Covenant Medical Group

Disclaimer: Thank you for your interest in being a patient of Covenant Medical Group. This form is used to collect information about new patients and is used for internal purposes only. The information you supply is confidential and will be treated accordingly.

PATIENT DETAILS

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

Date of Birth: _____ **Gender**: ☐ Male ☐ Female ☐ Other

Street Address: _____

City: _____ **State**: _____ **ZIP Code**: _____

Home Phone: _____ **Mobile Phone**: _____

E-Mail: _____ **Ethnicity/Race**: _____

Weight: _____ **Height**: _____

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

EMERGENCY CONTACT

Emergency Contact Name: _____

Relationship: _____ **E-Mail**: _____

Home Phone: _____ **Mobile Phone**: _____

PRIMARY INSURANCE POLICY

Primary Insurance Company: _____

Group #: _____ **ID #**: _____

Primary Insurance Type: ☐ HMO ☐ PPO ☐ Medicare ☐ Other: _____

Complete the following if you are ***not*** the policyholder for your primary insurance:

Insurance Policyholder: ☐ Spouse ☐ Child ☐ Parent ☐ Other: _____

Policyholder Name: _____ **Date of Birth**: _____

SECONDARY INSURANCE POLICY (IF ANY)

Secondary Insurance Company: _____

Group #: _____ **ID #**: _____

Secondary Insurance Type: ☐ HMO ☐ PPO ☐ Medicare ☐ Other: _____

Complete the following if you are ***not*** the policyholder for your secondary insurance: **Insurance Policyholder**: ☐ Spouse ☐ Child ☐ Parent ☐ Other: _____

Policyholder Name: _____ **Date of Birth**: _____

PATIENT PORTAL

Email: _____(Must include to sign up for the portal)

Consent to Texts: ☐ Yes ☐ No

Consent to Voice Messages: ☐ Yes ☐ No

TREATING PHYSICIANS

Primary Care Physician: _____ **Phone**: _____

List all other active treating physicians:

Physician:_____ **Specialty**:_____

Physician:_____ **Specialty**:_____

Physician:_____ **Specialty**: _____

ALLERGIES

List your allergies and describe the reactions to your body:

Allergy: _____ **Reaction**: _____
Allergy: _____ **Reaction**: _____
Allergy: _____ **Reaction**: _____
Allergy: _____ **Reaction**: _____

MEDICATION

List the medications you are currently taking including the dosage:

Medication: _____ **Dose**: _____
Medication: _____ **Dose**: _____
Medication: _____ **Dose**: _____
Medication: _____ **Dose**: _____

SOCIAL HISTORY

(Complete the following if applicable)

Are you planning a pregnancy? ☐ Yes ☐ No

Are you pregnant now? ☐ Yes ☐ No

Are you breast-feeding? ☐ Yes ☐ No

When was your last menstrual cycle? _____

PREFERRED PHARMACY

Pharmacy Name: _____ **Phone**: _____

Street Address: _____

City: _____ **State**: _____ **ZIP Code**:_____

PATIENT CONSENT

By signing below, I hereby acknowledge, agree, and authorize all the following:

a) **Accurate Information**. I certify that the information provided on this form is accurate, complete, and up to date to the best of my knowledge.

b) **Patient Rights and Responsibilities**. I understand that the healthcare facility maintains a Notice of Privacy Practices, which describes how my protected health information may be used and disclosed, and how I may access my health records. I understand that I have the right to review this healthcare facility's Notice of Privacy Practices prior to signing this form.

c) **Release of Medical Information**. I authorize the release of my health information to the healthcare facility in accordance with the healthcare facility's Notice of Privacy Practices. This includes, but is not limited to, releasing medical information to my referring physician, primary care physician, and any physician(s) I may be referred to. The healthcare facility shall ensure all health information remains confidential, as required by HIPAA, and will not release any of my health information without my consent.

Covenant Medical Group may leave a message with the following person(s):

Name:_____Phone:_____Relationship:_____

Name:_____Phone:_____Relationship:_____

d) **Consent for Treatment**. I grant the healthcare facility, including its affiliated providers, physicians, and other medical personnel, permission to use the health information provided for the purpose of my medical treatment as necessary.

e) **Consent to Communication**. I consent to receiving communications from the healthcare facility regarding appointment reminders, test results, and other necessary healthcare-related information via phone, email, or channels.

f) **Acknowledgment**. By signing below, I hereby acknowledge, agree, and authorize all the above, and I authorize the healthcare facility to retrieve and review my medical history and authorize the healthcare facility to release the information required in obtaining procedure authorization or the processing of any insurance claims.

Patient Signature: _____**Date**: _____

Print Name: _____

HEALTH & SOCIAL NEEDS QUESTIONNAIRE

What is your living situation today?

☐ I have a steady place to live

☐ I have a place to live today, but I am worried about losing it in the future

☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, in a car, abandoned building, etc.)

During the last 12 months, was there a time when you were not able to pay your mortgage, rent, or utility bills?

☐ No

☐ Yes

During the last 12 months, how often did the food that you bought not last, and you didn't have money to get more? Was that…

☐ Always

☐ Sometimes

☐ Never

During the last 12 months, how often were you unable to afford to eat balanced meals? **For example, a starch like potatoes or rice, vegetables or fruit, and some protein like meat, fish, cheese, or eggs.**

☐ Always

☐ Sometimes

☐ Never

During the last 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

☐ No

☐ Yes

During the last 12 months, how often did your doctors, nurses, or other health providers explain things about your health in a way that was easy to understand?

☐ Always

☐ Sometimes

☐ Never

Stress means a situation in which a person feels tense, restless, nervous, or anxious, or is unable to sleep at night because their mind is troubled all the time. *Within the last 30 days, how often have you felt this kind of stress?*

☐ Always

☐ Sometimes

☐ Never

During the last 12 months, how often would you say you get the social and emotional support you need?

☐ Always

☐ Sometimes

☐ Never

During your life, how often have you felt that you were treated badly or unfairly because of your race or ethnicity?

☐ **Always**

☐ **Sometimes**

☐ **Never**