DR MARTIN IS CURRENTLY NOT ACCEPTING ANTHEM BLUE CROSS BLUE SHIELD INSURANCE. THIS INCLUDES ANTHEM MEDICARE AND ANTHEM MEDICAID

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NO PASSPORT MEDICAID

Thank you for your interest in using Health Quest Medical Care for your primary care needs. In an effort to use your time wisely at your first visit, we request that you fill out the enclosed forms completely. Please do not leave any blanks empty.

When you have finished filling out the forms, drop off at Health Quest Medical Care or mail the forms to Health Quest Medical Care. Once it has been reviewed, you will receive a call to schedule an appointment.

Thank you for your time and energy in completing the forms.

Jennifer A. Martin, M.D.

How did you hear about Health Quest Medical Care, PSC? ____________

Patient Information

Please print clearly - Confidentiality

Date: ____________ Age: ____ yrs/DOB__________ Marital Status: S, M, W, D, Sep (circle one)

Patient Name:______________________________ Sex: ____________

Home Address: ______________________________City____________Zip__________

Primary Phone:____________ Secondary number:____________ E-mail: ____________

SSN: ____________________ Occupation: ____________________

Employer's Name:____________________ Employer's Phone:____________________

Employer's Address: ____

Insurance Coverage: ____

Emergency Contact Name: ____________________ Relation: ____________

Primary Phone:____________________ Secondary number:____________________

Responsible Party if other than patient:

Name:______________________________ DOB: ____________

Home Address: ____

Primary Phone:____________________ Secondary number:____________________

SSN: ____________________ Occupation: ____________________

Employer's Name:____________________ Employer's Phone:____________________

Employer's Address: ____

Financial Agreement and Authorization for Treatment:
I authorize examination and any other medical services deemed necessary.

I agree to assume full financial responsibility for all charges by this practice, even if my insurance does not cover these services. I authorize payment of medical benefits to Health Quest Medical Care, for services provided. A copy of this can be considered an original for insurance purposes.

I authorized the release of any medical or information necessary to process is claimed to my insurance company, included but not limited to any medical service, test results, alcohol and drug abuse, psychiatric care, HIV testing results in financial reports. I also authorized the release of any test results, reports, and/or medical services, including but not limited to alcohol and drug abuse, psychiatric care, and HIV results to any physician I may be referred to.

If a minor under the age of 18,Ihereby authorize Health Quest Medical Care to provide any of the medical information to my parent or other legal guardian upon request of that parent or legal guardian. __________ Yes __________ No

Patient's signature: ______________________________ Date: ____________

Parent/Guardian (if minor) ______________________________ Date: ____________

New Patient Information

Please list **ALL** current medications you are currently taking including over the counter, vitamins, supplements, and anything taken on an as needed basis. (Please turn over for additional space if needed)

Name	Strength	Frequency

Allergies (please list drug and reaction, if any)

____

____

Past Medical History

Problem	Diagnosed Date	Problem	Diagnosed Date

Family History (Please specify who and if they are deceased)

Mother's Side: ____

____

Father's Side: ____

____

Past Surgical History

Surgery / Date

Surgery / Date

____

____

____

Have you ever had the following:

Colonoscopy: Yes / No If yes, Date :__________ Where? __________

Bone Density: Yes / No If yes, Date :__________ Where? __________

Mammogram: Yes / No If yes, Date :__________ Where? __________

Vaccines:

Flu Vaccine Yes / No Date : __________

Pneumonia Yes / No Date : __________

Prevnar 13 Yes / No Date : __________

COVID-19 Yes / No Date : __________

Tetanus Yes / No Date : __________

Zostavax Yes / No Date : __________

Shingrix Yes / No Date : __________

Do you work - Day shift, 2nd Shift. 3rd Shift, Swing Shift, other? __________

Tobacco Use: Never Former Current

If former when did you Start: __________Quit: __________ What form of tobacco did you use? __________

If current when did you start: __________ What form of tobacco do you use? __________

Alcohol Use: Never Occasional Moderate Daily If former when did you quit: __________

Illicit Drug Use: Never Occasional Moderate Daily If former when did you quit: __________

Do you have any diet restrictions? Yes / No If yes, what are they? __________

Do you regularly exercise? Yes / No If yes, how often: __________

What is your current daily water intake: __________

What is your current daily caffeine intake: __________

Do you currently see any other healthcare providers? Yes / No If yes please list below.

____

____

____

Confidentiality Release and Restriction Request

I, ____ have given Health Quest Medical Care, P.S.C. and its employee's permission to release my protected health information to the following person or persons.

Name of person	**Relationship**	**Phone Number**

☐Check if there is no one other than yourself we may release information to

Information that can be released to the above individual(s) Please check all that apply.

☐ All office visits and progress notes permitted by law

☐ Lab and test Results

☐ Diagnosis and treatment pan

In addition, I request that you:

☐ Continue to contact me with this information initially

☐ Notify the above specified individual, rather than me, with any information related to my health care.

Restriction Requested:

____

____

Patient Name: ____ D.O.B. ____________________

Patient Signature: ____ Date: ______________________

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I, ____, was given a copy of Health Quest Medical Care, PSC Notice of Privacy Practices.

Ways of Communication

Health Quest Medical Care will contact patients by e-mail and/or telephone. Messages will be left on any answering machine in a brief format or an extended format. Please choose one of the following

- ☐ Brief Message (example - please return call regarding labs/imaging)
- ☐ Extended Message (example – results of tests, medication information)

Patients can contact our office by phone, fax, or letter. Any Message left on our voicemail will be taken care of with 24 business hours and in the order, they are received. Any messages left on our voicemail after hours or on the weekend will be returned the next business day.

Patient Responsibility

- It is the patient's responsibility to provide Health Quest with correct telephone number(s), address, insurance information, and e-mail address. If anything changes, please let us know.
- If the patient is not going to show for an appointment for any reason, it is the patient's responsibility to notify the office within 24 hours prior to scheduled appointment. Failure to do so will result in a charge to the patient's account. Our current "No Show" policy states there will be a fee of $25.00 for failure to cancel within 24 hours and a $50.00 fee for No Showing your scheduled appointment. This must be paid in full prior to your next office visit.

I have read and agree to the above policies.

Signature: ____ Date: _______________

Consent for External Prescription Verification

Health Quest Medical Care uses a system that allows us to look at your prescription(s) filled by your pharmacy. We would have the ability to see any medications you have started through another healthcare professional or if anything was changed by another healthcare professional. We are informing you of this capability and asking for consent; this is not required but helps us to provide excellent patient care. Please sign and date giving us this access if this is something you are comfortable with.

Signature: ____ Date: ____________________

Current Pharmacy and Location: ____

Patient Portal

As a patient we have a patient portal that you may look up your personal medical history directly from your computer or smart phone. If you provide us with a valid e-mail address, we will provide you the website, user name and password to access your patient portal. How active and involved you are with your health care is dependent on you. If you would like to participate, please sign and date and provide a valid e-mail address.

E-Mail Address: ____

Signature: ____ Date: ________________

Health Quest Medical Care Controlled Substance Agreement

1. Your health care provider is or has considered using a medication that has an abuse/addiction potential and requires extra care on your part with use.
2. You may or may not receive medications that require a green prescription. The use of the green prescription pad indicates medications that are easily abused and have more stringent regulations. The decision to this type of medications made by the health care provider and based on
   a) Whether or not the medication will be effective for what you are experiencing.
   b) Whether the benefit of the medication use outweighs the risk of use.
   c) Your OWN personal medical history and physical exam.
   d) Your OWN ability to be compliant with the directions give to you.
3. Your health care providers may reduce or stop the medication(s) at anytime, if it is in your best interest. No harassment of the health care provider and/or staff will ever be tolerated. This will result in termination as a patient from the practice. This includes but is not limited to inappropriate language, multiple calls for controlled medications, or deception in trying to obtain these medications.
4. Your health care provider will decide what dose you will be taking and how often it is taken. Self-dosing will not be tolerated. The health care provider reserves the right, at any point in treatment, to refer you to a specialist.
5. Your prescriptions will be written at **scheduled appointments only**. Once you have received your prescription, you are required to turn it in to your pharmacy. No controlled medications will be filled after hours, weekends, or holidays.
6. You will only be allowed to fill your controlled medication at ONE pharmacy. Please designate the pharmacy you will be using. Pharmacy and Location - ______________________________. There are situations where it may require you to fill at another pharmacy. You must inform us of the change in pharmacy immediately. Failure to do so may result in termination of all controlled substances.
7. It is against the law to share your prescribed medication. It is your responsibility to keep it in a safe and secure place. If you lose your prescription or it is stolen you must file a police report.
8. It is your responsibility to know when your medication is running out, schedule your refill visits, and keep these appointments. If you miss an appointment and/or run out of medication you will have to wait until our next available appointment.**NO EXCEPTIONS.**
9. No other controlled medications, in the same class, will be obtained from any other physician. We reserve the right to call your pharmacy and check on your medications anytime. We reserve the right to require a pill count and you**MUST** bring in your bottle(s) at the time of visit.
10. You may be asked to obtain a random drug screen at anytime. If you fail to get your urine drug screen when asked you will be terminated.
11. Any medications that can potentially be abused will not be prescribed to patients who are abusing alcohol or using any illicit drugs. Some of these medications can impair your ability to operate machinery and/or drive a motor vehicle. You are not to drive with these types of medications. You are not to use alcohol or illicit drugs while you are using a controlled medication.

These rules are absolute concrete.
Any deviation from these rules will result in immediate termination from this practice.
NO EXCEPTIONS

Your signature below indicates you have read and understand this agreement, consent to treatment with a controlled medication, informed of side effects, aware of the risks and are willing to take those risks, and you will abide by this agreement.

Patient Name: ______________________________ Date of Birth: ______________

Patient's Signature: ______________________________ Date: ______________

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