TOTAL CARE 280

AMY ILLESCAS, MD

Todays Date_____

Last Name_____ First name_____

WHAT IS THE PURPOSE OF YOUR VISIT TODAY?

[ ] Annual Exam Only- I am here for my "Annual wellness examination" which will include a physical exam and may include a pap smear. I require no other testing or evaluation other than a renewal of my current birth control or hormone replacement therapy which have been prescribed here in the past if applicable.

[ ] Annual Exam & Other Reason- I am here for my "annual wellness examination" but I also have a problem, complaint or issue that I need to have evaluated/discussed or I may require a new prescription or refill. I understand that my insurance will require a co-pay for any of these additional evaluations or where a prescription is given other than birth control or hormone replacement therapy.

[ ] Office Visit- I am not here for my "annual wellness examination" but for a specific problem, complaint, or recheck that I need evaluated or I am requesting a new prescription. I understand that my Insurance will require that a co-pay be made for these services.

What Specific issues would you like to discuss today?

1.)_____

Signed_____ Date_____

TOTAL CARE 280
AMY BENTLEY ILLESCAS, MD
2827 GREYSTONE COMMERCIAL BLVD
BIRMINGHAM, AL 35242

PATIENT INFORMATION

Date: _____ email address: (PRINT!) _____

Patient Name: _____

Date of Birth: _____Age: _____ Sex: M F Marital Status:_____

SS#: _____ Preferred Language: _____

Race: ___African Am ____Am Indian ____Asian ____Native Hawaiian ____White ____Other

Ethnicity: ____Hispanic/Latino _____ Non Hispanic/Latino

Phone: Home: _____ Work: _____ Cell: _____

PLEASE PROVIDE AT LEAST 2 TELEPHONE NUMBERS FOR US TO REACH YOU. FAILURE TO DO SO MAY RESULT IN DELAYS IN COMMUNICATING TEST RESULTS, ETC WITH YOU.

Address: _____

_____ZIP: _____

Occupation: _____

Employer: _____

Who referred you to us? _____

Primary Insurance: _____

Policy #: _____

Group #: _____

Who is the insured: _____

Relationship to patient: _____

Insured's date of birth: _____

Secondary Insurance: _____

Policy #: _____

Group #: _____

Who is the insured: _____

Relationship to patient: _____

Insured's date of birth: _____

Pharmacy name: _____

Address: _____

Telephone Number: _____

PLEASE COMPLETE THIS PAGE & RETURN WITH INSURANCE CARD & DRIVER'S LICENSE – THEN COMPLETE ADDITIONAL PAGES

SOUTHERN CARE INTERNAL MEDICINE, PC
Amy L. Illescas, MD

The following people have my permission to obtain or have discussed with them my Protected Health Information (PHI):

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

_____ I do not wish to list anyone. I do not want any information to be released.

I understand that you may be transmitting my medical records electronically to other doctors and authorize you to do so. If another party receives them in error, I absolve Total Care 280 (Amy Bentley Illescas, MD) of any and all liability to such submission of said records.

AUTHORIZATION TO LEAVE MESSAGES WITH OTHER PERSONS OR ON ANSWERING MACHINES/VOICE MAIL

I, the undersigned, authorize Southern Care Internal Medicine, PC to leave messages containing medical information, test results, doctor's recommendations on an answering machine/voice mail at the following phone number: _____

I the undersigned, authorize Southern Care Internal Medicine, PC to discuss my medical condition with the following person(s), which may include leaving a message with this person(s) regarding medical information, tests results or doctor's recommendations.

NAME	PHONE NUMBER	RELATIONSHIP

Patient Signature: _____ Date: _____

SOUTHERN CARE INTERNAL MEDICINE, PC
Amy Bentley Illescas, MD
2827 Greystone Commercial Blvd
Birmingham, AL 35242
(205)547-2323

Patient Name _____

Patient's Date of Birth: _____

ASSIGNMENT AND RELEASE

I, the undersigned, authorize my insurance carrier/worker's compensation, including Medicare, to pay benefits directly to Southern Care Internal Medicine, PC and furthermore authorize the release of any and all information required to process my claim to my insurance carrier, including the Centers for Medicare and Medicaid Services (CMS).

I understand I am responsible for all non-covered services, deductibles and co-pays. In the event of a nonpayment or denial of payment by my insurance carrier/workers compensation carrier, I agree to pay all amounts due within 30 days. If I fail to pay the balance due on my account, I will assume all costs of collections, including reasonable attorney's fees as well as the legal rate of interest on the account until paid in full.

CONSENT FOR TREATMENT

Knowing that I (or the patient indicated on the top of this form) desire evaluation and/or treatment at Southern Care Internal Medicine, PC, I voluntarily consent to such care. I consent to routine diagnostic procedures, including but not limited to x-rays, blood draw, laboratory tests, administration of medication and to medical treatment by physicians and staff members of Southern Care Internal Medicine, PC. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of my examination or treatment at Southern Care Internal Medicine, PC. Patients at Southern Care Internal Medicine, PC will be treated regardless of race, color, age, national origin, disability or religion. Notwithstanding the above, Southern Care Internal Medicine, PC reserves the right to refuse care to any individual who may have an unpaid balance, exhibits rude or disruptive behavior or any other reason at the discretion of the office.

This consent shall remain in force until such time as it is specifically revoked.

_____ _____

Patient Name (please print) Date

_____ _____

Patient Signature/Guardian Witness

COMPREHENSIVE PATIENT MEDICAL HISTORY FORM

Your answers on this form will help your clinician understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details or date. Thank you!

PERSONAL INFORMATION:

Preferred Name:_____ DOB:_____ Date:_____

Current Health Concerns: _____

_____

MEDICATIONS: (Prescription and non-prescription medications, vitamins, birth control pills, herbs and supplements.)

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY

Drug Allergies or Reactions to Medications / Foods / Other Agents: Yes No Please list:

_____

_____

PERSONAL MEDICAL HISTORY: Do you have any of the following? (Explain below)

Acid Reflux (heartburn)
Alcoholism
Allergies (environmental)
Anxiety
Asthma
Atrial Fibrillation
Cancer (list below)
Cholesterol Problem
Coagulation (bleeding) Problem
Chronic Low Back Pain
Depression
Diabetes
Erectile Dysfunction
Gout
High Blood Pressure
Heart Disease (explain below)
Migraines
Osteopenia / Osteoporosis
Prostate Problems
Thyroid Problems
Joint Problems
Ulcers
Eye Problems
COPD

Other Chronic or Recurring Medical Problems (Please list below)

_____

_____

_____

_____

Patient Name: _____ Date: _____

PRIOR SURGERIES AND HOSPITALIZATIONS: Yes No (Please list all prior operations and hospitalizations)

DATE	SURGERY OR HOSPITALIZATION	DATE	SURGERY OR HOSPITALIZATION

Have you received a blood transfusion? Yes No When? _____

FAMILY HISTORY: Please indicate with a check any family members who have had any of the following conditions:

Check here if you don't know your family history

MEDICAL CONDITION	MOM	DAD	BRO	SIS	DAUG	SON	OTHER CLOSE RELATIVES	MEDICAL CONDITION	MOM	DAD	BRO	SIS	DAUG	SON	OTHER CLOSE RELATIVES
Alcoholism								Genetic Diseases							
Anemia								Glaucoma							
Anesthesia Problem								Allergies							
Arthritis								High Cholesterol							
Asthma								Heart Disease (Heart attack, stent or bypass surgery)							
Birth Defects								High Blood Pressure							
Cancer, Breast								Kidney Disease							
Cancer, Colon								Migraine Headaches							
Cancer, Melanoma								Osteoporosis							
Cancer, Other Skin								Rheumatoid Arthritis							
Cancer, Ovary								Seizures							
Cancer, Prostate								Strokes							
Cancer (other list below)								Thyroid Disorders							
Colon Polyps								Tuberculosis							
Depression								Other:							
Diabetes, Type 1															
Diabetes, Type 2															

Patient Name:_____ Date:_____

SOCIAL HISTORY:

Tobacco Use

Please circle

I have never smoked

I have smoked, but rarely

When was the last time?_____

I have quit smoking. Quit Date:_____

How many packs/day?_____ How many yrs?_____

I currently smoke_____pack(s)/day.

How many yrs._____

Other Tobacco: pipe cigar snuff chew

Are you interested in quitting? Yes No

Alcohol Use

Do you drink alcohol? Yes No

never occasionally regularly

Average # drinks/week? 5 oz. wine_____

12 oz. beer_____ 1.5 oz. hard liquor_____

Is alcohol use a concern for you or others? Yes No

Drug Use

Do you use recreational drugs? Yes No

Have you ever used needles? Yes No

Sexual History

Birth control method:_____

Are you sexually active? Yes No Not currently

Current sexual partner(s) is/are male female

Have you ever had any sexually transmitted diseases (STD's)? Yes No Date:_____ Which STD?_____

Are you interested in being screened for sexually transmitted diseases? Yes No

Exercise

Do you exercise? Yes No How often? Daily 4 – 6x a week 1 – 3x a week less than one time a week

What form of exercise? (e.g., jogging, cycling, swimming) _____

Safety

Do you use seat belts consistently? Yes No

Is violence at home a concern for you? Yes No

Are you currently in a relationship? Yes No

If yes, do you feel safe in this relationship? Yes No

Other concerns?_____

Socioeconomics

Marital Status: single married separated divorced widow

Occupation: _____

Education completed: grade school high school college graduate school

Number of children:_____ Who lives at home with you? _____

Frequent foreign travel? Yes No Where?_____

Immunizations: Please circle any immunizations you were given and your best estimate of the month and year it was given.

Tetanus: Yes_____ No Pneumonia: Yes_____ No Chicken Pox: Yes_____ No Hepatitis A: Yes_____ No

Hepatitis B: Yes_____ No HPV (genital warts): Yes_____ No Shingles: Yes_____ No