Clifford Family Practice – New Patient Information

Please arrive 10-15 minutes early with this paperwork and your Insurance Card.

You **must** fill in **all** parts of this sheet. Please **print** all information **legibly**. Please **use your legal name on your Insurance Card**.

Legal Name:_____ Date of Birth: ____/____/_____
(Last) (First) (Middle Initial)

Mailing Address: _____
(Street) (Apt #) (City) (State) (Zip)

Sex: □ Male □ Female Marital Status: □ Single □ Married □ Divorced □ Legally Separated □ Widowed □ Other _____

Home Phone #: _____ Cell Phone #:_____ (please circle which number is the best to use to reach you.)

Social Security #:_____-_____-_____ eMail:_____@_____._____

Employment status: □ Full Time □ Part Time □ Retired □ Unemployed □ Student (Full / Part Time) □ Other _____

Current Occupation & Employer:_____

Previous Jobs: _____

Education: _____ Years of High School _____ Years of College _____ Years of Post Graduate

Preferred Language: □ English □ Spanish Other_____ Translator Needed? YES NO

Race: □ White □ African American □ Asian □ Hispanic □ American Indian □ Refuse to Report □ Other _____

Ethnicity: □ Hispanic □ Non-Hispanic □ Other_____

For Children:
Mother's Name: _____ Mother's Phone #:_____

Father's Name: _____ Father's Phone #:_____

Emergency Contact & Other Contacts

Name:_____ Phone #: _____ Relationship:_____

Other Contacts we may discuss your care with (other Family or Friends):

Name	Phone #
_____	_____
_____	_____
_____	_____

Insurance Information

Policy Holder's Name:_____ Date of Birth:____/____/_____
(Last) (First) (Middle)

Social Security #:_____-_____-_____ Home Phone #:_____ Work Phone #:_____

Address:_____ Relationship:_____

Primary Insurance Company Name:_____ ID #:_____

Group #:_____ Start/Effective Date:___/___/_____ Suffix (ex: 00, 01, 02…):_____

Secondary Insurance Company Name:_____ ID #:_____

Group #:_____ Start/Effective Date:___/___/_____ Suffix (ex: 00, 01, 02…):_____

AGREEMENTS (must be filled out)

Below are a list of agreements and authorizations that by signing this page you are entering into with Clifford Family Practice, the office of Dr. David S. Clifford.

I authorize Clifford Family Practice to perform procedures and treatment that may be medically necessary.

I authorize the release of any medical information necessary (including the release of HIV/AIDS, Mental Health, Substance Abuse/Alcohol/Drugs) to process a claim and hereby assign benefits payable to Clifford Family Practice in the event of another health insurance becoming primary over my current health insurance. This also authorizes the release of my information to any specialists, hospitals, pharmaceutical companies, lawyers or life insurance companies (with signed consent), other care providers (oxygen/PT INR companies, social workers), or other health care agencies (including interoperability frameworks such as Carequality and Commonwell or research studies) for the continuity of my care or to conduct normal and required health care operations, such as quality assessments and Physician certifications or recognitions.

I agree that:

- **I am responsible for my own health**
- **I am responsible for all expenses for treating the patient**, including those that are not covered under my insurance, such as Annual Deductibles, non-covered insurance benefits, and co-pays. High Deductible policies can be charged $60 at the time of visit in order to reduce the amount of billing statements being mailed out. If you need assistance in understanding your insurance plan and benefits, please contact your insurance provider. If I cannot pay my copay and/or bill at the time of my visit, I understand that I may be asked to reschedule my appointment.
- **Payment of charges is due at the time of the appointment**, including co-pays, account balances, and fees for cancelled or missed appointments. Cash, Check, and all major credit cards are accepted. *If a check is returned from your bank, there will be a $40 charge added on to your payment*.
  If you have difficulty paying your bill on time, please contact our Billing Manager. Accounts over 90 days past due and/or those who have received 3 billing statements will be referred to a Collection Agency. In the event that your account is forwarded to a Collection Agency, you agree to pay an additional fee equal to 33% of the balance forwarded to the Agency and any additional fees from our practice. If your account is forwarded to a Collection Agency at any time, you may be dismissed from our practice and not allowed to return.
- **Clifford Family Practice may call my home** or other alternative location and leave a message on voicemail in reference to any items that assist the practice in carrying out health care operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory test results, among others.
- **Clifford Family Practice may mail to my home** any items that assist in carrying out health care operations, such as patient statements, laboratory scripts and test results, among others.

I understand that **this practice requires 24 Hours advance notice for any and all appointment cancellations and reschedules**. <u>If an appointment is broken with less than 24 Hours notice, you will be charged a $50 fee</u>. Missing or rescheduling more than two (2) appointments is grounds for dismissal from our practice.

You give Clifford Family Practice permission to do the following, unless the box before it is checked:

□ use your email to sign you up for our Patient Portal. This enables appointment reminder emails and gives you easier access to your health information and allows you to send our office emails for prescription refills and any questions.

□ report any immunizations given to the New York State and Center for Disease Control registries. We will ALWAYS ask your consent before administering any vaccinations.

I understand that I have the right to revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, later revoke it, or do not uphold my portions of the agreement, Clifford Family Practice has the right to decline to provide treatment to me.

Clifford Family Practice is highly committed to ensuring all patient information remains private. If patient rights and confidentiality are considered to be violated, disciplinary action will be enforced.

Patient's Printed Name:_____ Date: ____/____/_____

Signature of Patient/Guardian:_____

Relationship: □ Self □ Parent □ Legal Guardian

Advanced Care Planning

In the event that I,_____, am unable to make my own health care decisions**, I hereby appoint**, _____

(Name, Home Address, & Phone Number)

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

If the person I appoint is unable, unwilling, or unavailable to act as my health care agent, I hereby appoint,

_____

(Name, Home Address, & Phone Number)

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

Unless I revoke it or state an expiration date or circumstances under which it will expire below, this proxy shall remain in effect indefinitely. _____

(Date or Circumstances of Expiration)

I direct my health care agent to make health care decisions according to my wishes and limitations. **Below are my directions and limitations of care**, should my health care agent not be aware.

_____

_____

I do / do not want cardio-pulmonary resuscitation (CPR)

I do / do not want mechanical respiration/intubation Trial Period Allowed

I do / do not want artificial nutrition and hydration Trial Period Allowed

I do / do not want antibiotics

I do / do not want maximum pain relief, even if it may hasten my death.

I hereby make an anatomical gift, to be effective upon my death of:

□ None

□ Any needed organs and/or tissues

□ The following organs and/or tissues: _____

□ Limitations:_____

If you do not state your wishes or instructions about organ/tissue donation, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Printed Name:_____ **Date**:_____

Your Signature:_____

Your Address:_____

Witnesses: (Completed by our office when handed in)

Printed Name:_____ Signature:_____

Address: 256 Center Road West Seneca, NY 14224 Date:_____

Printed Name:_____ Signature:_____

Address: 256 Center Road West Seneca, NY 14224 Date:_____

David S. Clifford, M.D., A.B.F.P.
Heather L. Bailey, P.A. – C
Deirdre L. Schwartz, FNP
256 Center Rd.
West Seneca, NY 14224
Phone: (716) 677-4159

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

By signing this authorization, I authorize DR. DAVID CLIFFORD to obtain certain protected health information (PHI) about me.

Name and address of entity (PREVIOUS DOCTOR) to release this information:

_____

_____

This release permits the above Previous Doctor to disclose the following individually identifiable health information about me from the **PAST TWO YEARS ONLY**. This should include, but is not limited to: all office notes, latest labs, test results, consultation letters, and any other important information. Information will be used or disclosed for the following purpose: **future medical care**.

Please, DO NOT FAX as it ties up our fax line. Please mail the records as a paper copy or on a CD, or send them electronically through eClinicalWorks P2P.

I understand the implications and hereby authorize the release of the following records relating to:

____Alcohol/Drug Abuse ____HIV/Sexually Transmitted Disease

____Mental Health Concerns (Including any care for anxiety or depression)

I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at the practice listed above.

_____ _____
Signature of Patient or Legal Guardian Date

_____
Print Patient Name Birthdate Address

_____ Relation (If Parent/Guardian or Name other than patient)

SEE HEALTHELINK ELECTRONIC CONSENT IN OFFICE AT FRONT WINDOW

Please list all of your **current medications** (prescription & non-prescription), including their strength and how often.

Medical History: Have you ever had or do you currently have?
(Check the box if you have been diagnosed, write next to it when you were diagnosed)

- □ High Blood Pressure
- □ Low Blood Pressure
- □ Heart Disease
- □ Heart Attack
- □ Blood Clots
- □ Phlebitis
- □ Anemia
- □ Stroke
- □ Diabetes
- □ High Cholesterol
- □ Gout
- □ Goiter
- □ Sinusitis
- □ Asthma
- □ Cancer Type?_____ When?_____
- □ Emphysema
- □ Bronchitis
- □ Epilepsy
- □ Duodenal Ulcer
- □ Stomach Ulcer
- □ Gall Bladder Disease
- □ Gall Bladder Stones
- □ Kidney Stones
- □ Kidney Infection
- □ Bladder Infection
- □ Colitis
- □ GERD
- □ Irritable Bowel Syndrome
- □ Cirrhosis
- □ Tuberculosis
- □ Anxiety
- □ Depression
- □ Nervous Breakdown
- □ Rheumatic Fever
- □ Polio
- □ Mumps
- □ German Measles
- □ Chicken Pox
- □ Gonorrhea
- □ Syphilis

Any other medical problems?

Allergies: Please list all of your allergies and the reaction you have.

Surgeries & Hospitalizations: Please list all of your surgeries and hospitalizations (including the year).

Family Medical History

Status/Cause	Age	No Known	Diabetes	Hypertension	Heart Disease	Cholesterol	Cancer (Type)	Stroke	Epilepsy	Suicide	Anxiety/ Depression	Alcohol Abuse	Drug Abuse	Smoking
Mother		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Siblings (#, M/F?)														
1		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Grandmother (Maternal)		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Grandfather (Maternal)		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Grandmother (Paternal)		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Grandfather (Paternal)		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Children (M/F?)														
1		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Social History

Do you have a home smoke & CO detector? □ Yes □ No
Do you text while driving? □ Yes □ No
Do you smoke? □ Yes □ No
If yes: For how many years?_____ What do you smoke? □ Cigarettes □ Cigar □ Pipe □ Other _____
How often/how much do you smoke? _____ packs per day
Are you interested in quitting? □ Yes □ No
Do you drink alcohol? □ Yes □ No
If yes: How often do you drink alcohol? □ Rarely □ Moderately □ Heavily
_____ per day _____ per week Number of years? _____
What do you drink? □ Beer □ Wine □ Other _____
What do you consider yourself?
□ Non-Drinker □ Social Drinker □ Moderate Drinker □ Heavy Drinker □ Alcoholic □ Former Alcoholic
Do you use any other recreational drugs? □ Yes □ No
if yes: What do you use? □ Cocaine □ Marijuana □ Other_____
How often & How much?_____
Do you exercise? □ Yes □ No If yes: How often?_____ For how long?_____
What type?_____
Do you drink caffeine? □ Yes □ No If yes: How often?_____ How much?_____
Do you drink water? □ Yes □ No If yes: How many ounces per day?_____
Do you like your work? □ Very Satisfied □ Satisfied □ Unsatisfied
Are you sexually active? □ Yes □ No
If yes: Are you trying for pregnancy? □ Yes □ No
If not trying, please list contraceptive/barrier used_____
Any discomfort with intercourse? □ Yes □ No

Do you live alone? □ Yes □ No If no, who do you live with?_____

Do you have frequent falls? □ Yes □ No
Do you worry about falling? □ Yes □ No
Do you use a cane or walker to assist you in walking? □ Yes □ No

Year of last: Tetanus Shot_____ Flu Shot _____ Pneumonia Shot_____ Shingles Shot_____

Specialists

Name/Group	What for?

Mark the box of all of the symptoms you are experiencing

General	☐ Fever ☐ Night Sweats ☐ Unexplained Weight Loss or Gain ☐ Fatigue ☐ Appetite Changes ☐ Lack of Energy ☐ Sleeping Issues ☐ Fever ☐ Weakness
Skin	☐ Rashes ☐ Cancers ☐ Change in hair, skin, or nails
Eyes	☐ Glasses ☐ Far Sighted ☐Near Sighted ☐ Vision Changes ☐ Discharge ☐ Contacts ☐ Pain Diabetics, Date of last eye exam_____
Ears, Nose, Throat	☐ Ear Pain ☐ Change in Hearing ☐ Hearing Impaired ☐ Hearing Aids (☐ Right ☐Left ☐ Bilateral) ☐ Persistent Runny Nose ☐ Congestion ☐ Sputum/Phlegm ☐ Sinus Trouble ☐ Sore Throat ☐ Change in Voice
Heart	☐ Chest Pain ☐ Swelling in Ankles ☐ Palpitations ☐ Heart Murmur
Lungs	☐ Cough ☐ Short of Breath ☐ Wheeze
Gastrointestinal	☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Abdominal Pain ☐ Gas Pain ☐ Heart Burn ☐ Angina ☐ Blood in Stool ☐ Ulcers ☐ Constipation ☐ Change in Bowel Movements
Genital/Urinary	☐ Blood in Urine ☐ Painful or Frequent Urination ☐ Difficulty Urinating ☐ Smell to Urine ☐ Issues controlling Urination Women: ☐ Vaginal Discharge ☐ Change in Menstrual Cycle ☐ Breast tenderness/lumps/discharge ☐ Menstrual tension, pain, bloating, irritability at or around time of period ☐ Heavy periods, irregularity, spotting ☐ Hysterectomy ☐ Mastectomy Age at onset of menstruation _____ Date of last menstruation_____ Period every _____ days Usual duration_____ days How many pregnancies?_____ Born alive_____ Still born_____ Premature_____ Miscarriages_____ Abortions_____ Cesarean Sections_____ Any complications?_____ ☐ Currently Pregnant How far along?_____ ☐ Currently Breastfeeding Date of last mammogram_____ Date of last pap smear_____ ☐ Hot flashes/Menopausal Symptoms Date of last bone density_____ Men: ☐ Testicular pain/swelling ☐ Decreased urinary stream ☐ Penile discharge ☐ Change in Sexual Function ☐ Difficulty with erection or ejaculation ☐ Urination during the night Number of times_____ Date of last prostate exam_____ Last PSA (Prostate Blood Test)_____
Orthopedic	☐ Painful Joints ☐ Muscle Weakness ☐ Numbness/Tingling
Neuro/Psych	☐ Seizures ☐ Tremors ☐ Paralysis ☐ Frequent Headaches ☐ Dizziness ☐ Fainting Spells ☐ Depression ☐ Anxiety ☐ Stress issues ☐ Frequent crying ☐ Suicide attempt ☐ Though of hurting yourself or others ☐ Been to a counselor
Allergies	☐ Hives ☐ Hay Fever ☐ Pet Dander ☐ Nuts
Circulation	☐ Leg Swelling ☐ Blood ☐ Bruise easily ☐ Bleed easily