unnecessary, I agree to pay the balance in full.
- Assignment of Benefits: I hereby authorize my insurance carrier to make payments directly to Raffee Medical Group for medical services provided to me.
- If you are experiencing financial difficulties, please discuss this with the billing department or the office manager. We will work with you to make arrangements.
- Sometimes waiting periods can be longer due to unforeseen circumstances that occur after scheduling; please be patient with us as we take pride in giving all our patients the utmost care.

Acknowledgment of Notice of Privacy Practices (HIPAA)

- I acknowledge that I have been provided access to or a copy of the Raffee Medical Group's Notice of Privacy Practices. This notice describes how my protected health information (PHI) may be used and disclosed, and how I can gain access to this information. I understand that I have the right to review the notice prior to signing this document.

Patient/Guardian Signature: _____

Date: _____