Print Form

MSMancina, M.D. & Associates, P.A.

Office : (816) 569-2200
Fax: (816) 581-2090

PATIENT INFORMATION AND MEDICAL SCREENING FORM

PATIENT INFORMATION				
Name		Date of Birth		Social Security Number
Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other				Number of Children
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other Race				Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Home Address (e.g., P.O. Box or Street, City, State, Zip)		Mailing Address (if different)		
Home Phone	Work Phone		Cell Phone	
Occupation	If retired, previous occupation:		Email Address	
Preferred Language	Can you read and write? ☐ Yes ☐ No		Do you have a living will? ☐ Yes ☐ No	
Do you have cultural/spiritual beliefs that may affect your care? ☐ Yes ☐ No		If Yes, please explain:		
Reason for Your Visit				
Referring Physician	Primary Care Physician		Other Physician(s)/Specialty	

EMERGENCY CONTACT INFORMATION		
Name of Contact	Relationship to Patient	
Address (if different than above)		
Home Phone	Work Phone	Cell Phone

PERMISSION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS/FRIENDS		
The following person(s) have permission to access my medical records, to receive information about me and my medical history, and to speak to the physician on my behalf.		
Name	Relationship	Phone

INSURANCE INFORMATION		
Do you have medical insurance? ☐ Yes ☐ No	Primary Insurance:	Secondary Insurance:

Name of Patient:	

ALLERGIES
List all medication or food allergies, as well as your reaction

CURRENT MEDICATIONS
List ALL current medications including over the counter medications/vitamins/herbal/supplements.

Medication Name	Dosage	# Times Daily
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

MEDICAL PROBLEMS

☒	Condition	Year	☒	Condition	Year
☐	Angina		☐	Thyroid Disease ☐ Hyper? ☐ Hypo?	
☐	Coronary Artery Disease		☐	Liver Disease	
☐	Heart Attack		☐	Kidney Disease	
☐	Heart Failure (CHF)		☐	Arthritis	
☐	Heart Valve Disease		☐	Migraine Headaches	
	Type:		☐	Seizures	
☐	High Blood Pressure		☐	Stroke	
☐	High Cholesterol		☐	Anemia	
☐	Irregular Heart Rhythm		☐	Bleeding/Clotting Disorder	
	Type:		☐	Cancer	
☐	Peripheral Vascular Disease			Type:	
☐	Asthma		☐	GERD	
☐	Lung Disease (COPD)		☐	Depression	
☐	Tuberculosis		☐	Emotional/Behavioral Illness	
☐	Colitis			Explain:	
☐	Stomach Ulcer		☐	AIDS/HIV	
☐	Gout		☐	Other	
☐	Diabetes ☐ Type I? ☐ Type II?			Explain:	

Name of Patient:	

PREVIOUS SURGERIES

Surgery	Year
1.	
2.	
3.	
4.	
5.	

FAMILY MEDICAL HISTORY

Does anyone in your *immediate family* have the following? Who?

☒	Condition	Relationship	☒	Condition	Relationship
☐	Coronary Artery Disease		☐	Cancer (type)	
☐	Heart Attack		☐	Diabetes	
☐	Sudden Cardiac Death		☐	COPD	
☐	High Blood Pressure		☐	Stroke	
☐	High Cholesterol		☐	Aneurysm:	
☐	CHF/Heart Failure		☐	Other	

Father's cause of death	Age	Mother's cause of death	Age

SOCIAL HISTORY

Do you exercise regularly? ☐ Yes ☐ No	Type of Exercise? How Often?

Tobacco Use
(Cigarettes, cigars, pipes, and smokeless tobacco)

☐ Never		
☐ I quit	Packs/day?	How Long?
☐ I still smoke	Packs/day?	How Long?
☐ Smokeless Tobacco	No. of cans/day?	How Long?

Alcohol and Drug Use

How often do you drink?	☐ Never	☐ Occasionally	☐ Socially	☐ Daily	☐ Weekly
Drinks per week?	☐ Beer	☐ Red Wine	☐ White Wine	☐ Liquor	

Any alcohol-related legal, personal or health problem?	☐ Yes	☐ No
Previous DT's or Seizures?	☐ Yes	☐ No
Treatment for any alcohol-related problem?	☐ Yes	☐ No
Any drug-related legal, personal or health problem?	☐ Yes	☐ No

Name of Patient:	

FINANCIAL POLICIES

MSM & Associates accepts most major insurance plans, we will file your claims for you. Please bring your insurance card(s) with you to your appointments.

Patients are financially responsible for all charges not paid by insurance. **Your co-pay is expected at the time of service.** We accept cash, checks, and VISA, MasterCard, and Discover. If you believe that you will have difficulty paying your bill on time, please contact our Billing Office before or during your visit.

There will be a fee of $25.00 charged by this office for each check returned to us by your bank.

In fairness to others, we require advance notice to cancel or change an appointment. You may be charged a fee for each appointment or test missed or not cancelled with appropriate advance notice. Missing more than two appointments without providing advance notice is grounds for discharge from the practice.

In the event that your account is forwarded to a collection agency, you agree to pay an additional fee equal to 33% of the balance forwarded to the collection agency and any additional attorney fees or court costs.

REFERRAL REQUIREMENTS

If my insurance company requires a referral, I understand that I am responsible for obtaining the referral. If the referral is not obtained, I can be held responsible for payment in full for services rendered on the date of service.

NOTICE OF PRIVACY PRACTICES

I understand that I have certain rights to privacy regarding my protected health information. I further understand that this information can and may be used for any of the following:

1. To conduct, plan and direct my care and follow-up with the multiple healthcare providers who may be directly or indirectly involved in the treatment(s).
2. To obtain payment from third party payers (insurance, etc.)
3. To conduct normal and required healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received or been offered a copy of MSM & Associates Notice of Privacy Practices (available in our office or on our website).

CONSENT FOR MEDICAL CARE

I voluntarily consent to medical care by MSM & Associates that may include examinations, tests, photographs, and treatments by physicians and the staff. No promises have been made to me as to the results of treatments or examinations.

CONSENT FOR MEDICAL HISTORY

I authorize MSM & Associates to access my medical history from outside sources to help keep my medical record as complete as possible. This includes many but not necessarily all medications used in the past. I understand my prescription history from other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here.

SIGNATURE

I have read and agree to the above policies.

Patient Name:	Signature Of Patient Or Legal Representative	Date

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other