Solstice Medicine & Wellness

Date:___________ Name:____ Birth Date:______________

Phone Home:__________________________ Cell:_______________ Work:__________________

New in Town? Yes No Mailing address:________________________________

Referral source: family friend ad phone book Other :______________

Reason for a New Doctor____

Payment method: cash Insurance if ins. What type_________________________

Insurance ID#_______________________ Group#______________________ Primary insured:___________

Main Reason you want to be seen:____

Medical problems/history____
____

Who is your current medical provider/clinic_____________________________ last seen________________

Why were you seen____

Will you sign a medical record release YES NO if NO, why not__________________________________

Hospitalizations in the last two years/where____

LIST ALL MEDICATIONS:____
____

Any other family members needing to establish:
____

Anything we should know, such as latex allergies, disabilities, wheelchair, and special requirements:

ALL NEW PATIENTS MUST BRING PHOTO ID & CURRENT INSURANCE CARD.

Authorization to Bill Insurance

SECTION 1: Patient Information

Last Name: ____ First Name: __________________________________ Middle Initial: ________

DOB: ___________________ SS#: ______________________________________ Daytime Phone: (_________)___________________

SECTION 2: Benefits and Billing Information

Please notify the front desk staff if your visit is related to an injury or accident

I. Does your insurance have alternative medicine benefits? Yes No

Who is your Primary Care Provider?: Dr. ______________________________________ Clinic Phone #: (_______)________________

Clinic Address: ____ City:___________________ State: ______ Zip Code: ____________

Does your plan require you to have a referral from you Primary Care Provider to receive coverage? Yes* No

*If yes, which licensed provider were you referred to at our clinic?:____

II. Primary Insurance Company & Plan Name: ____

ID Number: ____ Group/Policy Number: _____________________________________

Name of Policy Holder: ____ Policy Holder's Date of Birth: _________________________

The policy holder is my: _____________________________ (specify relationship) Policy Holder's Gender (circle): Male Female

Is your Primary Insurance Policy a (circle): POS PPO EPO HMO Don't Know Other (specify): __________

III. Secondary Insurance Company & Plan Name: ____

ID Number: ____ Group/Policy Number:_____________________________________

Name of Policy Holder: ____ Policy Holder's Date of Birth: _________________________

The policy holder is my: __________________________ (specify relationship) Policy Holder's Gender (circle): Male Female

Is your Secondary Insurance Policy a (circle): POS PPO EPO HMO Don't Know Other (specify): __________

SECTION 3: Guarantor Information

This section must be completed if someone other than the patient is financially responsible for the patient's account.

Last Name: ____ First Name: ______________________________________ Middle Initial: ________

Address: ____________________________________ City: _______________ State: _______ Zip: ___________ Phone: (_______)____________

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient and that I am subject to all financial terms listed below.

X ____ _____________________

Guarantor's Signature **Date**

I understand that all co-pays are due at the time of service and that I am financially responsible for all charges whether or not they are paid by my insurance. I understand that finance charges will begin accruing on accounts that are 60 days past due for payment at a rate of 1.5% per month. I further understand that excessively overdue accounts will be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that some third-party payers may require that my medical information, including copies of treatment notes, be submitted along with requests for payment. I hereby authorize **Solstice Medicine & Wellness, LLC; Dr. Gina Escobar** to release all medical information necessary to secure payment of benefits from the third-party payers specified above, and I authorize the use of this signature on all related submissions. I understand that this information may include medical information related to drug and alcohol abuse, sexually transmitted diseases, HIV/AIDS and mental health. I understand that this authorization shall remain valid without expiration unless expressly revoked by me in writing.

X ____ ______________________

Patient's Signature Date

X ____ ______________________

Guardian/Representative's Signature Date

____

Relationship to Patient/Representative Authority

ADULT MEDICAL HISTORY
(18 and up)

Patient Name:			**DOB:**		
Source of information: [ ] Self [ ] Spouse [ ] Family member [ ] Another person					
MEDICAL HISTORY					
List all allergies (Foods, medications, environmental etc.): ______________					
Please answer all questions that apply to you:			High blood pressure	YES	NO
Asthma	YES	NO	High cholesterol	YES	NO
Blood clots in leg or lung	YES	NO	HIV infection/AIDS	YES	NO
Cancer (Location): ________________________			Kidney disease	YES	NO
Chronic bronchitis or emphysema	YES	NO	Liver, stomach, or bowel disorder	YES	NO
Congestive Heart Failure	YES	NO	Seizure disorder	YES	NO
Depression/Anxiety	YES	NO	Stroke	YES	NO
Diabetes	YES	NO	Thyroid disease	YES	NO
Heart disease	YES	NO	Tuberculosis	YES	NO
Hepatitis	YES	NO	Others not listed: __________________________________		

Are you presently taking medications to include prescription drugs, over the counter or herbal remedies? If YES, please list below what medications, strength and for what condition.

Medication	Dose	Frequency

Please list the date you received any of the following preventive health items:	Date of last Tetanus/Tdap vaccine:
Date of last colonoscopy:	Date of last tuberculosis skin test (PPD): If PPD was positive, did you complete treatment?
Date of last Shingles vaccine:	Date of last eye exam
Date of last pneumovax:	Date of last chest X ray:
FEMALE HISTORY	
Age of first menstrual period:	Date of last pap:
Number of pregnancies:	Date of last mammogram:
Number of deliveries:	Current birth control method:

SURGICAL/HOSPITALIZATION HISTORY

Please list all surgeries, date and if any complications/Also list recent hospitalizations and reason:

SOCIAL HISTORY	Complete all that apply:				
Do you drink alcohol?	YES	NO	How many drinks per week?		
Do you consume drugs?	YES	NO	What type of drugs?		
Did you ever smoke?	YES	NO	How many cigarettes per day? When did you start? When did you quit?		
How many years have you been smoking?			Are you currently sexually active?	YES	NO
Highest level of education:			Do you consume caffeine? If yes how many cups per day?	YES	NO
Marital Status:			Do you exercise weekly? What type?	YES	NO
What does your diet mostly consist of?			What is your occupation?		
FAMILY HISTORY: Have any of your blood relatives (Mother,			**Father, Brother, Sister, grandparents)**	**had any of the**	
following conditions?					
Bleeding problems:		YES	Mental health illness	YES	
Cancer (specify type): Breast Cancer: ___________________ Colon Cancer: ___________________ Prostate Cancer: _________________ Stomach Cancer: _________________ Other: _______________________			High blood pressure:	YES	
Diabetes:		YES	Stroke:	YES	
Heart disease:		YES	Substance abuse:	YES	
High cholesterol:		YES	Other:		

Any other information you would like Dr. Escobar to know:

____

Patient Signature

____

Date

Rev: 11/09/2017

Notice of Privacy Practices

Acknowledgement of Receipt

Patient Name:______________________________________Date of Birth:______________
[Please print]

Solstice Medicine & Wellness, LLC, / Dr. Gina Escobar is required to provide you with a copy of its Notice of Privacy Practices and to obtain written acknowledgement, if possible, that you have received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of your healthcare information at our clinic, wish to inquire about your rights or if you wish to schedule an appointment to view your medical record, please call (907)456-6334.

I hereby acknowledge that I have received a copy of Dr. Gina Escobar's Health Notice of Privacy Practices.

X _________________________________ _______________
Patient's Signature Date

X _________________________________ _______________
Guardian/Representative's Signature Date

_____________________________________ _______________
Relationship to Patient/Representative Authority Date

<u>Office Use Only:</u>

I hereby affirm that Gina Escobar, MD has made a good faith effort to obtain written acknowledgement from the above named patient.

Staff members initials:_______