Christopher E.Beney, M.D., P.C.

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Adult Registration

Patient Name:___________________________________ D.O.B:____________________

Address:____

City:_____________________ State: _______________________ Zip:________________

Home Phone:__________________ Cell Phone:________________ Carrier: ____________

Email:____

Preferred Method Of Contact: Home Phone Cell Phone Email

Date of your last physical with your previous medical provider:______________________

Race: White/African American/ Hispanic/ American Indian/ Asian/ Other

Ethnicity: Hispanic or Latino/ Not Hispanic or Latino

Primary Language: ____

Employer: ___________________________ Occupation: ___________________________

Marital Status: Single / Married / Divorced / Widowed

Spouse Name: ____

Spouse Phone Number: ___________________________ Spouse D.O.B:_____________

Emergency Contact Other Than Spouse

Name:________________ Relationship: ________________ Phone Number:____________

Name:________________ Relationship: ________________ Phone Number:____________

Name:________________ Relationship: ________________ Phone Number:____________

PLEASE BE PREPARED TO PRESENT YOUR INSURANCE AT EVERY VISIT!

Name of Insurance Company:____

Insurance ID Number:____

Annual Comprehensive Health Questionnaire

The following questionnaire will assist your physician in formulating a comprehensive medical assessment for you at your annual wellness exam. It is essential that you provide interval changes in your medical and family situation as well as details of any current health concerns to allow your physician to be more effective in assessing your present and future health concerns. Of course, if there have been no changes since your last visit, you may simply write "No change." Your responses will be reviewed with you by your physician during your evaluation.

Section 1: Present Health Status:

1. How do you asses your overall health status? ___Excellent ___Good ___Fair___ Poor
2. What would you say your overall health status is over the past few years?

   ___Stable ___ Improving ___ Declining
3. How content are you with your general health?

   ___Very Content ___Somewhat content ___Disappointed in present health.
4. Do you see a Dentist routinely? ___ Yes ___ No When was your last visit? ________

   Are there any concerns regarding your teeth? ___ Yes ___No

   If yes, please explain: ____
5. When was your last eye exam? ____
6. Do you wear glasses or contacts? ___ Yes ___ No
7. Do you have hearing aids? ___ Yes ___ No
8. Do you have an Advanced Care Plan or Directive?

   ___Yes ___No (If yes please bring a copy with you to your next appointment.)

   Would you like to discuss an Advanced- Directive today? ___ Yes ___ No

Section 2: Past Medical History

1. Have you had any significant medical illnesses since your last physical? __Yes__ No

   If yes, please explain:____

   ____
2. Have you been in the hospital or emergency room since your last physical?__Yes__No

   If yes, please list with dates: ____

   ____

3. Have you had any surgical procedures or diagnostic testing since your last physical?

___Yes ___No

If Yes, please list with dates: ____

____

4. Please list your food and drug allergies:____

____

5. Have you had any vaccinations since your last physical? ___Yes ___ No

If Yes, please list with dates: ____

____

6. Do you see any other doctors (specialists)? ___ Yes ___ No

If Yes, please list: ____

____

7. Please list any past surgeries you have had: ____________________________________

____

Section 3: Family History

1. Any new medical illnesses or hospitalizations with your immediate family since your last physical? ___ Yes ___ No If yes, please list who: ____________________________

2. Is there any behavioral health issues in your immediate family? (i.e. depression, stress, alcoholism, illegal drug use, prescription drug abuse.) ___ Yes ___ No

Mother:____

Father:____

Siblings:____

Section 4: Social History

1. What is your marital status? ________ What is your current occupation? ___________

2. Are you sexually active? ___ Yes ___ No Self described Gender orientation? _______

3. Number of Children? ___ Boys ___ Girls

Besides spouse and children, any one else living in your home?

Explain: ____

4. Do you smoke tobacco? ___ Yes ___ No How many per day? ___________________

For how many years? ________________ Are you ready to quit? _________________

5. Are you exposed to secondhand smoke? ___ Yes ___ No

6. Do you drink alcohol? ___ Yes ___ No

7. Do you use illegal drugs or abuse prescription medications? ___ Yes ___ No

   If yes, please explain: ____

8. Have you felt the need to cut down on drinking alcohol or drug use? ___ Yes ___ No

   Have you felt annoyed by others criticizing your drinking or drug use? ___ Yes ___No

   Have you ever felt guilty about drinking or drug use? ___ Yes ___ No

   Have you ever felt you needed a drink first thing in the morning? ___ Yes ___ No

9. Do you follow a healthy diet? ___ Yes ___ No   Specific Diet? ________________

10. Do you exercise? ___ Yes ___ No How Often? ___________________________

11. Do you consume caffeinated beverages? ___ Yes ___ No How Much? _________

12. Do you feel you have an adequate social life? ___ Yes ___ No

13. Do you feel you have the resources necessary (i.e. food, housing, transportation, etc) to meet your daily needs? ___ Yes ___ No

14. Do you have difficulty sleeping at night? ___ Yes ___ No

    Average hours of sleep per night? ________________

15. In the last few weeks have you felt nervous, anxious or on edge? ___ Yes ___ No

16. In the last few weeks have you been unable to stop or control worrying about things? ___ Yes ___ No

17. In the last few weeks have you felt down, depressed or hopeless? ___ Yes ___ No

    If so, please explain: ____

____

____

____

Medications

PLEASE BE AWARE: It is our office policy that we do not prescribe controlled medications. If you are on a controlled medication, you must currently be established with a Physician who can prescribe them.
(Pain specialist, Psychiatrist, Etc.)

Current Medication List:

Medication Name | Strength | How Many Per Day

1.____
2.____
3.____
4.____
5.____
6.____
7.____
8.____
9.____
10.____
11.____
12.____
13.____
14.____
15.____

Name and Address of your preferred pharmacy:_______________________

Phone Number of pharmacy: ________________________________

Signature: ____

**** Please note, if this page is not signed your new patient paperwork will not be entered. ****

Christopher E. Beney, M.D., P.C.

Permission to release Medical Information

I authorize information regarding my care and treatment to be released as set forth on this form to the following person/persons:

I understand that: This authorization may include disclosure of information relating to my medical records, I have the right to revoke this authorization at any time by writing to the provider listed. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditional upon my authorization of this disclosure.

Name_________________ Relationship___________ Phone Number________________

Name_________________ Relationship___________ Phone Number________________

Name_________________ Relationship___________ Phone Number________________

Name_________________ Relationship___________ Phone Number________________

Patient Name: ___________________________________ Date of Birth:_____________

Responsible Party:____

Signature:_______________________________________ Date:___________________

<u>Christopher E. Beney, M.D., P.C.</u>

Financial Policy

*Insurance: We participate in most managed care plans and will bill your insurance plan as may be necessary. If we do not participate with your managed care plan, payment in full is required at the time of service, unless other arrangements have been made in advance. We may be able to bill your plan as a courtesy to you and credit your account if we receive any additional payment. Knowing your insurance benefits- including eligibility, covered benefits, and medically necessary procedures is your responsibility, please contact customer service at your insurance company for questions you may have regarding your coverage. You are responsible for any charges not covered by your plan. We do not accept Worker's Compensation.

*Proof of Insurance: All patients must complete and/ or update our Patient Information form at each office visit. You must furnish valid and up-to-date proof of insurance coverage and a copy of your driver's license. If you provide false or expired insurance information you will be responsible for the balance of the claim. Please notify us of any changes in insurance coverage prior to time of service. Insurance denials for termination of coverage will be automatically billed to you.

*Co-Payments and Deductibles: All co-payments and unsatisfied deductibles must be paid at the time of service. By contractual law your insurance company requires us to change for, and you to pay for, all required co-payments, coinsurances, deductibles, and non-covered services.

*Claim Submission: We will submit your insurance claims to assist you in a way reasonable to help get your claim paid. Your insurance company may need you to supply information directly to them. It is your responsibility to comply with their request in a timely manner. Texas insurance law requires your insurance company to provide timely payment. Please be aware that the balance of your claim is your responsibility to pay whether or not your insurance company has paid. We are not a party to your insurance contract.

*Referrals: If your managed care plan requires approval or authorization for referrals to a specialist, radiological imaging, medical care facility care, etc., It is your responsibility to inform the office of this requirement prior to referral. We require 72 hours notice to facilitate a referral request and cannot issue retroactive referrals.

*Out-Of-Network Care/Self Pay: Please be aware that you have an option to seek care from Physicians even though they are not participating in your network. In this situation, your out-of-pocket expense will be greater. As a courtesy to our out-of-network patients, we will file your insurance claim if desired, and offer a 10% reduction from our usual fees. This benefit also applies to individuals without insurance.

I certify that I, and/or my dependent(s) have insurance and assign directly to Dr.Christopher Beney all insurance benefits, if any, otherwise payable to be for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I also acknowledge the use of my health care information by the above physician may be disclosed to insurance companies and their agents for the purpose of obtaining payment for services and determining benefits payable to related services.

Patient Name: ______________________________ Date Of Birth: __________________

Signature:____ Date: ______________

Christopher E. Beney, M.D., P.C.
Late Arrival Policy

Christopher E. Beney M.D., P.C. would appreciate all patients to be on time for their scheduled appointments. We do understand that things come up and are sympathetic to this. In the event of a patient coming to their appointment 10 minutes late or more after their scheduled appointment time, this would be deemed as “LATE”.

“LATE” is the term we use when a patient arrives later than their scheduled appointment time. Unfortunately being late to an appointment is an inconvenience to those patients present at their scheduled time, and those who need access to medical care in a timely manner. In the event that you arrive “LATE” to your appointment please note that you may be asked to reschedule.

A failure to present at the time of a scheduled appointment will be recorded in your medical chart as a “LATE”. You will be sent a letter alerting you to the fact that you have been late for a scheduled appointment. This is a warning letter. A copy of that letter will be placed in your medical record. After 6 “LATE” Appointments are recorded in the chart, that will result in dismissal from the practice.

By signing below I acknowledge and read Christopher E. Beney M.D., P.C.’s Late Policy.

Name (Please print): ____

Signature: _____________________________________ Date: ____________________

<u>Christopher E. Beney M.D., P.C.</u>
Patient Contract

By signing below, I state that I understand that, as a patient of Dr.Beney's Practice, I am held to the following:

I will follow the direction of the Providers in the practice, whether it is told to me personally by them or thru a staff member.
I will come to the office for a complete physical every year or as prescribed by my Provider.
I will follow thru on referrals my Provider sends me to in a timely manner.
I will get testing done that my Provider prescribes for me in a timely manner, or at the direction of the Provider.
I understand that it is my responsibility to arrange a time to have consultations or testing done.
I understand that the Providers will give me prescriptions to have preventative services done (for example colonoscopy, mammogram, etc.) and I will have these tests done in a timely manner, unless I have refused to have these done and it is documented in my electronic medical record.
When possible, I will contact the office prior to going to an Emergency Room or Urgent Care Center to see if the office can accommodate my acute problem.
If I have an emergency, I will go to the closest Emergency Room, or the Emergency Department the provider directs me to.
I will follow the posted policies of the practice.
I understand that the Practice expects me to pay my account balance in a timely manner.
I understand that the Practice can make financial arrangements with me if I am unable to pay off my bill.
I understand that the Practice will contact me ONCE if I am delinquent in following thru with referrals or testing.
I understand that there is a $50.00 charge for any missed appointments without 24 hours advanced notice.
I understand that if I miss 3 appointments without calling the office to cancel I will be DISCHARGED from the practice.
I understand that if I am delinquent, I risk being DISCHARGED from the practice.
If discharged, I understand that I will be given 30 days to find another Doctor, in accordance to New York State Law.

Signature: ____ Date:________________________