STONELEIGH MEDICAL GROUP

David Burns, MD **Sejal Lauro, RPA-C** **Michael Grill, DO**

Office and Insurance Policies

1) Your co pay is due upon check in on the day of your visit.
2) You will be notified by your insurance company on their explanation of benefits what portion of the charges they will cover and what portion you will be responsible for paying. **Our office will send you a statement for these balances, which should be settled within 60 days**. Please contact our office to arrange for payment plans or other ways to settle your account fairly.
3) **Accounts not paid within 60 days of invoice are subject to 1.5% monthly finance charge**.
4) We participate with most insurance plans, please contact your insurer for questions regarding network coverage.
5) We reserve to right to charge a $25.00 fee for patients who do not show for their appointments, this charge is not covered by insurance.

Please initial in the space provided to confirm understanding of the above: _____

Patient E Mail Address: _____

Can your results be given to your spouse, parent, or family member? _____Yes _____ No

If yes, name: _____

Can your appointment confirmation be left on your answering machine? _____ Yes _____ No

Can normal test results be left on your answering machine? _____ Yes _____ No

Can your test results be faxed to another physician's office? _____ Yes _____ No

Name and address of Pharmacy_____

For State Regulatory Measures please answer the following questions:

Primary Language Spoken: _____ Race: _____ Ethnicity: _____

_____ _____

Patient's Signature Date

STONELEIGH MEDICAL GROUP

Patient Name: _____ Date of Birth: _____

Mailing Address: _____ City: _____ State: _____ Zip:_____

Social Security: _____ Gender: ☐ Male ☐ Female

Please check which phone number we can reach you at and leave a message.

□Home Phone: _____ □Work Phone: _____ □Cell Phone: _____

Emergency Contact Name: _____ Relationship to Patient: _____

Emergency Contact Phone Number: _____

Primary Care Provider: _____ Phone Number: _____

Pharmacy Name: _____ City: _____ State: _____

Mail Order Pharmacy Name: _____ Phone Number: _____

I grant permission to view my prescription history from external sources: □ Yes □ No

Insurance Information:

Primary Insurance: _____Policy # _____ Group # _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Secondary Insurance: _____Policy # _____ Group # _____

Subscriber Name: _____ Subscriber Date of Birth: _____

AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF BENEFITS, ADVANCED BENEFICIARY NOTICE

MEDICARE / MEDICAID

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr._____ for services furnished to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Dr._____ for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr._____ to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.

Signature: _____ Date: _____

Stoneleigh Medical Group

Patient History

Name: _____**Date:** _____
Language Preference: English Spanish Other: _____
Chief Complaint: _____**Allergies:** _____

Medical History:

Do you or any of your immediate family members have any of the following medical problems? For each problem, check all that apply.

Condition:	Self	Mother	Father	Sibling	Child
Anemia	☐	☐	☐	☐	☐
Anesthesia problem	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Bleeding disorder	☐	☐	☐	☐	☐
Bowel disease	☐	☐	☐	☐	☐
Breast cancer	☐	☐	☐	☐	☐
Bronchitis	☐	☐	☐	☐	☐
Cervical cancer	☐	☐	☐	☐	☐
Colon/rectal cancer	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Dizziness	☐	☐	☐	☐	☐
Emphysema / COPD	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐
Frequent headaches	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐
Hearing impairment	☐	☐	☐	☐	☐
Heart attack	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐	☐
Immunodeficiency disease	☐	☐	☐	☐	☐
Jaundice	☐	☐	☐	☐	☐
Kidney/bladder disease	☐	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐	☐
Lung disease	☐	☐	☐	☐	☐
Mental illness	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐
Prostate cancer	☐	☐	☐	☐	☐
Rheumatic fever	☐	☐	☐	☐	☐
Seizures/convulsions	☐	☐	☐	☐	☐
Stomach or intestinal problems	☐	☐	☐	☐	☐
Stroke / CVA of the brain	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐

Past Surgeries & Hospitalizations:

Please list corresponding dates.

1.
2.
3.
4.
5.

List of Medication, Vitamins & OTC's
1.
2.
3.
4.
5.
6.
7.

Do you have an Advance Directive?

Healthcare Proxy	Yes	No
Living Will	Yes	No
DNR	Yes	No

Social History:

	None	Daily	Weekly	Occasional
Tobacco	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐
Caffeine	☐	☐	☐	☐
Drug use	☐	☐	☐	☐
Stress	☐	☐	☐	☐
Violence	☐	☐	☐	☐
Exercise At-risk sexual contact	☐	☐	☐	☐

Preventative Exams	**Date**
Cholesterol	_____
Colonoscopy	_____
Mammogram	_____
Pelvic Exam/Pap	_____
Bone Density Scan	_____
Prostate Check	

Immunizations:	**Date**
Chicken Pox	_____
Hepatitis A Vaccine	_____
Hepatitis B Vaccine	_____
MMR	
_____	

Immunizations	**Date**
Influenza (Flu)	_____
Pneumovac	_____
Tetanus Vaccine	_____
Tv Test/ PPD	

Occupational History:

Occupation:

_____

Occupational Exposures:

_____

Stoneleigh Medical Group

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Consent to Obtain External Pharmacy History

Why are we asking for this?

An accurate prescription history reduces medication errors and enhances your safety.

When you authorize Stoneleigh Medical Group to access your external prescription history, you provide our staff with information about the medications you are already taking. This information will help Stoneleigh Medical Group to minimize adverse drug events.

Drug interactions are examples of an adverse drug event. When you sign this consent, you are agreeing that Stoneleigh Medical Group may request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.

The Consent Statement

I understand that the prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be accessed by my provider and Stoneleigh Medical Group. This may include prescriptions dating back several years.

My signature certifies, that I read and understood the scope of my consent and that I authorize the access.

Print Name _____ Date of Birth _____

Patient or Guardian Signature _____ Date _____