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Amico, Stock & Associates  
Amy R. Kelley, MD  
Arlington-Mill Run  
Building Blocks Pediatrics  
Capital City Medical  
Association  
Central Ohio Medicine  
Columbus Infectious  
Disease  
Columbus Internal Medicine  
COPC Hospitalists  
COPC Internal Medicine  
Group  
COPC Metro West  
COPC Westerville  
Dublin Internal Medicine  
EMG & Rehabilitation  
Fairway Family Physicians  
Family Medicine &  
Pediatrics at Winchester  
Square  
Family Medicine North  
Family Physicians of  
Gahanna  
Family Practice Center of  
Westerville  
Harris & Associates  
Jasonway Internal Medicine  
J. William Wulf, MD  
LaHue, Gramann, Bucci,  
Boezi  
Marysville Primary Care  
May & Broyles  
Family Physicians  
McConnell Family  
Practice  
Michael R. Ports, MD  
Northside Internal Medicine  
Northwest Family  
Physicians  
Ohio Center for Pediatrics  
Parsons Avenue Medical  
Clinic  
Professional Pediatrics of  
Hilliard  
Provider Physicians East  
Provider Physicians North  
Riverside Infection  
Consultants  
Riverside Medical Group  
Riverside Pediatric  
Association  
Step By Step Pediatrics  
Stonegate Family Health  
Suburban Internal Medicine  
Tallo & Associates  
Tri County Family  
Physicians  
Westerville Internal  
Medicine  
Westerville Medical  
Associates  
Worthington Internal  
Medicine  
Same Day Care Center  
Winchester Laser Cosmetic

## To Our Patients:

You are scheduled to come in for a preventative health assessment and physical exam. Enclosed are forms that you will need to complete and bring in with you when you come. Your exam should take 20-30 minutes depending on your current health status. You should come in after a 12-hour fast unless you have made other arrangements for laboratory work. You may have as much water and black coffee as you would like.

There have been many changes in the health insurance industry in the past few years and we all share the confusion. Physicals exams or preventative medical exams are covered under many health insurance plans, but not by all. You should check with your insurance carrier to determine what benefits you have for this type of exam.

If Medicare is your primary insurance, routine physicals are not a covered benefit. If you have on going health problems that will be assessed at the time of our exam, part of the exam may be covered. As confusing as it may seem, Medicare will usually pay benefits for the part of the exam that is considered due to illness but will not cover the part that is considered to be preventative or routine. The amount covered depends on the complexity of your medical problems. For example, if you have many complex problems, a large part of the exam may be covered but not all of it. If you have no medical problems, Medicare may not cover the services at all.

This may seem like a change from the past, but with health care benefits, change is the only constant. The above method of determining benefits for preventative health assessments is based on the most current information we can get from Medicare.

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Susan Goodlive, M.D.  
Jennifer Forbush, R.N., CNP



**CENTRAL OHIO  
PRIMARY CARE**

<b>PATIENT INFORMATION</b> Please print & complete the form and bring it to your appointment.				<b>TODAY'S DATE</b>	
Name	DOB:	Age:	Sex: M F	SS#	
Address:		Phone <i>primary</i> : ( )		Phone <i>alternate</i> : ( )	
City:	State:	Zip:		Cell # ( )	
Employer:	Employer Address:		City:	State:	Ph: ( )
Marital Status: S M D W		Spouse Name:		Spouse DOB:	Spouse SS #
Spouse Address if different		City:	State:	Zip:	Spouse Ph. ( )

**NEAREST RELATIVE (EMERGENCY CONTACT) OTHER THAN SPOUSE:**

Name	Relationship:	Ph:			
Address:	City:	State:	Zip:		

**Personal consent for care and treatment:**

I authorize Dublin Internal Medicine and/or Central Ohio Primary Care Physicians to provide care and treatment under my physician's direction.

\_\_\_\_\_

Patient Signature & Date

\_\_\_\_\_

Witness (office staff) & Date

**ALTERNATE CONSENT:**

**I hereby authorize Dublin Internal Medicine and/or Central Ohio Primary Care Physicians to provide care and treatment for \_\_\_\_\_, who is unable to give consent because he/she is a minor, is unable to comprehend, or is other wise unable to personally give consent at the time of treatment.**

\_\_\_\_\_

Relationship to patient      Date      alternate signature      Witness (office staff)

**INSURANCE INFORMATION:**

**In order for Central Ohio Primary Care Physicians to submit an accurate claim to your insurance company, please be prepared to present your insurance card (s) at each and every visit.**

By signing below I acknowledge that I have been offered a copy of the privacy practices for COPC/Dublin Internal Medicine. Name: \_\_\_\_\_ Date: \_\_\_\_\_

I am aware that appointments not cancelled with 24 hours notice will result in a \$25.00 fee that will not be billed to insurance. Signed \_\_\_\_\_

**Please present your insurance cards at every appointment. To submit a claim to your insurance company, we will need complete and accurate insurance information. Thank you.**

**RELEASE OF INFORMATION AND PAYMENT AUTHORIZATION**

**All other Insurance companies and/or third party payers:** I hereby authorize Central Ohio Primary Care Physicians, Inc. and/or any of its representatives to submit a claim to my insurance carrier or its intermediaries to issue payment directly to Center Ohio Primary Care Physicians, Inc. and or physicians(s) rendering service. I authorize the release of any and all medical information to my insurance carrier or its intermediaries regarding services rendered.

**Medicare and Medicaid:** I certify that the information given by me in applying for payment under Title XVIII 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 or carriers any and all information for this or related Medicare of Medicaid claim. I authorize and request that payment be made directly to Central Ohio Primary Care Physicians, Inc. **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 Central Ohio Primary Care Physicians, Inc 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 for Worker's Compensation and/or claims due to personal injury, accidents or illnesses.

I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

(If patient is 18 years or older, his/her signature is required, in addition to the "responsible party".

**RESPONSIBLE PARTY:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

(if other than patient)



Name: \_\_\_\_\_

**Medication allergies or reactions:**

Medication	Reaction	Medication	Reaction
1.		3.	
2.		4.	

**Family History:**

Family Member	Age(s)	Living	Deceased	Diseases
Father				
Mother				
Brother (s) # _____				
Sisters (s) # _____				

**Diseases in the family:** Check all that apply

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Liver disease     |
| <input type="checkbox"/> Heart disease         | <input type="checkbox"/> Mental illness     | <input type="checkbox"/> Bleeding Problems |
| <input type="checkbox"/> High blood pressure   | <input type="checkbox"/> Addiction problems | <input type="checkbox"/> Arthritis         |
| <input type="checkbox"/> High cholesterol      | <input type="checkbox"/> Kidney disease     | <input type="checkbox"/> Other             |
| <input type="checkbox"/> Details / Other _____ |   |  |

**Social History:**

Do you smoke?  NO  YES \_\_\_ packs per day for \_\_\_ years. Other tobacco products \_\_\_\_\_  
Do you drink alcohol?  NO  YES  Beer  Wine  Liquor. How many drinks per week? \_\_\_\_\_  
How many servings of caffeine per day? \_\_\_\_\_  Coffee  Tea  Sodas  
Any recreational drug use?  NO  YES Type \_\_\_\_\_  
Occupation \_\_\_\_\_ Any known occupational exposures? \_\_\_\_\_  
Do you exercise regularly?  Yes  No How many times per week? \_\_\_\_\_ Type of exercise \_\_\_\_\_

**Preventative Care:**

Last Colon and Rectal Cancer screening:  Rectal exam  Checking for blood  Sigmoidoscopy  
 Colonoscopy  Barium Enema Date \_\_\_\_\_  
Do you use your seatbelts / shoulder restraints?  Yes  No

**Immunizations:**

Immunizations:	Date	Immunizations:	Date
Tetanus		Hepatitis A	
Influenza		Hepatitis B	
Pneumonia			

**For our Female Patients:**

Last PAP test \_\_\_\_\_ Last mammogram \_\_\_\_\_ Do you do self-breast exams?  Yes  No  
Menstrual or period problems:  Irregular  Heavy  Change in frequency \_\_\_\_\_  
Have you gone through menopause?  Yes  No  
Number of pregnancies \_\_\_\_\_ Live births \_\_\_\_\_ Vaginal \_\_\_\_\_ C-section \_\_\_\_\_ Miscarriages \_\_\_\_\_  
Can you think of anything else that you think we should know about your health and lifestyle that is not listed here?  
\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_

**Review of Systems (Symptom Review):** Check all that apply:

**Constitutional:**  Fever  Chills Sweats  Weight gain / Loss  Fatigue  Weakness  
 Dizziness (room spinning)

**Head:**  Headache  Sores  Sinus pressure or pain

**Eyes:**  Blurred vision  Double vision  Eye pain  "floaters"  
 Excess tearing  Irritation

**Ears:**  Ear pain  Decreased hearing  Dizziness (light headed, room spinning)  Ringing

**Nose:**  Congestion  Post nasal drip  Difficulty breathing through nose  Frequent nose bleeds

**Throat:**  Sore throat  Fullness or sensation of mass  Difficulty swallowing

**Neck:**  Neck pain  Fullness or mass

**Chest:**  Chest discomfort (pain, pressure, fullness squeezing) with exertion or exercise  Heart pounding  
 Heart racing  Shortness of breath while lying down or with exertion (out of proportion to activity)  
 "skipping beats"

**GI:**  Nausea  Vomiting  Abdominal pain  Excess belching  
 Heartburn  Cramps  
 Diarrhea  Constipation  Blood in stool  Change in frequency of stools

**Genitourinary:**  Pain with urination  Increased frequency of urination  Getting up more than twice a night  
 Blood in urine  Sexual problems  Difficulty with erections  Vaginal pain  
 Vaginal discharge

**Musculoskeletal:**  Joint pains  Muscle weakness  Muscle pain  Back pain

**Skin:**  Rash  Sores  Moles that are changing  Itching  Dry skin  
 Eczema

**Neurological:**  Numbness  Tingling  Weakness  Speech abnormalities  
 Abnormal movements

**Psychological:**  Anxiety  Eating disorder  Obsessive behavior  Depression  
 Mood swings  Crying spells  Lack of motivation  Drug dependence  
 Alcohol problems

In the last 2 weeks, have you felt down, depressed or hopeless?  Yes  NO

In the last 2 weeks, have you felt little interest or pleasure in doing things?  Yes  NO

Reviewed with patient on \_\_\_\_\_ Signature \_\_\_\_\_



Office Use Only: P#: \_\_\_\_\_

Dr. #: \_\_\_\_\_

### ADULT REQUEST FOR CONFIDENTIAL COMMUNICATION

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

**(Please Print)**

Patient Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ DOB: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ **(Please Print)**

**You may communicate my protected health information with the following:**

**(Please Print)**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

You may leave limited protected health information on a voicemail or answering machine of the names listed above (lab or test results, information about scheduling or prep for a test or procedure or information regarding follow up with a specialist)

Yes \_\_\_\_\_ No \_\_\_\_\_

Address where I would like my protected health information mailed to:

Street \_\_\_\_\_ Apt \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_

You may leave messages on voicemail or Answering Machine **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

**I understand COPC will notify me if COPC 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 situation. I have been offered the office Notice of Privacy Practices for COPC** Yes \_\_\_\_\_ No \_\_\_\_\_

**Signature** of patient/legal guardian: \_\_\_\_\_ Date: \_\_\_\_\_  
(if over the age of 18/if under the age of 18)

**(Please Print)**

Name of person signing: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Office Use Only**

Date received: \_\_\_\_\_ Entered into Mysis: \_\_\_\_\_ Entered into IC: \_\_\_\_\_

Initials: \_\_\_\_\_