Family Practice
Meritra Clinics LLC.
109 Commerce Park Dr.
Westerville, OH 43082
Phone: 614-882-9355 Fax: 614-882-9576

New Patient Form

Please present valid identification and your insurance card to the receptionist. All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient Demographics

Today's Date: _____
Patient Name: _____ ☐ Male ☐ Female
What you prefer to be called: _____
DOB: _____ Age: _____ SSN: _____
Home Address: _____
Street *City* *State* *Zip Code*
Phone Number: _____ Work Number: _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Spouse's Name: _____
Race: ☐ American Indian/Alaska Native ☐ Asian ☐ African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Previous or Referring Doctor: _____
Date of last physical exam: _____
How did you hear about us? ☐ Referred by (Name): _____
☐ Other: _____

Insurance Information

Insurance Company: _____
Insurance Phone Number: _____
Insurance Billing Address: _____
Street *City* *State* *Zip Code*
☐ Check if Patient is Subscriber. If not, Subscriber Name: _____
Subscriber DOB: _____ Relation to Patient: _____
Policy Number: _____ Group Number: _____

Patient Health History

Childhood Illness: □ Measles □ Mumps □ Rubella □ Chicken Pox □ Rheumatic Fever □ Polio

Immunizations and Dates:

□ Tetanus	□ Pneumonia
□ Hepatitis	□ Chickenpox
□ Influenza	□ MMR (Measles, Mumps, Rubella)

List any medical problems that other doctors have diagnosed:

_____
_____
_____

Past Surgeries and Recent Hospitalizations:

Year	Reason	Hospital

Other Hospitalizations:

Year	Reason	Hospital

List your prescribed drugs and over-the counter drugs, such as vitamins and inhalers:

Name	Strength	Frequency

Allergies to medications:

Name of the Drug	Reaction You Had

Check if you have, or have had, any significant symptoms in the following areas:

☐ Skin	☐ Chest/Heart	Recent Changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy
☐ Nose	☐ Bladder	☐ Sleep
☐ Throat	☐ Bowel	☐ Other:
☐ Lungs	☐ Circulation	☐ Other:

Briefly Explain:_____

_____

Family Health History:

Relation	Age	Gender	Significant Health Problem
Father		-	
Mother		-	
Grandmother (maternal)		-	
Grandfather (maternal)		-	
Grandmother (paternal)		-	
Grandfather (paternal)		-	
Sibling			
Sibling			

Health Habits and Personal Safety

Drugs and Tobacco:

Do you use tobacco? ☐ Yes ☐ No

If yes, how and how much? ☐ Cigarettes __/day ☐ Chew __/day ☐ Pipe __/day ☐ Cigars __/day

_____

Number of Years: _____ Number Years Quit: _____

Do you currently use recreational or street drugs?	☐ Yes ☐ No
Have you ever given yourself street drugs with a needle?	☐ Yes ☐ No

Sexual History:

Are you sexually active?	☐ Yes ☐ No
If yes, are you trying for a pregnancy?	☐ Yes ☐ No
If not trying for a pregnancy, list contraceptive or barrier method used:	
Any discomfort with intercourse?	☐ Yes ☐ No
Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes ☐ No

Personal Safety:

Do you live alone?	☐ Yes ☐ No
Do you have frequent falls?	☐ Yes ☐ No

Do you have vision or hearing loss?	☐ Yes ☐ No
Do you have an Advance Directive and/or Living Will?	☐ Yes ☐ No
Physical and/or mental abuse have also become a major public health issue in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes ☐ No

Women Only		
Age at onset of menstruation:		
Date of last menstruation:		
How often do you get your menstrual cycle?	Every_____Days	
Heavy periods, irregularity, spotting, pain, or discharge?		☐ Yes ☐ No
Do you have any menstrual tension, pain, bloating, irritability, or other symptoms?		☐ Yes ☐ No
Number of Pregnancies:		
Number of Live Births:		
Are you pregnant or breastfeeding?		☐ Yes ☐ No
Have you had a D&C, hysterectomy, or Cesarean?		☐ Yes ☐ No
Any urinary tract, bladder, or kidney infections in the last year?		☐ Yes ☐ No
Any blood in your urine?		☐ Yes ☐ No
Any problems with control of urination?		☐ Yes ☐ No
Any hot flashes or sweating at night?		☐ Yes ☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?		☐ Yes ☐ No
Date of last pap and rectal exams?		
Men Only		
Do you usually get up to urinate during the night?		☐ Yes ☐ No
If yes, how many times?		
Do you feel pain or burning with urination?		☐ Yes ☐ No
Any blood in your urine?		☐ Yes ☐ No
Do you feel burning discharge from penis?		☐ Yes ☐ No
Has the force of your urination decreased?		☐ Yes ☐ No
Have you had any kidney, bladder, or prostate infections within that last year?		☐ Yes ☐ No
Do you have any problems emptying your bladder completely?		☐ Yes ☐ No
Any difficulty with erection or ejaculation?		☐ Yes ☐ No
Any testicle pain or swelling?		☐ Yes ☐ No
Date of last prostate and rectal exams?		

Other Problems

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain:

☐ Skin	☐ Chest/Heart	Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other:
☐ Lungs	☐ Circulation	☐ Other:

I. Patient Consent Form

I authorize Meritra Clinics LLC to release any medical or other information that may be necessary to process medical claims on my behalf to related physicians, rehabilitation counselors, social workers, insurance carriers, or attorneys.

I authorize Meritra Clinics LLC to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

II. Financial Responsibility / Assignment of Benefits

I understand that I am responsible for paying my co-payments and deductibles at the time of service. I also understand that I am responsible for any balance due after payment by my insurance company.

I, the undersigned, understand that Meritra Clinics LLC will bill my insurance company for services rendered upon verification of coverage by my insurance company. If my insurance company fails to render payment for services rendered, I hereby personally guarantee payment for medical care and services rendered. If your insurance company does not remit payment within 60 days, the balance will be due in full from you.

I hereby request that my insurance carrier make payment directly to Meritra Clinics LLC for all services rendered by this facility. If my current policy prohibits direct payment to Meritra Clinics LLC, I hereby instruct and direct my insurance company to make the check out in my name but send the check to the listed address of Meritra Clinics LLC.

If my insurance carrier makes a payment to me I agree to immediately pay over these funds to Meritra Clinics LLC. I also authorize Meritra Clinics LLC to deposit checks received on my account when made out to me.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

Charges related to Worker's Compensation injury shall be forwarded to the Worker's Compensation Insurance carrier. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you will be held responsible for the total amount of charges for services rendered to you.

I, the undersigned, acknowledge that by signing this form authorize Meritra Clinics to submit my charges via mail or internet to my insurance carrier. This is a "Signature on File" authorization.

Patient recognizes that Policy quotes are not a guarantee of payment by carrier and the patient is responsible for obtaining actual Policy benefits, limits from the carrier and if needed any referrals from primary care physicians or pre-authorization for chiropractic treatment. Patients are responsible to confirm referrals/pre-authorization with insurance. All referrals or recommendations from our office have no confirmation of payment or benefits to referring provides.

I authorize my healthcare provider and/or entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging or other electronic communication to contact me for any reason by any telephone number, email address and/or mailing address provided. I authorize all my numbers that I have provided to the office in my file able to accept phone and/or text messages. I authorize stating a detailed message to all phone numbers I have given Meritra Clinics LLC.

The patient, legal guardian or parent (if patient is under 18 years old) will be responsible for the co-payment and the deductible that the time of service.

III. Cancellation / No Show Policies

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. **If the appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollar ($50.00) fee; this will not be covered by your insurance company.**

We understand that delays can happen, however, we must try to keep the doctors and other patients on schedule. **If a patient is 15 minutes past their scheduled time, we will have to reschedule the appointment.**

After three (3) No Show appointments, a patient will be dismissed from the practice.

IV. Acknowledgment of Receipt of Notice of Privacy Practices

I certify that I was offered a copy of Meritra Clinics LLC's Notice of Privacy Practices. The Notice of Privacy Practices describes the types and uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Meritra Clinics LLC's health care operations. The Notice of Privacy Practices also describes my rights and Meritra Clinics LLC's duties with respect to my protected health information. The Notice of Privacy Practices is also posted in the reception area.

Meritra Clinics LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I, the undersigned, state that I have read Sections I, II, and III, and agree to the terms and conditions set forth.

_____ _____

Patient Signature *Date*

_____ _____

(Or) Guardian Signature *Date*

_____ _____

Physician Signature *Date*