MAGNOLIA
Health Care

First Name:_____ **Last Name:**_____

Address: _____

City:_____ **State:**_____ **Zip Code:**_____

Phone Number:_____ **Alternate:**_____

Date of Birth:_____ **Age:**_____**Gender:**_____**Race:**_____

Social Security Number:_____

Email Address:_____

Emergency Contact

Name: _____**Phone:**_____ **Relationship:**_____

May we release protected health information to this person? Yes_____ **No**_____

Pharmacy:_____

Primary Insurance:_____

Secondary Insurance:_____

ASSIGNMENT OF BENEFITS:

I hereby authorize payment directly to Magnolia Health Care for all services rendered. I hereby authorize Magnolia Health Care to release any information required to determine medical benefits payable for services. I understamd that I am financially responsible to the organization for any charges not covered by my health care benfits. It is my responsibility to notify the orginazation of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment.

Signature:_____ **Date:**_____

We would like to thank you for choosing and trusting Magnolia Health Care to be your medical provider. We have written this policy to keep you informed of our office policies.

Hours: Monday-Thursday 8:00-5:00 and Friday 8:00-12:00pm.

We see patients by appointment only. Same day appointments are usually available for urgent needs.

For a serious emergency call 911. If you are not sure and you call our office, be sure to inform who answers the phone that it is an emergency. After hours you will reach our answering service.

We have a limited number of "same day" visits available. Please call early in the day, as these appointments fill up quickly.

Call within 24 hours if you are unable to keep your scheduled appointment.

We know your schedule is busy and that your time is valuable. Please let us know if you have waited more than 15 minutes so we can make sure you have been checked in properly. Please remember that we are providing different services. If someone who arrived after you is called before you, they might be having lab work or seeing another provider.

We believe that routine, annual complete physical exams with screening lab tests are very important to the maintenance of good health. However, insurance benefits vary. Some policies cover "wellness" and others cover visits when you have a complaint. Please learn about your benefits prior to your appointment so you will know what your insurance plan covers.

Often times you will be directed to the voicemail of the nurse. If the nurse does not answer leave a detailed message. The nurse will return your call, normally the same day.

If you have any testing done, you must schedule a follow up appointment for results. Results will not be provided over the phone.

Make sure to request all refills at your appointment. If you do need to call the office for a refill, do not wait until you have ran out. Most refills require the doctors approval. If your doctor is out that day, it could take up to two days for you prescription to be approved. Typically, all prescription refill requests can be sent within 24 hours. Some prescriptions may be required to be picked up.

Some medications have potential side effects that must be monitored. We require check ups every 3-4 months for these medications. Be sure to always keep your appointments.

Referrals are handled by our referral department. Sometimes this can be done on the same day as your appointment and sometimes it can take 2-3 days, depending on your insurance and/or the urgency of your situation. You will be contacted as soon as your appointment has been scheduled.

If you are "dismissed" from the practice, you no longer can make appointments, get any refills or consider us to be your health care provider. You will have to find another physician. Common reasons for dismissal include, but are not limited to; non compliance, chronic "no shows," or abusive to staff. If you have a medical emergency within 30 days of the date on your dismissal letter, we will accommodate you. We will forward a copy of your medical records to your new primary care provider.

I acknowledge that I have read a copy of Magnolia Health Care Policy

Signature:_____

Date:_____

Health Questionnaire

Name:_____ Date of Birth:_____

Do you have any allergies? _____

- _____ Reaction_____
- _____ Reaction_____
- _____ Reaction_____

Please list all medications you are taking. Include prescribed medications and over the counter medications.

Drug Name	Strength	Frequency Taken

Are your immunizations up to date? Yes_____ No_____

PAST MEDICAL HISTORY

Please check all that apply.

_____ Anxiety
_____ Depression
_____ Fibromyalgia
_____Liver Disease
_____ Asthma
_____ Bleeding disorder
_____ Heartburn
_____ Heart Murmur
_____Stroke
_____ Diverticulosis/Diverticulitis
_____ High Cholesterol
_____ Kidney Disease
_____ Leg/Foot Ulcers
_____ Heart Attack
_____ Peptic Ulcer Disease
_____ Cancer
_____ Coronary Artery Disease
_____ Kidney Stones
_____ Appendicitis
_____ Gout
_____ Pacemaker
_____ IBS
_____ High Blood Pressure
_____ Tuberculosis
_____ Pulmonary Embolism
_____ HIV or AIDS
_____ Arthritis
_____ Gallstones
_____ Osteoporosis
_____ Blood Clots
_____ IBD (Chrons/UC)
_____ Hiatal Hernia
_____ Thyroid Disorder
_____ Diabetes
_____ Dialysis
_____ Other

PAST SURGICAL HISTORY

Surgery: Year:

_____

_____

_____

_____

FAMILY HEALTH HISTORY

Has anyone in your *immediate* family been diagnosed with any of the following?

Cancer Diabetes Heart Disease High Blood Pressure
Arthritis Depression Dementia Other _____

Family Member:	Living?	Age:	Diagnosis:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CHILDHOOD HISTORY

Did you have a lot of antibitoics as a child? _____ Steroids as a child? _____

OBESITY AND WEIGHT LOSS

Do you think your weight is a problem? Yes _____ No_____
Have you ever tried to lose weight? Yes_____ No _____
Would you like weight loss or nutritional counseling? Yes _____ No _____

SOCIAL HISTORY

Are you currently employed? Yes_____ No ____
Occupation:_____
Disabled? Yes_____ No _____

Education:

High School/GED ____ Some College ____ 2 year College ____ 4 year College____ Post Graduate _____

Marital Status:
Married _____ Single _____ Divorced _____ Separated _____ Widowed _____

Who do you live with? Family _____ Roommate _____ Other _____

Exercise Level: Mild _____ Moderate _____ High _____

Caffeine: None _____ Occasional _____ Moderate _____ Heavy _____

Do you drink alcohol? Yes _____ No _____
If so, how often? Less than 3x per week _____ More than 3x per week _____

Do you use tobacco? Yes _____ No _____
Have you ever? _____Year Quit:_____
Cigarettes _____ packs per day Chew _____ per day Cigars _____ per day