NALLY FAMILY PRACTICE

Patient Health History

Please complete prior to your first office visit, so we can better assist you with your health during that visit.

Name: _____ **Preferred Nick-Name**: _____ **Date of Birth**: _____ **Age**: ___

Marital Status: □Single □ Married □Divorced □Widowed. **Number of Children**: _____

Occupation: _____ **Religious Preference**: _____

PAST MEDICAL HISTORY

Please ☑ those conditions you have been diagnosed with and write in any that are not listed below.

VISION PROBLEMS: □Cataracts □Glaucoma □Macular Degeneration

HEARING: □Hearing loss □ Tinniuts (Ringing in Ears) □Vertigo □Dizziness

ALLERGIES (Environmental): □Allergic rhinitis (Runny Nose) □ Chronic Sinusitis (Sinus Infections)

LUNGS: □Asthma □COPD □Emphysema □Pulmonary Embolis □Valley Fever

CARDIOVASCULAR: □ Hypertension (Elevated blood pressure) □Dyslipidemia (High cholesterol) □CAD (Heart disease) □Myocardial Infarction(Heart Attack) □CHF (heart failure) □ Atrial fibrillation □Dysrhythmia(Abnormal heart rhythm) □Heart Murmur

VASCULAR DISEASE: □Coagulopathy (Clotting Disorder) □Hemophilia (bleeding disorder) □ Peripheral Vascular Disease (PVD) □ DVT (blood clot in extremity) □Use of Anti-Coagulant (Blood Thinner daily) □CVA (Stroke) □TIA (Mini-Stroke)

ENDOCRINE: □ Diabetes mellitus (DM) – type I (insulin use) □DM type II □CKD (Chronic kidney disease) □Hypothyroidism □Hyperthyroidism □Graves Disease □Hashimoto's Disease □Thyroid cancer □Anemia □Iron deficiency □Vit B12 deficiency □Vit D deficiency

CANCER: □Previous type _____ □Current type_____

NEUROLOGIC: □Seizure disorder □Tremor □Parkinson's disease □Alzheimer's Disease □Encephalopathy _____ □Neuropathy _____ □Concussion/Closed Head trauma (date): _____ □Neuritis □Sciatica (location): _____

RHEUMATOLOGIC: □Rheumatoid arthritis □Lupus □Connective tissue disorder □Fibromyaliga □Chronic fatigue Syndrome □Osteoarthritis: *Spine Hips Knees Ankles/Feet Shoulders Hands* □Chronic Back Problems: *Neck Mid back Low back* □Herniated Disc □Osteoporosis □Osteopenia

GASTROINTESTINAL: □GERD(Acid reflux) □Hiatal hernia □Peptic Ulcer Disease (PUD) □Irritable or Inflammatory bowel disease (IBS, Crohn's Disease, Colitis) □Cholecystitis (Gallstones/Gall bladder) □Diverticulosis □Diverticulitis □Hemorrhoids

GENITOURINARY: □Overactive bladder □Incontinence: *stress OR urge* □Recurrent UTI □Kidney Stones □Chronic Hematuria (Blood in urine) □Sexually Transmitted Disease (STD): *Herpes Gonorrhea Trichomonas HPV*

MALE: □BPH (Prostate Enlargement) □Prostate Cancer □Erectile dysfunction

FEMALE: □Fibrocystic Breast Disease □Uterine fibroid □Ovarian cysts □Abnormal Menses

SKIN: □Eczema □Psoriasis □Actinic keratosis (pre-cancers) □Fungal skin infections

PSYCHIATRIC: □Depression □Anxiety □Mood disorder □Alcoholism □Drug abuse

PREVIOUS FRACTURES (Broken Bones): _____

OTHER: _____

SURGICAL HISTORY

Please ☑ all that apply and year done (approximate) and write in any that are not listed below.

ENT: □Cataract □Retina □Myringotomy (tubes in ears) □Tonsillectomy □Sinus Surgery □Thyroid Surgery

GI: □Appendectomy □Cholecystectomy (Gall Bladder) □Colostomy □Bowel Surgery □Hernia Repair (*Inguinal Ventral Umbilical*) *RIGHT/ LEFT* □Laparoscopy

CARDIO: □CABG (Heart Bypass) □Heart Transplant □PTCA (Cardiac Stent) □Valve Replacement □Pacemaker □Cardiac Ablation
GU: □C-Section x 1 2 3 4 5 □Hysterectomy □Bladder Surgery
EXTREMITIES: □TKA (Total Knee Replacement) *Left/Right* □THA (Total Hip Replacement) *Left/Right* □Shoulder Surgery *Left/Right* □Joint Arthroscopy *Left/Right* (location):_____
OTHER: _____

Your Pregnancy / Menstrual History

Pregnancy: (circle) 0 1 2 3 4 5 6 7 8 9 ___ **Birth(s)**: 0 1 2 3 4 5 6 7 ___ **Still birth(s):** 0 1 2 ___

Miscarriage(s): 0 1 2 3 4 5 ___ **Elective abortion(s):** 0 1 2 3 4 ___

Abnormal PAP History: (circle) *yes no*

Date of Last menstrual period: _____ **Menstruation regularity**: (circle) Monthly Irregular Menopausal

Last PAP: (date)_____ **Last Mammogram** _____ **Last DEXA (bone density) Scan**: _____

OTHER SCREENING EXAMS

Please give the latest year the following tests were completed:

EKG: _____ **Chest X-ray (CXR)**: _____ **EGD**: _____ **Colonoscopy**: _____

FAMILY HISTORY

Please circle all those that apply and write in any that are not listed.

YOUR FATHER: ***Adopted / Unknown***

CARDIOVASCULAR: □ Hypertension (Elevated blood pressure) □Dyslipidemia (High cholesterol) □CAD (Heart disease) □Myocardial Infarction(Heart Attack) □CHF (heart failure) □ Atrial fibrillation □Dysrhythmia(Abnormal heart rhythm) □Heart Murmur
LUNGS: □Asthma □COPD □Emphysema □Pulmonary Embolis □Valley Fever
VASCULAR DISEASE: □Coagulopathy (Clotting Disorder) □Hemophilia (bleeding disorder) □ Peripheral Vascular Disease (PVD) □ DVT (blood clot in extremity) □CVA (Stroke)
NEUROLOGIC: □Seizure disorder □Tremor □Parkinson's disease □Alzheimer's Disease □Encephalopathy _____ □Neuropathy _____
ENDOCRINE: □ Diabetes mellitus (DM) – type I (insulin use) □DM type II □CKD (Chronic kidney disease) □Hypothyroidism □Hyperthyroidism □Graves Disease □Hashimoto's Disease □Thyroid cancer □Anemia □Iron deficiency □Vit B12 deficiency □Vit D deficiency
GASTROINTESTINAL: □GERD(Acid reflux) □Hiatal hernia □Peptic Ulcer Disease (PUD) □Irritable or Inflammatory bowel disease (IBS, Crohn's Disease, Colitis) □Cholecystitis (Gallstones/Gall bladder)
RHEUMATOLOGIC: □Rheumatoid arthritis □Lupus □Connective tissue disorder □Fibromyaliga □Chronic Fatigue □Osteoarthritis □Herniated Disc □Osteoporosis □Osteopenia
PSYCHIATRIC: □Depression □Anxiety □Mood disorder □Alcoholism □Drug abuse
CANCER: □Prostate □Colon □Gastric □Pancreatic □Lung □Bone □Leukemia

YOUR MOTHER: ***Adopted / Unknown***

CARDIOVASCULAR: □ Hypertension (Elevated blood pressure) □Dyslipidemia (High cholesterol) □CAD (Heart disease) □Myocardial Infarction(Heart Attack) □CHF (heart failure) □ Atrial fibrillation □Dysrhythmia(Abnormal heart rhythm) □Heart Murmur

LUNGS: □Asthma □COPD □Emphysema □Pulmonary Embolis □Valley Fever
VASCULAR DISEASE: □Coagulopathy (Clotting Disorder) □Hemophilia (bleeding disorder) □ Peripheral Vascular Disease (PVD) □ DVT (blood clot in extremity) □CVA (Stroke)
NEUROLOGIC: □Seizure disorder □Tremor □Parkinson's disease □Alzheimer's Disease □Encephalopathy _____ □Neuropathy _____
ENDOCRINE: □ Diabetes mellitus (DM) – type I (insulin use) □DM type II □CKD (Chronic kidney disease) □Hypothyroidism □Hyperthyroidism □Graves Disease □Hashimoto's Disease □Thyroid cancer □Anemia □Iron deficiency □Vit B12 deficiency □Vit D deficiency
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PSYCHIATRIC: □Depression □Anxiety □Mood disorder □Alcoholism □Drug abuse
CANCER: □Breast □Uterine □Colon □Gastric □Pancreatic □Lung □Bone □Leukemia

YOUR Siblings _____ Paternal family _____ Maternal Family _____

DRUG ALLERGIES / INTOLERANES

Please list all medications that you have had an allergy to or side effects from plus the type of reaction.

_____
_____

MEDICATIONS / VITAMINS / SUPPLEMENTS

Please list the name, strength and dosing of all medications including herbal products and supplements.

Medication & Strength	Dosing	Frequency
i.e. Lisinopril 10mg	**1 tablet**	**Once a day**

IMMUNIZATIONS

Please give the last date of the immunizations below.

Tetanus: _____ Influenza: _____ Pneumonia: _____
Hepatitis B: _____ Hepatitis A: _____ Small Pox: _____
TB Skin Test: _____ (circle one) Positive Negative
Yellow Fever: _____ Typhoid: _____

SOCIAL HISTORY

Circle all those that apply.

Marital Status: *Single Married Divorced Remarried Widowed*

Who do you live with? _____ Number of Children: 0 1 2 3 4 5 6 7 8 9 10

Sexual Activity: *Inactive Active-Single Partner Active-Multiple partners Active-Same gender partner*

Tobacco Use: *Never* Quit (____) Current: (Cigarette Cigar Chew) Packs per day: ____ for _____ years

Alcohol Use: *None* Number of beers / glasses of wine _____ per day / week/ month: _____

Illicit Drug Use: *Never Quit* Current: *Marijuana Methamphetamines Cocaine Heroin Ecstasy*

ADVANCED DIRECTIVES

Do you have an Advanced Medical Directive? Yes No **Do you have a Living Will?** Yes No

Do you have a medical Power of Attorney? Yes No

If you have any of the above documents, please bring a copy in for your medical record.

What are we seeing you for today? _____

What are your main symptoms? _____

How did you find us? _____

Welcome to the Practice!!!

Nally Family Practice

ERISA Authorization

For good and valuable consideration, I _____, do hereby designate, authorize, and convey to Dr. Adam S. Nally, D.O. to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: a) the right and ability to act on my behalf in connection with any claim, right or chose in action that I may have under such insurance policy and/or any employee Health care benefit plan; and b) the right and ability to act on my behalf to pursue such claim, right or chose in action in connection with said insurance policy and/or employee health care benefit plan (including but not limited to, the right to act in my behalf in respect to an employee health care benefit plan governed by the provisions of the Employee Retirement Income Security Act of 1974 as provided in 29 CFR §2560.503-1(b)(4)) with respect to any medical or other health care expense incurred as a result of the service I received from the above-named doctor and, to the extent permissible under law, to claim on my behalf, such medical or other health care service benefits, insurance or health care benefit plan reimbursement and any other applicable remedy.

I acknowledge full responsibility for all charges incurred, regardless of possible insurance coverage. I hereby authorize the office of Adam S. Nally, D.O. to obtain, on my behalf, any insurance information covered by "The Privacy Act" from my insurance company(s) files. I further agree to pay all collection on costs, attorney fees, and any other collection costs that may be incurred to enforce collections of any amounts outstanding. A late fee of $10 per statement cycle for accounts over 60 days. Collections fees are 35% of balance and will be submitted to collections Action Recovery for accounts over 120 days past due. I authorize payment of medical benefits to the provider for services of these insurance companies listed on Insurance Information form.

Date: _____ Signature: _____

Nally Family Practice

ADVANCED BENEFICIARY NOTICE (ABN)

This notice is to inform you that periodically your doctor may order testing or perform an examination that is not a covered item or service under your insurance plan. Your insurance only pays for covered items and services when certain rules are met. The fact that your insurance may not pay for a particular item or service does not mean that you should not receive it. There are legitimate reasons your doctor may recommend particular items or services that are not covered. It is ultimately your responsibility, as the insured, to know what your individual insurance plan will and will not cover. By signing this form, you are agreeing to pay for services rendered that are not covered by your insurance company.

The most common items or services not covered but frequently recommended by your doctor are:

MEDICARE
Pap Smear collection Q0091 modifier GA mean you understand that this collection at this office will be patient responsibility $50
Hepatitis A injection – 90632 – 90634 $90
Hepatitis B injection 90746 $65
TDaP – 90715 $45
Tetanus vaccine 90703 $45
Tuberculosis Screening (TB Skin Test) – 86580
EKG G0403 is covered with welcome to Medicare physical G0402 but any subsequent EKGs 93000 for screening purposes will be patient responsibility $75

Commercial Payers Any patient requesting to schedule a preventive service such as a physical that wishes to discuss any other health problems with the doctor needs to ask their insurance carrier if they bundle a problem-oriented visit with preventive service. It is our recommendation to schedule the problem-oriented visit first and the preventive service another day.

If two different appointments is an inconvenience and lost work time for a patient they are encouraged to contact their insurance company and his or her employer and state that the consequences of the insurer's payment policy is a inconvenience. It takes many voices to make a change for the better.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them out of your own pocket. If you do not understand why your insurance may not cover these services or you would like to know how much these items or services may cost, please ask one of the members of the staff.

*By signing this form, I understand that my insurance may not cover the above items or services and that I may have to pay the bill while my insurance makes it's decision. If my insurance does pay, I will be refunded any payment that is due to me. If my insurance denies payment, I agree to personal and full responsibility for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand that I can appeal my insurance's decisio*n.

_____ _____
Print Patient Full Name Date

_____
Signature of patient, parent or guardian

Nally Family Practice

Patient Information Sheet

Patient Name: _____ ____ _____ _____
First MI Last Suffix

Preferred Name: _____ Date of Birth: _____Age: _____

Gender (circle one): Male Female Social Security Number: _____

Ethnicity (circle all that apply): Caucasian Black Hispanic Asian Other: _____

Primary Language: English Spanish Other: _____

Marital status (circle one): Married Divorced Single Widowed

Primary Address: _____

City: _____ State: _____ Zip Code: _____

Primary Telephone: _____ Secondary: _____

Occupation: _____ Employer: _____

Employer's Address: _____

City: _____ State: _____ Zip Code: _____

Preferred local Pharmacy (Name & cross streets): _____

Preferred mail off Pharmacy (Name): _____

Parent/ Spouse/ Guardian Information

Name: _____

Telephone: _____Secondary Tel: _____

Relationship: _____ Address: _____ City:

_____ State: _____ Zip Code: _____

Emergency Contact

Contact Name: _____

Relationship: _____ Telephone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Nally Family Practice
Insurance Information

Primary Insurance

Insurance Name: _____ Effective date _____

ID-Policy-Subscriber Number: _____Group Number: _____

Insurance Address to submit claims:_____

City: _____ State: _____ Zip Code: _____

Policy Holder's Name: _____

Policy Holder's SSN: _____ Date of Birth: _____

Relationship to Patient: _____

Employer of policy holder: _____

Secondary Insurance

Insurance Name: _____ Effective date _____

ID-Policy-Subscriber Number: _____Group Number: _____

Insurance Address to submit claims:_____

City: _____ State: _____ Zip Code: _____

Policy Holder's Name: _____

Policy Holder's SSN: _____ Date of Birth: _____

Relationship to Patient: _____

Employer of policy holder: _____

Tertiary Insurance

Insurance Name: _____ Effective date _____

ID-Policy-Subscriber Number: _____Group Number: _____

Insurance Address to submit claims:_____

City: _____ State: _____ Zip Code: _____

Policy Holder's Name: _____

Policy Holder's SSN: _____ Date of Birth: _____

Relationship to Patient: _____

Employer of policy holder: _____

(The above information must be filled out completely or patient will be considered a cash pay and be billed for services rendered)

I hereby authorize Adam S. Nally, DO.'s office to release any information acquired in the course of my examination or treatment to the referring physician or insurance carriers listed above.

Date: _____ Signature: _____

Nally Family Practice

Our office is piloting a notification program for our patients who have e-mail. If interested, you would receive notification on your laboratory, radiological or other diagnostic data via e-mail instead of by phone.

This program will be for normal studies only. If your diagnostic data is normal, you will receive an e-mail including a copy in "PDF" format of your study as an attachment to your e-mail. Any abnormal labs will not be e-mailed and you will be notified via the phone regarding instructions that Dr. Nally would like you to follow.

Our office also offers an E-statement option. You have the choice of receiving your billing statements via e-mail, or regular mail. It is a secure 256 bit encryption and SSL protected way to receive your statements.

By checking yes and signing this form, you are giving Nally Family Practice (Adam S. Nally, D.O., P.C.) permission to send diagnostic studies and E-statements for your review to the e-mail address below. It is your responsibility to ensure that the address below is secure and protected. It is also your responsibility to immediately notify our office when changes to your e-mail address occur.

It is our intent to help you receive information about your medical care in a more efficient manner.

Electronic Diagnostic Results

- o Yes – I would like to receive my results via e-mail.
- o No – I do not want my results via e-mail

Electronic Billing Statements

- o Yes – I would like to receive E-statements.
- o No – I do not want my billing statements via e-mail.

_____

Patient Full Name

_____

E-mail Address (**Please Print**)

_____ _____

Signature of Patient or Guardian Date

We do not create individual profiles with the information you provide. If information is collected, it will be used solely in connection with Nally Family Practice. We do not give, sell, or transfer any personal information to a third party. All information is securely stored with 256-bit encryption and SSL protection

NALLY FAMILY PRACTICE

ADAM S. NALLY, D.O.
BRADLEY G. HALL, P.A.-C
FAMILY PRACTICE & OSTEOPATHIC MANIPULATION
BOARD CERTIFIED

Disclosure of Health Information to Family, Friends or Others

☐ **No, do not** disclose my medical information to anyone, including family members, other relatives, close personal friends, etc.

☐ **Yes, allow** disclosure of my medical information to the following person(s):

Full Name:_____
Relationship:_____ Phone#:_____

Full Name:_____
Relationship:_____ Phone#:_____

Full Name:_____
Relationship:_____ Phone#:_____

Patient Name:_____ Birth Date:_____

Patient Signature:_____ Date:_____