



WELCOME TO COLUMBUS INTERNAL MEDICINE

Dear Patient:

The physicians, manager and staff of Columbus Internal Medicine would like to take this opportunity to welcome you to our practice.

In your New Patient Packet, you will find general information about the office and forms for you to fill out and bring with you to your appointment. We also ask that you arrive 15 minutes prior to your scheduled appointment so we may complete the registration process. Also, we ask that you bring your insurance card(s), photo I.D. and any applicable co-pay as required by your insurance company.

We are located at 4605 Sawmill Road, Suite 102 in Columbus between Bethel and Henderson roads. Our suite is on the lower level of the Orthopedic Center of Excellence building with a convenient entrance to our suite and free parking in the back of the building.

Please feel free to contact our office if you have any questions. Our staff will be happy to assist you.

We look forward to meeting you and helping with all your healthcare needs.

Central Ohio Primary Care / Columbus Internal Medicine
(COPC / CIM)

PATIENT REGISTRATION FORM - Please print clearly

Today's Date: _____ Patient Name: _____ Date of Birth: _____ Age: _____

Address: _____ Home Phone: _____ Email: _____

City: _____ Work Phone: _____ Employer: _____

State: _____ Zip Code: _____ Cell Phone: _____ Occupation: _____

Social Security Number: _____

Marital Status: S M D W Spouse Name: _____ Spouse Date of Birth: _____
Spouse SS#: _____ Address: (if different) _____

NEAREST RELATIVE / EMERGENCY CONTACT OTHER THAN SPOUSE:

Name: _____ Relationship: _____ Phone(s): _____

PERSONAL CONSENT FOR CARE AND TREATMENT:

** I authorize Columbus Internal Medicine to provide care and treatment under my physician's direction:*

Patient Signature

CIM Staff Witness

Alternate Consent: IF APPLICABLE -

** I authorize Columbus Internal Medicine to provide care and treatment for _____, who is unable to give
(patient name)
consent because he/she is a minor OR is unable to comprehend OR is other wise unable to personally give consent at the time of treatment.*

Alternate Signature

Relationship of person signing

CIM Staff Witness

INSURANCE INFORMATION / PRIVACY NOTIFICATION / ACKNOWLEDGEMENT :

In order for us to submit an accurate claim to your insurance company, please be prepared to present your insurance card(s) at every visit.

** By signing below, I acknowledge that I have been offered a copy of the privacy practices policy for COPC/CIM.*

Patient Signature

Date

** I am aware that appointments not cancelled within 24hours of my appointment will result in a \$25.00 fee for an office visit and \$50.00 for a complete physical that will not be billed to insurance.*

Patient Signature

Date

RELEASE OF INFORMATION AND PAYMENT AUTHORIZATION: I hereby authorize COPC/CIM and/or any of its representatives to submit a claim to my insurance carrier to issue payment directly to COPC/CIM and/or physician(s) rendering service. I authorize the release of any and all medical information to my insurance carrier or its intermediaries regarding services rendered. MEDICARE / MEDICAID: I certify that the information given by me in applying for payment under Title XV111 of the Social Security Act is correct. I authorize any holder of medical or other information about me to release it to the Social Security Administration, Medicare, Medicaid or its intermediaries. I authorize and request that payment be made directly to COPC/CIM. Guarantee of Payment: I understand that filing a claim with my insurance company or other third party payer, under any circumstances, does not relieve me from my responsibility for the payment of all charges. I further acknowledge that I am responsible for the payment of all charges for services rendered by COPC/CIM to me or the patient as indicated. By signing this document I personally guarantee the payment of these charges for medical services rendered. This includes, but is not limited to claims filed due to personal injury, accidents or illness. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

PATIENT SIGNATURE: _____ **DATE:** _____

RESPONSIBLE PARTY: _____ **DATE:** _____

if other than patient ** If patient is 18 years or older, his/her signature is required, in addition to the 'Responsible Party.'*

Columbus Internal Medicine
Request For Confidential Communication
New Patient Forms

Name: _____ SSN: _____ DOB: _____

Primary Physician: _____ Date of Request: _____

I hereby request to receive confidential communications from the practice in the following manner:

Phone number(s) where I wish to be contacted: _____

Alternate address where I would like my protected health information mailed to me **if different** from my current address on my chart today:

Street: _____ City: _____ State/Zip: _____

Other confidential communication request: _____

1) You may leave limited protected health information on my voicemail or answering machine (lab or test results, information about scheduling or prep for a test or procedure, or information regarding follow up with specialists):
please circle choice – **YES NO**

2) You may communicate my protected health information with a family member:

please circle choice – **YES NO**

If you circled YES, please list family member(s):

Effective date will be today unless you specify other wise. _____

I understand that COPC/CIM will notify me if COPC/CIM is unable to comply with my request. I also understand that my protected health information may be released as my physician determines appropriate in an emergency.

Signature of the Patient: _____ Signature of Guarantor: _____

(Sign if Patient is a Minor)

* Note: COPC reserves the right to communicate sensitive health information only directly to the patient.

The Health Insurance Portability and Accountability Act of 1996 requires that health care providers offer patients a copy of the office Notice of Privacy Practices and make a good faith effort to obtain an acknowledgment of receipt of same. You may refuse to sign this acknowledgment form.

By signing this form, I confirm that I have been offered this office Notice of Privacy Practices for COPC/CIM.

Print Name _____ Sign Name _____ Date _____

Office Use Only:

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Policy Acknowledgement, but was unable to do so as documented below:

Date: _____ Staff Initials: _____ Reason: _____

**COLUMBUS INTERNAL MEDICINE
NEW PATIENT QUESTIONNAIRE**

Date: _____

Patient Name: _____

Date of Birth: _____

What is the reason for your visit today? _____

**If you are here for a Preventative, or 'Well Visit', and more than two diagnosis or problems are listed and addressed, your visit will not be considered or billed as a preventative or well visit and you will be asked to make another appointment for your preventative or well visit for another date. We will not change diagnosis codes after your claim has been submitted to your insurance company in order to qualify your visit as a preventative exam if you were seen for two or more problems as stated previously.*

Please list your current medications and check the box if you need REFILLS today OR WILL NEED THEM in the near future:

- _____
- _____
- _____
- _____

Medication Allergies

List allergies to any medications and the type of reaction associated with the allergy:

Name of Drug	Reaction
_____	_____
_____	_____
_____	_____

Surgery History

List any past surgeries and the date of the surgery:

Surgery	Date
_____	_____
_____	_____

Social History

- Do you use Alcohol? If yes, list average amount per week No Yes _____ / week
- Do you use tobacco? If yes, list type/amount/how long No Yes _____ type / _____ amount / _____ how long
- Do you use recreational drugs? If yes, list type / amount No Yes _____ type / _____ amount
- Do you have a particular diet? If yes, list type of diet No Yes _____
- Do you use Caffeine? If yes, list type / amount No Yes _____ type(s) / _____ amount per day
- Do you have any recent lifestyle changes? If yes, please list type of change (ex., marriage, job change, etc.) No Yes _____
- Do you exercise? If yes, list what kind of exercise No Yes _____
- What is your occupation? How many hours do you work? _____ job / _____ hrs per week
- Any known exposures from your job/activities? No Yes _____ type
- What is your spouse's occupation? _____
- Do you wear a seat belt? No Yes

Patient Name: _____

Health Maintenance History

When was your last CHOLESTEROL test done? _____

When was your last EYE EXAM? _____

When was your last COLONOSCOPY? _____

When was your last BONE DENSITY test? _____

*** Females – please answer this section**

Date of last Menstrual Period _____

Date of last Pap Smear Test _____

Date of last Pelvic Exam _____

Date of last Mammogram _____

Are you sexually active? NO YES

Are you using birth control? NO YES

If yes, please specify type _____

Are you pregnant or could you be pregnant? NO YES

Are you nursing? NO YES

*** Males – please answer this section**

Date of last PSA (prostate) Test _____

Are you sexually active? NO YES

IMMUNIZATIONS / VACCINES

Please list the last date you had any of the following injections:

TETANUS _____

PNEUMONIA _____

SHINGLES (Zostavax) _____

HPV (Gardasil) _____

Other _____

ADVANCE DIRECTIVES

Do you have a living will? No Yes

Copy of living will at our office? No Yes

Are you an Organ Donor? No Yes

Do you have Power of Attorney for HEALTHCARE? No Yes

-If 'yes', please write their name and relationship to you on the line below:

Name of POA for Healthcare Relationship

How did you hear about Columbus Internal Medicine? _____

Patient Name: _____

REVIEW OF SYSTEMS

Are you experiencing any of the following TODAY? Please circle your response 'No' or 'Yes'

General / Constitutional Symptoms

Fever NO YES
Chills NO YES

Skin

Rash NO YES
New Lesion(s) NO YES
Change in Moles NO YES

Eyes

Blurred Vision NO YES
Changes in Vision NO YES

Ears

Ear Pain NO YES
Difficulty Hearing NO YES

Nose

Nasal Congestion NO YES
Nasal Discharge NO YES
Nasal Bleeding NO YES

Mouth / Throat

Mouth Pain NO YES
Neck Pain NO YES
Neck Swelling NO YES
Throat Pain NO YES
Throat Swelling NO YES

Respiratory

Shortness of breath NO YES
Cough NO YES
Wheezing NO YES

Cardiovascular

Palpitations NO YES
Chest Pain NO YES
Swelling in Extremities NO YES
Fainting NO YES
Leg Cramps with walking NO YES

Genitourinary

Painful Urination NO YES
Frequency with Urination NO YES
Urgency with Urination NO YES
Hesitancy with Urination NO YES

Gastrointestinal

Nausea NO YES
Vomiting NO YES
Diarrhea NO YES
Constipation NO YES
Abdominal Pain NO YES
Rectal Bleeding NO YES
Blood in Stool NO YES

Musculoskeletal

Joint Pain NO YES
Muscle Pain NO YES
Back Pain NO YES

Neurological

Localized Numbness NO YES
Weakness NO YES
Tingling NO YES
Headaches NO YES

Endocrine

Fatigue NO YES
Heat Intolerance NO YES
Cold Intolerance NO YES
Weight Loss NO YES
Weight Gain NO YES
Increasing Thirst NO YES

Hematoimmunologic

Easy Bruising NO YES
Easy Bleeding NO YES
Oral Ulcerations NO YES
Recurrent Infections NO YES

Have you ever had a blood transfusion NO YES

Psychiatric

Depression NO YES
Anxiety NO YES
Substance Abuse NO YES
Suicide Attempts NO YES

Do you have problems sleeping? NO YES

How many hours per night do you usually sleep? _____

Patient Name: _____

PERSONAL / FAMILY HISTORY

Please check the box if applicable to you or a family member. Please list the relationship for family history (ex., 'mother', etc.) and age if known.

<u>PROBLEM</u>	<u>SELF / AGE</u>	<u>FAMILY MEMBER / AGE</u>
Alcoholism	<input type="checkbox"/> _____	<input type="checkbox"/> _____ / _____
Asthma / Allergies	<input type="checkbox"/> _____	<input type="checkbox"/> _____ / _____
Bleeding / Clotting Disorder	<input type="checkbox"/> _____	<input type="checkbox"/> _____ / _____
Cancer *please specify type	<input type="checkbox"/> _____	<input type="checkbox"/> _____ / _____
Diabetes	<input type="checkbox"/> _____	<input type="checkbox"/> _____ / _____
Glaucoma	<input type="checkbox"/> _____	<input type="checkbox"/> _____ / _____
Heart Disease:		
M.I. (Heart Attack)	<input type="checkbox"/> _____	<input type="checkbox"/> _____ / _____
Stents	<input type="checkbox"/> _____	<input type="checkbox"/> _____ / _____
Bypass Surgery	<input type="checkbox"/> _____	<input type="checkbox"/> _____ / _____
Other Cardiac Condition	<input type="checkbox"/> _____	<input type="checkbox"/> _____ / _____
High Blood Pressure	<input type="checkbox"/> _____	<input type="checkbox"/> _____ / _____
Kidney Disease	<input type="checkbox"/> _____	<input type="checkbox"/> _____ / _____
Mental Illness:		
Anxiety	<input type="checkbox"/> _____	<input type="checkbox"/> _____ / _____
Bipolar	<input type="checkbox"/> _____	<input type="checkbox"/> _____ / _____
Depression	<input type="checkbox"/> _____	<input type="checkbox"/> _____ / _____
Substance Abuse	<input type="checkbox"/> _____	<input type="checkbox"/> _____ / _____
Migraine	<input type="checkbox"/> _____	<input type="checkbox"/> _____ / _____
Osteoporosis	<input type="checkbox"/> _____	<input type="checkbox"/> _____ / _____
Stroke	<input type="checkbox"/> _____	<input type="checkbox"/> _____ / _____
Thyroid Disease	<input type="checkbox"/> _____	<input type="checkbox"/> _____ / _____
Other	<input type="checkbox"/> _____	<input type="checkbox"/> _____ / _____

Mother's current age if applicable

Father's current age if applicable

