Johnston Medical Associates
Specialty Services

Name ____ Date of Birth : _______________________________

Right Handed / Left Handed _________________________________

Reason for visit : _______________________________________

Referring Physician : _______________________________________

Primary Care Physician : ____________________________________

Please list ALL medications you are currently taking, the dosage, and the times per day

CURRENT MEDICINES DOSE/FREQUENCY	Taken Today		CURRENT MEDICINES DOSE/ FREQUENCY	Taken Today	
	Yes No			Yes No	
	Yes No			Yes No	
	Yes No			Yes No	
	Yes No			Yes No	
	Yes No			Yes No	
	Yes No			Yes No	

Drug Allergies : yes / no If yes, please specify : ______________________________________

Have you ever had surgery ? YES NO If yes, please specify : ________________________________

What are your current or past medical conditions ? (Circle all that apply)

Anemia	**Arthritis**	**Bladder Disorder**	**Cancer**
Depression	**Diabetes**	**Fatigue**	**Headache**
Heart Disease	**High Blood Pressure**	**High Cholesterol**	**Infectious Disease**
Inflammatory Bowel Disease	**Kidney Disease**	**Liver Disease**	**Lung Disease**
Pain	**Respiratory Difficulty**	**Seizures**	**Sleep Disorder**
Stroke	**Ulcer or Stomach Disease**		**Vascular Disease**

Other conditions, please specify) : ____

Family Medical History : ____

Social History :

Married / Unmarried / other

School Status / Level of Education : ____

Drinking : ______________ Smoking (number of packs / day & duration) : ________________________________

Working History / Retired : ____

Do you currently have any of the following : (circle ALL that apply)

Anxiety	**Appetite Change**	**Abdominal Pain**	**Bleeding Tendency**
Blurred Vision	**Back / Neck Pain**	**Bruising**	**Chills**
Chest Pain	**Choking**	**Constipation**	**Diarrhea**
Energy Change	**Dry Mouth**	**Dry Eyes**	**Difficulty walking or standing**
Fever	**Hair Loss**	**Heat or Cold Intolerance**	**Headache**
Increased Thirst	**Joint Pain**	**Muscle Pain**	**Numbness / Tingling**
Palpitations	**Pneumonia**	**Psychosis**	**Rash**
Rhinitis	**Sore Eyes**	**Speech Difficulty**	**Suicidal Thoughts**
Swallowing Problems	**Urinary Incontinence**	**Urinary Urgency**	**Urinary Retention**
Vision Changes	**Weakness**	**Wheezing**	**Weight Gain / Loss**

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Personal Information
Today's Date : ______________________
Patient Name : _________________________ Date of Birth : ___________________
Address : ____
City : ________________________ State : _____________ Zip : ________________
Social Security : ___________________ Race : ________ Sex : _____ Marital Status : ______
Home # ___________________________ Mobile # __________________________________

Responsible Party (If Different From Patient)
Relationship to Patient : ___________________________________
Name : _________________________ Date of Birth : ___________________
Address : ____
City : ________________________ State : _____________ Zip : ________________
Home # ___________________________ Mobile # __________________________________
Employer : ____
Employer's Address : ____
City : ________________________ State : _____________ Zip : ________________

Emergency Contact Information :
Name : _________________________ Relationship to Patient : _______________________
Home # ___________________________ Mobile # __________________________________

Insurance Information
Primary Carrier Information :
Insurance Company Name : ____
Policy # _______________________________________ Group # _______________________
Subscriber Name : _________________________________ DOB: ______________________
Subscriber Address : ____
City ____________________________ State ___________ Zip ______________________
Social Security # ____

Secondary Carrier Information :
Insurance Company Name : ____
Policy # ____ Group # _____________________
Subscriber Name : _______________________________ DOB: ________________________
Subscriber Address : ____
City ________________________________ State ________________ Zip _________________

Johnston Medical Associates

Patient Authorization for Treatment & Payment

I hereby request and authorize the performance of such medical treatment or procedures as may be advised and ordered by my attending physician and/or consulting physician(s) for my care while I am a patient in this physicality. I further acknowledge that no guarantees or assurances have been given to me as the outcome of such treatment.

I authorize that all payments be made directly to the facility and/or the physician(s) accepting this assignment. I understand that I am responsible to the facility and/or the physician(s) for all charges incurred by me and not paid for by a third party payer.
Where Medicare benefits are applicable, I certify that the information given by me in applying for payment under the XVII or XIX of the Social Security Act is correct and request that said payment of authorized benefits be made on my behalf.

I understand that my physician(s) (except for the physicians employed by Johnston Memorial Hospital) the anesthesiologist(s), Emergency Department physician(s), pathologist(s), or radiologist(s) who may treat me as a patient or otherwise be involved in my care while I am a patient at the facility are not employees or agents of the facility and the facility does not assume any liability for their actions. I further understand that my physician(s), the anesthesiologist(s), Emergency Depatment physician(s), pathologist(s), and/or radiologist(s) will send me a separate bill for their services. Their bill will be an addition to the facility bill. The facility will include all other professional fees.

Clothing/Medication/Valuables

I understand that the facility is not responsible for patients' and/or visitors belongings kept in a patient's or visitor's possession. The term "belongings" shall include, but not limited to, clothing, medication, and/or valuable (for example, cash, checks, credit cards, documents, jewelry, furs, and leather coats, eye glasses, contact lenses, dentures, hearing aids, firearms/weapons, cell phones or other electronic devices and assisting or prosthetic devices.) The facility has offered me an opportunity to secure my valuables and medications.

Acknowledge of Receipt of Joint Notice of Privacy Practices

I acknowledge receipt of the facility's Joint Notice of Privacy Practices.

X __________________________________ ________________________ __________________

Patient or Authorized Representative Signature | Witness Signature | Date