INTERNAL
MEDICINE
ASSOCIATES
of TUSCALOOSA, P.C.

Name: ______________________________ Dr. ______________________________

Address: ______________________________ **Birthdate:** ______________________________

______________________________ **Social Security No.** ______________________________

______________________________ **Gender:** ______________________________

Home Phone: ______________________________ **Marital Status**: ______________________________

Race: ______________________________

Cell Phone: ______________________________ **Ethnic Group**: Hispanic/Non-Hispanic

Preferred Language: ______________________________

E-Mail Address: ______________________________ **Interpreter required?** ______________________________

PREFERRED CONTACT METHOD

☐ Home Phone ☐ Cell Phone ☐ Patient Portal

PREFERRED APPOINTMENT REMINDER METHOD

☐ *Home Phone* ☐ *Cell Phone* ☐ *Patient Portal*

Do you have a Living Will? Yes ☐ No ☐

Retired: ☐ Yes ☐ No Employer: ______________________________ Work Phone: ______________________________

Person to Notify in Case of Emergency: ______________________________ **Relationship**: ______________________________

Emergency Phone No. ______________________________

INSURANCE POLICY INFORMATION:

Primary Insurance: ______________________________ Relationship of Policy Holder:

Policy Holder Name: ______________________________ Birthdate of Policy Holder:

Employer of Policy Holder: ______________________________ Contract/Group: ______________________________

Secondary Insurance: ______________________________ Relationship of Policy Holder:

Policy Holder Name: ______________________________ Birthdate of Policy Holder:

Employer of Policy Holder: ______________________________ Contract/Group: ______________________________

CONSENT FOR TREATMENT: I consent to necessary treatment, including drugs, medicine, procedures, x-rays, lab tests and/or other studies that may be used by the physician, the nurse, or staff.

AUTHROIZATION FOR RELEASE OF INFORMATION: I understand that my information may be given to the insurance company with whom I have coverage, agencies which may be assisting with payment for my care, billing agencies, agencies responsible for reviewing payments and/or quality of care, and other governmental agencies. I give permission for release of this information.

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to Internal Medicine Associates of Tuscaloosa, P.C., of benefits otherwise payable to me including major medical insurance and payment of medical benefits, but not to exceed the charges of Cardiac Electrophysiology of Alabama for these services. I understand that I am financially responsible to Internal Medicine Associates of Tuscaloosa, P.C., for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverages are subject to coordination of benefits.

GUARANTEE OF ACCOUNT: In consideration of medical services rendered, the undersigned accepts all fees charged as lawful debt and agrees to pay Internal Medicine Associates of Tuscaloosa, P.C. insurance notwithstanding, for all said charges. Furthermore, undersigned agrees to pay the costs of collection including reasonable attorney's fees and court costs if such be necessary, waiving now and forever the right of exemption allowed to the constitution of laws of the State of Alabama or any other state. Undersigned further understands that Internal Medicine Associates of Tuscaloosa, P.C. does not accept insurance assignment as a guarantee of full payment.

Health Insurance Portability and Accountability Act (HIPAA)

I consent to the use or disclosure of my protected health information (PHI) by Internal Medicine Associates of Tuscaloosa, P.C. for the purpose of diagnosis or providing treatment to me, obtaining payment for my healthcare bills, or to conduct healthcare operations. I have received a copy of the Company's Notice of Privacy Practices. The Notice describes the types of disclosures of my PHI that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of the Company.

______________________________ ______________________________

Patient Signature Dated

INTERNAL MEDICINE ASSOCIATES of TUSCALOOSA, P.C.

PERSONALIZED HEALTH HISTORY

Date: ____________________

Name: ______________________________ Date of Birth ____________________

Reason for Visit & Current Problems: ______________________________

____

____

____

____

ALLERGIES or Reactions to Medications:

Name of Medication Allergic To	Reaction

CURRENT MEDICATIONS (Prescription, nonprescription, vitamins, home remedies, herbs, etcetera):

Name of Medication	Dosage	How Many Times per Day

Pharmacy Name and Location: ______________________________

Name of Mail Order Pharmacy: ______________________________

Mail Order Pharmacy ID# (Usually different from your medical insurance): ____________________

If you have Medicare D, what is the name of your company and ID#: ____________________

Do you use a DME company, for diabetic testing supplies, oxygen, CPAP, walkers, etcetera? ____________________

Company and Location: ______________________________

Name: ______________________________ Date of Birth ______________________

PAST MEDICAL HISTORY: Have you ever had the following:

____ Measles	____ Anemia	____ Back Trouble	____ Hemorrhoids
____ Mumps	____ Blood/Plasma Transfusion	____ Arthritis	____ Hernia
____ Chickenpox	____ Infectious Mono	____ Gout	____ Ulcer
____ Whooping Cough	____ Hepatitis/Jaundice	____ Diabetes	____ Irritable Bowel Syndrome
____ Scarlet Fever	____ Bleeding Tendency	____ Glaucoma	____ Frequent Bladder Infections
____ Diphtheria	____ Blood Clots	____ Bronchitis	____ Kidney Disease
____ Smallpox	____ Heart Disease	____ Asthma	____ Liver Disease
____ Pneumonia	____ Low Blood Pressure	____ Emphysema	____ Thyroid Disease
____ Rheumatic Fever	____ High Blood Pressure	____ Migraine Headaches	____ Gallbladder Disease
____ Tuberculosis	____ Mitral Valve Prolapse	____ Cancer	____ Alcoholism
____ Polio	____ Stroke/TIA	____ Venereal Disease	____ Mental Illness
____ Epilepsy/Seizure	____ Heart Murmur	____ AIDS/HIV	____ Hives/Eczema

OTHER TREATING PHYSICIANS

Physician Name	Specialty

IMMUNIZATIONS: Please provide the dates.

Influenza (Flu) ____________ Tetanus (Td) ____________ Pneumococcal ____________ Shingles ____________

Hepatitis A ____________ Hepatitis B ____________ Measles (MMR) ____________ Other ____________

HEALTH SCREENING:

Colonoscopy Date: ______________ Findings Normal? Yes / No Next Due Date ______________ Performed By:

Bone Density Test Date:____________ Findings Normal? Yes / No Sigmoidoscopy Date ____________ Eye Exam Date:

TB Skin Test Date: ____________ Findings Normal? Yes / No

Ladies:

Last Pap Smear Date ____________ Findings Normal? Yes / No Last Mammogram Date ________ Findings Normal? Yes / No

Gentlemen:

Last PSA Screening Date __________ Findings Normal? Yes / No

PAST SURGICAL HISTORY:

Operations	Date

Name: ______________________________ Date of Birth ______________________

PAST HOSPITALIZATIONS:

Reason for Hospitalization	Date/Place

PAST SERIOUS ILLNESSES:

Illness	Date

FAMILY HISTORY:

Is your *mother* still living? Yes / No If deceased, at what age? ________ Is your *father* still living? Yes / No If deceased, at what age?

What health problems does/did your *mother* have?

What health problems does/did your *father* have?

Does/did any other close blood relative have any health problems such as heart disease, high blood pressure, diabetes, cancer, etc.?

Please list and describe: ______________________________

____

____

SOCIAL HISTORY

Relationship Status: ____ Single ____ Married ____ Divorced ____ Separated ____ Widowed

Caffeine (cups/day): ____ Coffee ____ Tea ____ Soda ____ Energy drinks

Exercise regularly? Yes / No Do you follow a regular diet? Yes / No Recreational Drug Use? Yes / No

TOBACCO HISTORY

Do you currently use tobacco? Yes / No ____ Cigarettes ____ Cigars ____ Pipe ____ Smokeless Tobacco

Have you ever used tobacco? Yes / No How much do/did you smoke per day ______________ For how many years ____________

Did you quit? Yes / No When? _________ Do you wish to quit? Yes / No Have you ever tried to quit? Yes / No

ALCOHOL HISTORY

Do you drink alcohol? Yes / No If so, how much do you drink per week? ______________________________

Is your drinking a concern for you or others? Yes / No Explain: ______________________________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform my physician's office of any changes in my medical status.

______________________________ ______________________

Signature of Patient Dated

INTERNAL
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of TUSCALOOSA, P.C.

Gene Alldredge, M.D. F.A.C.P.
Jim P. Ellison, M,D.
Richard Shamblin, M.D.
James Brian Wilhite, M.D.
Jenna Cooper, CRNP

100 Rice Mine Road, N, Suite B
Tuscaloosa, Alabama 35406
(205) 349-4200
FAX (205) 349-4285
www.InternalMedicineTusc.com

CONSENT TO OBTAIN ELECTRONIC MEDICATION HISTORY

I understand that my medication history may be obtained utilizing an electronic information exchange and that this protected health information may provide valuable information for my healthcare provider. I hereby authorize Internal Medicine Associates of Tuscaloosa physicians to access my medication history without limitation or exclusion as is required and/or reasonably advisable to disclose, process, retrieve, transmit, and view for the purpose of the transmission of an electronic prescription issued by a provider authorized by law to prescribe, as necessary for my care and treatment.

____ ____________________________

Patient Signature Dated

Date of Birth: ______________________________

Patient Name: ______________________________

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PERMISSION TO RELEASE INFORMATION

If you anticipate the need for anyone else to have access to Protected Health Information about you, please complete the following below:

I (we,) the undersigned patient and/or responsible party hereby authorize Internal Medicine Associates of Tuscaloosa, PC, physicians, agents, employees, or representatives to discuss or release any or all patient information about me including but not limited to past and current medical information, billing information, appointment scheduling, prescriptions, etcetera to the person or persons indicated below:

_____ Spouse Name: ______________________________ Phone #. ______________

_____ Parents Name(s): ______________________________ Phone # ______________

_____ Children Names(s) ______________________________ Phone # ______________

_____ Other Name(s) ______________________________ Phone # ______________

______________________________ ______________________
Patient Signature Dated

Patient Name: ______________________________

Date of Birth: ______________________________

SS No. ______________________________

INTERNAL MEDICINE ASSOCIATES
Of Tuscaloosa, P.C.

ACKNOWLEDGEMENT & CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

You are receiving healthcare services from INTERNAL MEDICINE ASSOCIATES OF TUSCALOOSA, P.C. You agree that all records concerning your care within INTERNAL MEDICINE ASSOCIATES OF TUSCALOOSA, P.C. shall remain the property of INTERNAL MEDICINE ASSOCIATES OF TUSCALOOSA, P.C. You understand and agree that such information is used for: (1) your treatment - the provision and coordination of your healthcare which may require disclosure of all or any portion of your medical record information to your attending physician, consulting physician(s) and other health care providers who have a legitimate need for such information in the care and continued treatment of the patient; (2) payment for your services - billing, claims management, medical data processing, reimbursement and for determining coverage which may necessitate disclosure of such information to any insurance company, third party payor or other entity (or their authorized representatives), including any copies or excerpts of your medical record which are necessary for payment of patient's account; (3) routine healthcare operations -including, but not limited to, quality assurance, utilization review, medical review, internal auditing, accreditation, certification, licensing or credentialing activities of INTERNAL MEDICINE ASSOCIATES OF TUSCALOOSA, P.C.; and (4) medical research and educational purposes. You acknowledge that you have been provided with INTERNAL MEDICINE ASSOCIATES OF TUSCALOOSA, P.C. Notice of Health Information Practices that provides a more complete description of the uses and disclosures of the patient's healthcare information, and that the Notice has been reviewed prior to the signing of this consent. You understand that INTERNAL MEDICINE ASSOCIATES OF TUSCALOOSA, P.C. reserves the right to change the Notice and that INTERNAL MEDICINE ASSOCIATES OF TUSCALOOSA, P.C. will provide you with a revised Notice when you come to INTERNAL MEDICINE ASSOCIATES OF TUSCALOOSA, P.C.. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Restrictions Requested: ____

INTERNAL MEDICINE ASSOCIATES OF TUSCALOOSA, P.C.: _____Agree _____Not Agree _____N/A

Patient Signature: ___________________________________ Dated: ________________________

Witness Signature: __________________________________ Dated: ________________________