SKINNER FAMILY PRACTICE

IMPORTANT INFORMATION

Primary Provider: (circle one) Anita Burleson Christie Skinner

Title: Mr. Mrs. Ms.

First Name: _____ Nick Name: _____

Middle Name: _____ Last Name: _____

Suffix: _____ (Jr, Sr, I, II, III etc)

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Email Address: _____

Preferred Communication: Phone Call Text Email

DEMOGRAPHICS

Patient SSN _____-_____-_____

Patient Date of Birth _____

Age _____ Gender: Male Female

Ethnicity: _____

Student Status: _____

Street Address: _____

Zip Code: _____ City: _____ State: _____

Mailing Address: _____

Zipcode: _____ City: _____ State: _____

Patient Marital Status: Never married Separated Divorced Married

Emergency Contact Name: _____

Emergency Contact Phone: _____

Emergency Contact Relation: _____

RESPONSIBLE PARTY

Responsible Party Name: _____
Responsible Party DOB: _____
Responsible Party Relation: _____
Responsible Party Phone: _____
Responsible Party Email: _____

EMPLOYER

Employer: _____
Employer Phone: _____
Employer Zip Code: _____
Employer Address: _____
Employer City: _____
Employer State: _____ Employer Zip Code: _____

PREFERRED PHARAMCY: _____

Are you currently seeing any other providers or specialists? If so, please list below so that we can better know your history, your current treatments, and share any tests results to allow a more holistic care team.

Dr. Name: _____
Specialty: _____
Phone Number: _____ Fax Number: _____
Address/location: _____
City: _____ State: _____ Zip: _____

Dr. Name: _____
Specialty: _____
Phone Number: _____ Fax Number: _____
Address/location: _____
City: _____ State: _____ Zip: _____

HIPPA PRIVACY ACT

Patient Name: _____

By signing below, I acknowledge that I have been notified of the availability of the Notice of Privacy Practices and a copy has been made available to me by Skinner Family Practice. I also authorize Skinner Family Practice and any authorized staff members to share pertinent protected health information with those listed below. I also understand that, with written request, I can amend or withdraw any names listed below at any time and that it is my responsibility to ensure the persons listed below do not divulge or use the information provided in any way without my authorization.

Please list below any individuals to which health information may be freely shared without further notification. Please DO NOT list other physicians of medical facilities.

PMI Names and Phone Numbers:

By including names and numbers below for PMI, you are consenting and authorizing Skinner Family Practice and any and all of it's Employees to release Personal Medical Information to the named individuals, allow these individuals to call on your behalf for medications and/or appointments, etc. If you wish for no one to receive PMI or be allowed to call in on your behalf, please simply write "NONE" below. Emergency Contact above is NOT permission to receive PMI.

_____

_____

_____

_____

_____

Signature: _____ Date: _____

PRIMARY INSURANCE INFORMATION:

PLEASE PRESENT YOUR CARD TO THE RECEPTIONIST FOR A COPY

Subscriber Name: _____

Insurance Company: _____

Insurance ID#: _____

Insurance Group #: _____

Insurance Plan Name: _____

Secondary Insurance:

Subscriber Name: _____

Insurance Company: _____

Insurance ID#: _____

Insurance Group #: _____

Insurance Plan Name: _____

Tertiary Insurance:

Subscriber Name: _____

Insurance Company: _____

Insurance ID#: _____

Insurance Group #: _____

Insurance Plan Name: _____

Authorization and assignment:

I hereby authorize Skinner Family Practice to furnish any information to my insurance carrier(s) and health care administrators or agents concerning my illness and/or treatment. I hereby assign to Skinner Family Practice all payments for services rendered to me/my covered dependents. I understand that I AM RESPONSIBLE FOR ANY AMOUNTS NOT COVERED BY INSURANCE AND THAT MY COPAYMENT IS DUE AT THE TIME OF SERVICE. I further understand that Skinner Family Practice is filing my insurance as a courtesy and convenience for me and that I am ultimately responsible for all billed amounts for services provided.

Signature: _____ Date: _____

HEALTH HISTORY

Patient Name: _____

DO YOU HAVE A PERSONAL HISTORY OF...

DIABETES (E11.9)	COPD (J44.9)	BLOOD PRESSURE (I10)	CROHNS DISEASE (K50.10)
HEART DISEASE (I51.9)	TUBERCULOSIS (A15.9)	DIVERTICULITIS (K57.90)	KIDNEY STONES (N20.2)
HEART ATTACK (I21.3)	LIVER DISEASE (K76.9)	ULCERATIVE COLITIS(K51.90)	SEIZURES (R56.9)
HIGH CHOLESTEROL (E78.5)	THYROID DISEASE (E07.9)	ASTHMA (J45.998)	AIDS/HIV (B20)
STROKE (I63.9)	HEPATITIS (K71.6)	MIGRAINES (G43.009)	CHRONIC PAIN* (G89.29)
CANCER (C80.1)	BACK INJURY (S39.92XA)	ULCERS (K12.1)	KIDNEY DISEASE (N28.9)

List any surgeries (please include year): _____

_____

_____

Medication Allergies: _____

Do you use tobacco? _____Type and amount: _____

Do you drink alcohol? _____ Amount and frequency: _____

Have you ever been treated for drug or alcohol abuse? _____

FAMILY HISTORY (PLEASE LIST ANY SIGNIFICANT HEALTH CONDITIONS)

FATHER: _____

MOTHER: _____

GRANDPARENTS: _____

SIBLINGS: _____

*PLEASE NOTE: SKINNER FAMILY PRACTICE DOES NOT PROVIDE PAIN MANAGEMENT.
PLEASE INITIAL HERE INDICATING YOUR UNDERSTANDING OF THIS: ____ DATE: _____

SKINNER FAMILY PRACTICE

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

I HEREBY GRAN MY PERMISSION FOR RELEASE OF MEDICAL RECORDS RELATING TO MY CARE TO THE PARTIES NAMED BELOW:

SEND RECORDS TO:
Skinner Family Practice
1000 N College Ave
El Dorado, AR 71730
Ph: (870) 881-8008
Secure Fax #s: 870-862-7374 or 501-904-4458

Physician/Clinic Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

The purpose of this release is for the continuation of care and treatment of the above-named patient by Skinner Family Practice, Christie Skinner, and/or Anita Burleson. Below is the specific description of information to be disclosed:

_____ ALL medical records including office notes, lab reports, test reports, radiology reports, etc.

_____ Limited medical records containing only information addressing current illnesses being treated by Skinner Family Practice and its providers. Information requested is limited to the following:

_____

By signing below, I certify that I have read and understand the following statement regarding my rights:

- I understand that the information in my health record may include information relating to sexually transmitted diseases, AIDS, HIV, or other sensitive information. It may also include information about behavioral or mental health services and treatment of alcohol and/or drug abuse
- I may revoke this authorization at any time PRIOR TO its expiration date by notifying Skinner Family Practice in writing. However, I understand that revocation will have no effect on any actions taken before receiving such notice.
- I may see a copy of the information described on this form by submitting a written request.
- I am not required to sign this form to receive health care benefits from Skinner Family Practice or its providers.

Signature: _____ Date: _____