Previous balances will be paid before reacceptance

ACC patients must

Name: ______________________ DOB: _______________________
Last 4 of SS#: _____________ Phone:______________________
Address:_________________ ____________________
____
____

Please provide a copy of insurance card with this form

New Patient Past Medical History Form

Have you been seen by a doctor anywhere in the last 5 years? Yes No
Do you have a Medicare Advantage plan? Yes No
(**We only accept traditional Medicare**)

Reason for wanting to establish care? (general wellness, problems, etc)
____
____
____

Surgical History (Type, body part, date):
____
____
____

Family History: (Alive, deceased, medical problems)
Father:____
____
____
Mother:____
____
____
Siblings:____
____
____
Other:____
____
____

Allergies:____
____
____

Medications:______________________________________
____
____
____
____

Do you have any relatives that are patients of the practice?
Yes No
If yes, whom and relationship:
____
____

Primary Insurance:_________________________________
Name of Insured:__________________________________
Insured's DOB:____________________________________
ID/Policy #: _____________________________________
Group#: ____
Insured's SS#: ____________________________________

Is the insured a patient here? If no, Insured's address:
____
____
____

If someone other than the patient is responsible for payments:
Name of responsible party: __________________________
Relationship to patient: _____________________________
Phone number: __________________________________
Address if different from patient:
____
____
____

Signature: _________________________________

Date: _______________

LOVELACE FAMILY MEDICINE, PA

Authorization **Request for** Disclose Health Information

Patient Name: ____ PHONE #____________________
Date of Birth: _______________________________ Chart Number: ___________________________

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:
   Name: ____
   Address: ____
   ____
3. The type and amount of information to be used or disclosed is as follows:

   problem list
   medication list
   immunization record
   most recent history and physical
   most recent provider encounter
   procedure record
   laboratory results Dates: from ___________ to ____________
   x-ray and imaging reports Dates: from ___________ to ____________
   office notes Dates: from ___________ to ____________
   entire record
   Other: ____
   ____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
5. This information may be disclosed to and used by the following individual or organization:
Name: **Lovelace Family Medicine, PA** **803-364-4852/FAX 803-364-2014**
Address**: PO Box 630, 600 N. Wheeler Avenue**
Prosperity, SC 29127
Purpose of Release:
   Medical Care Legal representation
   Other: ____
6. I understand that I have a right to revoke this authorization at any time. I must revoke this authorization in writing to the privacy officer of this practice. If I revoke this authorization, I understand that the revocation will not apply to information that has already been released. Unless otherwise revoked, this authorization will expire in six months from the date of authorization.
7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to assure treatment by my healthcare providers. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal or state privacy rules. If I have questions regarding the disclosure of my health information by this practice, I can contact the privacy officer.

_____________________________________ _____________________________________
Signature of Patient or Legal Representative Date

_____________________________________ _____________________________________
Relationship to Patient Signature of Witness

____
Description of Representative's Authority (attach any necessary documentation)