ALLERGY INSIDER

Family First Primary Physicians
1910 Highway 35 South, Oakhurst, NJ 07755
(P) 732 531-4747 (F) 732 663-0044

PATIENT NAME:_____

THIS GUIDE IS DESIGNED TO HELP YOU TALK WITH YOUR HEALTHCARE PROFESSIONAL ABOUT SYMPTOMS AND DETERMINE IF TESTING IS NECESSARY

Question 1. What symptoms are present?

☐ Runny nose ☐ Itchy eyes ☐ Itchy mouth ☐ Scratchy throat
☐ Sneezing ☐ Wheezing ☐ Difficulty breathing ☐ Cough
☐ Fatigue ☐ Chest tightness ☐ Red itchy patches of skin ☐ Hives on the skin
☐ Diarrhea ☐ Abdominal cramps ☐ Constipation ☐ Lip/eyelid swelling
☐ None

Question 2. How long have these symptoms been present?

☐ Since birth ☐ <1 week ☐ >6 weeks ☐ For the past several years
☐ None

Question 3. Do symptoms become worse at any time or place?

☐ At night ☐ In the morning ☐ At home ☐ In the Fall
☐ At school/work ☐ In the winter or with cold temperatures ☐ When sick ☐ other
☐ In the spring/summer ☐ After eating ☐ With exercise
☐ None

Based upon your answers above, consider these discussion points with your healthcare professionals:

- Patient history, symptoms, physical exam PLUS testing is needed to ensure appropriate diagnosis and management of allergies

- Specific IgE blood testing for food and /or respiratory allergens is a simple blood test which is readily available and can be ordered by your healthcare professional.

- Results of specific IgE blood tests can help rule 1 or rule out allergies and together with your healthcare professional determine if or what targeted exposure reduction to specific allergens is necessary.

CANCER FAMILY HISTORY FORM

Name: _____ Date: _____

Date of Birth: _____

I HAVE HAD HEREDITARY CANCER GENETIC TESTING:

☐ NO ☐ YES WHEN? _____ RESULTS: ☐ Negative ☐ Positive, Gene: _____

MY FAMILY MEMBERS HAVE HAD HEREDITARY CANCER GENETIC TESTING:

☐ NO ☐ YES WHEN? _____ RESULTS: ☐ Negative ☐ Positive, Gene: _____

Please provide information about the cancer in yourself and/or family history in the table below. Specify who had what kind of cancer, and estimate the age of diagnosis. Include information about yourself and the following relatives on both sides of your family:

Parents, Siblings, Half-Siblings, Children, Grandparents, Aunts, Uncles, Nieces, Nephews

		CANCER HISTORY	You	Siblings/ Children	Mother's Side	Father's Side	Age of Diagnosis
No	*Yes*	*Example: Breast cancer – UNDER AGE 50*			*Aunt*		*47*
No	Yes	**Ashkenazi Jewish** ancestry with breast cancer at any age					
No	Yes	Breast cancer - **UNDER AGE 50**					
No	Yes	Ovarian cancer at ANY age					
No	Yes	Pancreatic cancer at ANY age					
No	Yes	**Metastatic** prostate cancer at ANY age					
No	Yes	**3 OR MORE family members with breast cancer** on same side of family at ANY age (1st, 2nd, or 3rd degree relatives)					
No	Yes	Colon or endometrial/uterine cancer diagnosed **under age 50**					
No	Yes	**3 OR MORE family members with** colon, endometrial/uterine, gastric, pancreatic, brain, kidney, small bowel (same side of family at ANY age) (1st, 2nd, or 3rd degree relatives)					

Patient Signature _____

OFFICE USE ONLY

Patient offered genetic testing: Yes / No Accepted / Declined / Informed Provider Initials: _____

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Depression Screening PHQ2 (2015 Edition)

Patient Name: _____**Date**:_____

Little interest or pleasure in doing things

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day
- ☐ Declined to specify

Feeling down, depressed, or hopeless?

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day
- ☐ Declined to specify

Total Score ☐

Interpretation

Score	*Probability of major depressive disorder (%)*	*Probability of any depression disorder (%)*
1.	15.4	36.9
2.	21.1	48.3
3.	38.4	75.0
4.	45.5	81.2
5.	56.4	84.6
6.	78.6	92.9

Interpretation

- 0=Declined to Specify
- 0=Not at all
- 1=Several days
- 2=More than half the days
- 3=Nearly every day

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ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have read and received a copy of the HIPAA Notice of Privacy Practices

_____ _____ ____/____/____

Printed Name Patient Signature Date

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PLEASE CHECK ALL THAT APPLY

I authorize my physician/clinical staff to disclose my protected health information to:

- ☐ Myself only
- ☐ My spouse or significant other (specify names) _____
- ☐ My parent(s) (specify names) _____
- ☐ Others (please specify relationship) _____

I would like to be contacted in the following manner:

Home Telephone _____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ Do not leave messages or medical information

Cellular Telephone _____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ Do not leave messages or medical information

Written Communication

- ☐ OK to email through our patient portal
- ☐ OK to mail to my home address

I grant Family First Urgent Care permission to obtain information from external sources (Pharmacy) regarding medications that have been prescribed to me.

- ☐ [Check here if you **DO NOT** consent for external prescription history]

_____ ____/____/____

Patient Signature Date

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NAME: _____ DATE OF BIRTH: _____

Pharmacy (Name and Location):_____

CURRENT MEDICATIONS (prescription and over the counter)	DOSAGE	FREQUENCY

PAST MEDICAL HISTORY (Please ***CIRCLE*** all that apply to you)			
Alcohol/Drug Abuse	COPD/Emphysema	Heart Murmur	Liver Disease
Allergies	Coronary Artery Disease	Hepatitis	Pacemaker
Anemia	Congestive Heart Failure	High Blood Pressure	Psychiatric Problems
Atrial Fibrillation	Depression	High Cholesterol	Seizure
Asthma	Diabetes	Hypo/hyperthyroidism	Stroke
Cancer	Heart Attack	Kidney Disease	Vascular Disease

Please list any medical disease that you have that is not mentioned above:

_____

_____

ALLERGIES	**REACTION** (hives, anaphylaxis, etc.)

PAST SURGERIES	DATE	SURGEON

HOSPITALIZATION DATE	REASON FOR HOSPITALIZATION

FAMILY HISTORY	Status (Alive/Deceased)	Age	Diabetes	High Blood Pressure	Heart Disease	Cancer	Other
Grandfather (maternal)							
Grandmother (maternal)							
Grandfather (paternal)							
Grandmother (paternal)							
Father							
Mother							
Brother							
Brother							
Sister							
Sister							

Please list any significant medical disease that a member of your family has that is not mentioned above:

_____

SOCIAL HISTORY

Smoking History (Please circle): CURRENT
FORMER
NONSMOKER

If Current Smoker - # cigarettes or cigars/day: _____

# of years smoking: _____

If Former Smoker – Date quit: _____

# of years smoking:_____

Alcohol History (Please circle): FREQUENT (Weekly)
OCCASSIONAL (Monthly or less)
NEVER

How many drinks do you have on a typical day when you were drinking in the past year?_____

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Patient Name:		**Date of Birth:**
Mailing Address:		**APT#:**
City:	**State:**	**Zip Code:**
Can we contact you through our patient portal? YES or NO	**Email:**	
Home Phone #:	**Cell Phone #:**	**Social Security #:**
Sex: (CIRCLE ANSWER) Male Female Transgender	**Marital Status:** (CIRCLE ANSWER) Single Married Partnered Divorced Widowed	
Pharmacy Name and Address:		
Emergency Contact:	**Phone #:**	**Relationship to Patient:**

PRIMARY INSURANCE INFORMATION

Insurance:	**ID #:**	
Policy Holder Name:	**DOB:**	**Relationship to Patient:**
Policy Holder Address:		
Policy Holder Social Security #:		

SECONDARY INSURANCE INFORMATION

Insurance:	**ID #:**	
Policy Holder Name:	**DOB:**	**Relationship to Patient:**
Policy Holder Address:		
Policy Holder Social Security #:		

PRIMARYINFO@FAMILYFIRST-URGENTCARE.COM

FINANCIAL POLICY

Patient Name:_____Date of Birth: _____

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

Individual's Financial Responsibility

- I understand that I am financially responsible for any co-pay, co-insurance, deductible, or the cost of any non-covered service.
  **Please be aware that some services provided may not be covered and/or considered reasonable and necessary under the Medicare program and/or other medical insurances.*
- I understand that payment in **FULL** is due at the time services are rendered.
- I understand that if my insurance requires a referral, I must obtain it prior to my visit.
- I understand that I will be responsible for any charges should my insurance deem a service "not payable".
- Should payment be sent directly to me, I understand it is my responsibility to forward payment directly to MVP Medical Associates, d.b.a. Family First Urgent Care
- If I am uninsured, I agree to pay for the medical services rendered to me at the time of service.

****REFILLS, PRIOR AUTHORIZATIONS, & REFERRALS require AT LEAST 72 Hours for completion***

MISSED APPOINTMENTS: In fairness to other patients, we require ***24 hour notice*** to cancel appointments. You will be charged $25.00 for missed appointments. Repeat missed appointments may result in dismissal from the Practice.
LATENESS: Arrival 20 minutes after your scheduled appointment will result in cancellation of the appointment. You may incur a $25.00 missed appointment fee.

COMPLETION OF FORMS: $25.00 to complete physical/pre-employment/sports physicals/insurance request forms if not provided at time of service. *Please allow **at least 48-72 hours** for completion.*
MEDICAL RECORDS: Request for medical records must be made in writing. Please allow ***72 hours*** for completion.
COLLECTIONS: Any fees or surcharges imposed by a collection agency will be your responsibility, along with the full outstanding balance from your visit.

By signing:
I agree that I have read and understood the above policies.
I authorize the release of any information necessary to process the health claims for my care.
I authorize the insurance company to forward payment directly to the physicians.

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY **DATE**

1910 Highway 35 South • Oakhurst, NJ 07755 • Phone: 732-531-4747 • Fax: 732-663-0044
Web: www.familyfirst-primarycare.com

Physical Financial Wavier

Patient Name: _____ Date of Birth: _____

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that the annual check-up you are scheduled for is to assess your present condition and to help identify any potential risk or risk avoidance measures determined from your examination, pre physical lab work up, or other diagnostic tests. This may take between 15 to 30 minutes depending upon the complexity of the examination and any chronic conditions.

****Please note*: An annual physical does not include any other evaluations or treatments for the patient. Evaluation of chronic conditions, refills of medications, changes in medications or other acute injuries or illnesses are considered as treatments and must be coded as an examination. Most annual physicals are paid in full by the insurance company, however, any additional treatment/ examination must be coded accordingly and may require payment of a copay or deductible if it is completed simultaneously with the annual physical.

Please sign as acknowledgement that you have read and understand the above Financial Policy.

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY **DATE**