

WILSON FAMILY PRACTICE

899 AIGNER DRIVE
BOONVILLE, IN 47601
PHONE (812)641-0262
FAX (812)641-0557

PATIENT INFORMATION

First Name: _____ Middle Initial: _____ Gender: M F
Last Name: _____ SSN Number: _____
DOB: _____ Home Phone: _____
Cell Phone: _____ Work Phone: _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____ -
Email Address: _____

EMERGENCY CONTACT INFORMATION

Contacts Name: _____ Relationship: _____
Contact Phone: _____

PAYMENT RESPONSIBILITY

**THIS SECTION MUST BE FILLED OUT WITH PARENT INFORMATION FOR ALL PATIENTS UNDER 18*

First Name: _____ Last Name: _____

INSURANCE INFORMATION

Insurance Company: _____ Policy #: _____
Policy holder: _____ Relationship to patient: _____
Policy holder's SSN: _____ DOB: _____
Street Address: _____ City: _____
State: _____ Zip Code: _____
Home phone: _____ Cell Phone: _____
Employer _____

PRIMARY CARE PHYSICIAN

Name of Family Physician: _____
Street Address: _____ City: _____
State: _____ Zip Code: _____
Phone: _____ Date of Last Visit: _____

Please list all current medications with dosage and how often it is taken. Be sure to include over-the-counter medication, prescription drugs, and any supplements and vitamins:

Medication Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Primary Pharmacy _____

ALLERGIES

**PLEASE INCLUDE ALL FOOD, DRUG AND ENVIRONMENTAL ALLERGIES*

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SURGICAL HISTORY

**PLEASE LIST ALL PAST SURGERIES*

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PAST MEDICAL HISTORY

Heart Disease	yes	no	Hyperthyroid	yes	no
Heart Attack	yes	no	Kidney stones	yes	no
Heart Arrhythmia	yes	no	Kidney Disease	yes	no
Atrial Fibrillation	yes	no	Stroke	yes	no
Congestive Heart Failure	yes	no	Gallbladder Disease	yes	no
Hypertension	yes	no	Anemia	yes	no
Vascular Disease	yes	no	Chronic Back Pain	yes	no
Diabetes	yes	no	Lyme Disease	yes	no
*Insulin Dependent	yes	no	Psoriasis	yes	no
* Non Insulin Dependent	yes	no	Depression	yes	no
High Cholesterol	yes	no	Osteoporosis	yes	no
Lung Disease	yes	no	Neuropathy	yes	no
Asthma	yes	no	Hypothyroidism	yes	no
Reflux Diseases (GERD)	yes	no	Fibromyalgia	yes	no
Ulcers	yes	no	Colitis	yes	no
Cancer (location)_____	yes	no	Blood Clots (DVT or PE)	yes	no

FAMILY MEDICAL HISTORY

*PLEASE SPECIFY THE RELATION BETWEEN PATIENT AND FAMILY MEMBER

MOTHER:

Heart Disease: _____
Heart Attack: _____
Heart Arrhythmia: _____
Atrial Fibrillation: _____
Congestive Heart Failure: _____
Hypertension: _____
Vascular Disease: _____
Diabetes: _____
High Cholesterol: _____
Lung Disease: _____
Asthma: _____
Reflux Disease (GERD): _____
Ulcers: _____
Cancer (specify): _____
Blood Clots: _____
Neuropathy: _____
Osteoporosis: _____
Depression: _____
Psoriasis: _____
Arthritis (specify): _____
Chronic Back Pain: _____
Anemia: _____
Gallbladder Disease: _____
Stroke: _____
Kidney Disease: _____
Kidney Stones: _____
Hypothyroid: _____
Hyperthyroid: _____

FATHER:

Heart Disease: _____
Heart Attack: _____
Heart Arrhythmia: _____
Atrial Fibrillation: _____
Congestive Heart Failure: _____
Hypertension: _____
Vascular Disease: _____
Diabetes: _____
High Cholesterol: _____
Lung Disease: _____
Asthma: _____
Reflux Disease (GERD): _____
Ulcers: _____
Cancer (specify): _____
Blood Clots: _____
Neuropathy: _____
Osteoporosis: _____
Depression: _____
Psoriasis: _____
Arthritis (specify): _____
Chronic Back Pain: _____
Anemia: _____
Gallbladder Disease: _____
Stroke: _____
Kidney Disease: _____
Kidney Stones: _____
Hypothyroid: _____
Hyperthyroid: _____

TOBACCO/ALCOHOL/RECREATIONAL DRUG USE

Smoking Status:

Current smoker: yes no
If yes, how many packs per day: _____
Previous smoker: yes no
If yes, specify when you quit: _____
Chewing Tobacco: yes no

Alcohol Use: (circle the answer)

Occasional Daily None

Recreational Drug Use: yes no

If yes, please specify which drugs are used:

MRI/CT Procedure Questionnaire

Please provide a "yes" or "no" answer for every item below.

	Yes	No
Cardiac pacemaker or any other cardiac implants	☐	☐
Internal electrodes or wires (pacing wires, DBS or VNS wires)	☐	☐
Artificial heart valve, coil, filter, and/or stent	☐	☐
Aneurysm clips	☐	☐
Neurostimulator-TENS unit, Biostimulator, bone growth stimulator	☐	☐
Implanted drug pump (for chemotherapy medicine or pain medicine)	☐	☐
External drug pump (for insulin or other medication)	☐	☐
IV access port	☐	☐
Implanted post surgical hardware (pins, rods, screws, plates, wires)	☐	☐
Artificial joint and/or limb	☐	☐
Artificial eye and/or eyelid spring	☐	☐
Ear implant	☐	☐
Any type of implant held in by a magnet	☐	☐
Shunt or Sophy adjustable and programmable pressure valve	☐	☐
Spinal fixation device, spinal fusion, halo vest, or spinal cord stimulator	☐	☐
Surgical clips, staples, or mesh	☐	☐
Tissue expander (breast implants)	☐	☐
IUD, diaphragm, pessary	☐	☐
Radiation seeds	☐	☐
Kidney Disease	☐	☐
Diabetes	☐	☐
Liver Disease	☐	☐
Claustrophobia	☐	☐
Allergy to Contrast dye	☐	☐

PROTECTED HEALTH INFORMATION

I, _____, hereby authorize my personal health information may be released to the following people.

1.) Name: _____ Phone: _____

Relationship: _____

2.) Name: _____ Phone: _____

Relationship: _____

3.) Name: _____ Phone: _____

Relationship: _____

4.) Name: _____ Phone: _____

Relationship: _____

Signature _____ Date _____

General Consent to Treat

I consent to medical care of a routine/emergency nature from the authorized professional staff of Wilson Family Practice for myself or the above-mentioned minor for whom I am the parent/guardian. I authorize the release of any and all medical records and information obtained through my medical evaluation to those individuals that my doctor feels appropriate for my continued medical care.

I understand that I have the right to a full disclosure of the nature of any medical treatment received or proposed to be rendered and the risks, if any, involved and alternative means available.

It is understood that I may withdraw this consent at any time by contacting any member of the professional staff in writing.

Financial Agreement

I authorize payment to Wilson Family Practice of any medical benefits, which would otherwise be payable to me and which were established by my insurance company. The amount paid to Wilson Family Practice shall not exceed the practice's regular charges for the services.

I also authorize the release of my medical records to my insurance company/companies or other third-party payers or my employer as required for the collection of payments. I understand that I am responsible for the payment of charges that are not paid by my insurance company.

Medicare Agreement

The information provided by me in the applying for payment of Social Security benefits is true and correct. I also authorize the physician to initiate a complaint to the insurance commissioner for any reason on my behalf.

I request that the payment of benefits be made for me. The benefits due to me for services provided by my physician shall be paid directly to Wilson Family Practice. In the event the physician does not receive such payment, I authorize such physician to submit a claim to Medicare on my behalf.

If my current policy prohibits direct payment to Wilson Family Practice, I hereby direct the check made out to me and mail to: Wilson Family Practice, 899 Aigner Dr, Boonville, IN 47601.

Payment Agreement

Wilson Family Practice requests that you read your insurance policy and be fully aware of any limitations of the benefits provided. You should be aware that this insurance agreement is between you and the insurance company. We will gladly help you, but it is your responsibility to know the limitations of your policy. Any charge incurred beyond the reimbursement of your policy will be your financial responsibility.

Collection Fee Agreement

I understand that if any unpaid balance is assigned to a third-party collection agency for collection or placed with an attorney to obtain judgement or otherwise satisfy payment of my account, a collection fee equal to 33% of the unpaid balance will be added to my account. I agree to pay that fee. I further agree to pay reasonable attorney fees and court costs if a judgement is granted against me.

I have read the above and understand my financial obligation.

Patient Signature: _____

Date: _____

Signature of Responsible Party: _____

Relationship to Patient: _____ Date: _____

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No-show/late cancellation policy

We understand that you may need to cancel an appointment occasionally. In such circumstances, please contact us no later than 24 hours before your scheduled appointment time. You may do so by calling 812-641-0262 or using the patient portal.

*If you do not show up for your appointment or cancel or reschedule within 24 hours of your appointment time, we will consider that a no-show. **No-show appointments may be subject to a \$25 fee.** No-show fees are the patient's sole responsibility and must be paid in full before your next appointment. If the no-show fee might prevent you from receiving necessary care, please contact us.*

We know that unexpected situations sometimes arise. In the case of emergencies or extenuating circumstances, we may waive the no-show fee. Waivers are determined on a case-by-case basis at the practice management's sole discretion.

Patients with 3 no-show appointments can be discharged from the practice, under the provider's discretion.

Print Name: _____

Patient signature: _____

Date: _____