

**PATIENT DEMOGRAPHICS**

TODAY'S DATE \_\_\_\_\_

PATIENT NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_M\_\_\_F

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME#(\_\_\_\_) \_\_\_\_\_ CELL#(\_\_\_\_) \_\_\_\_\_ WORK #(\_\_\_\_) \_\_\_\_\_

May OSMC leave a message on your... Home Phone \_\_\_y\_\_\_n Work \_\_\_y\_\_\_n Cell \_\_\_y\_\_\_n

SS# \_\_\_\_-\_\_\_\_-\_\_\_\_ MARITAL STATUS \_\_\_M\_\_\_D\_\_\_S\_\_\_W

EMPLOYER \_\_\_\_\_ EMPLOYERS ADDRESS \_\_\_\_\_

PRIMARY CARE PHYSICIAN & CLINIC \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ PHONE# \_\_\_\_\_

CONTACTS RELATIONSHIP TO YOU \_\_\_\_\_

E-MAIL \_\_\_\_\_ REFERRED BY \_\_\_\_\_

WHERE DID YOU FIND US? \_\_\_\_\_

**\*\*Don't worry, if you give us your email address we will only send you emails related to our office and your treatment.**

PRIMARY INSURANCE \_\_\_\_\_ ID# \_\_\_\_\_ GROUP# \_\_\_\_\_

INSURED PERSON'S NAME \_\_\_\_\_ EMPLOYED BY \_\_\_\_\_

SS# \_\_\_\_-\_\_\_\_-\_\_\_\_ DATE OF BIRTH \_\_\_/\_\_\_/\_\_\_

SECONDARY INSURANCE \_\_\_\_\_ ID# \_\_\_\_\_ GROUP# \_\_\_\_\_

INSURED PERSON'S NAME \_\_\_\_\_ EMPLOYED BY \_\_\_\_\_

SS# \_\_\_\_-\_\_\_\_-\_\_\_\_ DATE OF BIRTH \_\_\_/\_\_\_/\_\_\_

**\*\*\*I authorize release of my health records to any provider who is being advised or consulted with in connection to my current treatment.** Initials \_\_\_\_\_

**ASSIGNMENT OF BENEFITS:** I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitle, including MEDICARE, private insurance and any other health plans to: One Stop Medical Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment. In the event that the patient fails to make payment or there is an outstanding obligation on the account, the patient hereby agrees to be responsible for all court costs and reasonable attorney fees in regards to the collection of this account.

**SIGNED** \_\_\_\_\_ **DATE** \_\_\_\_\_

PATIENT NAME \_\_\_\_\_

DATE \_\_\_\_\_

**HISTORY OF PRESENT ILLNESS:**

Purpose of this visit \_\_\_\_\_

What symptoms are you having & for how long? \_\_\_\_\_

**MEDICAL HISTORY** \_\_\_\_\_

Have you had a Colonoscopy in the past? No \_\_\_ Yes \_\_\_ When? \_\_\_\_\_

**MEDICATIONS:** List all medications, dosages and times taken per day.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you take aspirin? \_\_\_Yes \_\_\_No How much? \_\_\_\_\_

**ALLERGIES:** Medications/Foods

What was your reaction?

\_\_\_\_\_  
 \_\_\_\_\_

**SURGICAL/HOSPITALIZATION HISTORY:**

Date of surgery or hospitalization

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**FAMILY MEDICAL HISTORY:**

RELATIONSHIP	Living	Deceased	Age	Diseases
Father	___	___	___	_____
Mother	___	___	___	_____
Children	___	___	___	_____
Brother(s)	___	___	___	_____
Sister(s)	___	___	___	_____

**SOCIAL HISTORY:**

**Occupation** \_\_\_\_\_

Cigarettes or tobacco \_\_\_Yes \_\_\_No How much/how often? \_\_\_\_\_  
 Alcohol \_\_\_Yes \_\_\_No How much/how often? \_\_\_\_\_  
 Drugs \_\_\_Yes \_\_\_No How much/how often? \_\_\_\_\_

**AUTHORIZATION:** To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the medical office of any changes in my medical status.

\_\_\_\_\_  
 Signature of Patient or Guardian Date \_\_\_\_\_



## Patient Financial Responsibility Disclosure Statement

Your signature below forms a binding agreement between One Stop Medical Center (OSMC) - the provider of medical services) and the Patient who is receiving medical services or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical bills.

**All charges for services rendered are due and payable at the time of service.**

**MEDICAL INSURANCE:** We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason.

The person signing on behalf of the Patient as the Responsible Party must:

- Inform OSMC of the current address and phone number for the patient and the responsible party.
  - Present all current insurance cards prior to each office visit.
  - Verify at each visit that the information is current by signing our data sheet.
  - Pay any required copay at the time of the visit.
- Pay any additional amount owing within 30 days of receiving a statement from our office. *(When OSMC receives an explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you).*

### Returned Check Policy

If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a \$30.00 Service Charge. Once notice is received of the returned check, OSMC will send out a letter to notify the Responsible Party of the returned check. If a response is not made within 15 days from the letter date by the Patient or the Responsible Party, the account may be turned over to our collection agency and a collection fee of 50% will be added to the outstanding balance – in addition to the \$30.00 Check Service Charge.

### Non-Payment on Account

Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's Responsible Party, understands that OSMC has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient's Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, interest due at 18% APR, all court costs and Attorney fees, and a collection fee of 50% will be added to the outstanding balance.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient Name (Please Print) \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Responsible Party Name (Please Print) \_\_\_\_\_ Date \_\_\_\_\_

Responsible Party Signature \_\_\_\_\_