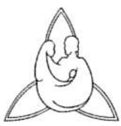


CREDO
FAMILY MEDICINE

Patient Intake Form

• Name: *First*:________________________ *Middle*: ____________________ *Last*:__________________________

Date of Birth: ______/_______/________ Gender: ____Male ____Female SSN:_____-______-________

Address: ____

City: ______________________________ State: __________________ Zip: ________________

Home Phone: (_______)____________________ Cell: (______)_____________________

Email Address: ____ ________________

Marital Status: ____ Single ____ Married ____ Legally Separated ____ Widowed

• Guarantor: ____

• ***Emergency Contact:*** ____

Phone: (_______)_______________________ ***Relationship to Patient:*** ____________________

• Patient Employer: ____

• Preferred Pharmacy: ________________________________ • *How did you hear about us?* ________________

---

1 **Primary Insurance**: ____

Policy Holder Name: ____ Relationship to Patient: ______________

DOB: ______/________/_________ SSN: ______-_______-________ Gender: ___Male ___ Female

Address: ____

If employer provides insurance, list employer here:____

Phone No.: (_______)________________________

2 **Secondary Insurance**: ____

Policy Holder Name: ____ Relationship to Patient: ______________

DOB: ______/________/_________ SSN: ______-_______-________ Gender: ___Male ___ Female

Address: ____

If employer provides insurance, list employer here:____

Phone No.: (_______)________________________

3 **Tertiary Insurance:** ____

If the policy holder information is the same as listed above, please indicate which information applies: 1 ___ 2 ___

CREDO
FAMILY MEDICINE

Consent and Financial Policy

Treatment:

- I hereby consent for Credo Family Medicine to administer health care in all forms, including care, treatment, services, examinations, tests, consultations or procedures to diagnose and treat me and my medical conditions. I voluntarily give such consent and acknowledge I may revoke this consent with a written notice at any time.
- I hereby consent for Credo Family Medicine to administer health care in all forms, including care, treatment, services, examination, tests, consultations, or procedures to diagnose and treat the minor/child ____ in my legal care as Parent/Legal Guardian. I agree that I have the legal authority to act on behalf of said minor and that said minor legally cannot sign for himself/herself.
- I hereby acknowledge that I am aware of the Mission, Values, and Ethics Statements of Credo Family Medicine (as found on their website www.credofamilymedicine.com), and I consent to receiving health care from Credo Family Medicine within the stated parameters of these statements.

Financial Responsibility:

- I hereby acknowledge that I am financially responsible for all services and health care administered to me from Credo Family Medicine, both in office and by form of telemedicine, with such limitations as provided by my insurance company or other third-party benefits contract. I agree that I am responsible and will pay all applicable balances on my account, including co-pays, deductibles and co-insurance amounts. I also agree that I am financially responsible for any services not covered by my insurance or for which my benefits have been exhausted, any out-of-network benefits, and for any services denied coverage through lack of prior authorization on my part. I agree that I will pay my balances with Credo Family Medicine by the dates specified on my account. I acknowledge that if I fail to pay said balances, I may be sent to collections and will be responsible for all processing fees and collection costs including applicable attorney fees and court costs.
- I hereby assign Credo Family Medicine with the ability to access my rights to be reimbursed by my insurance company or other third-party benefits contract. I hereby request that all payments for my health care be made from my insurance company to Credo Family Medicine on my behalf. In the event such payments are not made to Credo Family Medicine from the insurance company, I agree to forward such payments to Credo Family Medicine. I hereby grant permission for Credo Family Medicine to transfer/transmit/receive information regarding my applicable benefits and coverage with my insurance company or third-party benefits contract.
- If I miss without formally cancelling the appointment greater than 24 hours from the appointment time, I will be subject to a $40 fee. This fee will be billed directly to me and not covered by insurance.
- If I am more than 10 minutes late to my appointment, out of respect for the other patients following my appointment, Credo reserves the right to reschedule my appointment to a later time and the $40 fee will apply.
- I will be charged a $50.00 service fee for the completion of paperwork such as for FMLA, Disability, and the like.
- If payment is received via check and my payment is denied for insufficient funds, a $25.00 fee will be applied.
- The above listed fees are not covered by insurance and subject to change at any time.

Privacy Acknowledgement:

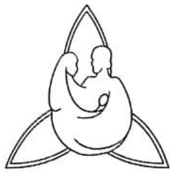
- I hereby consent for the providers and those involved in my medical care of Credo Family Medicine to transfer/transmit/receive my health information as may be required to any person, corporation, or agency who Credo Family Medicine has reason to believe is legally responsible for processing the payment of received health services on my behalf. I further consent that Credo Family Medicine and all providers and those persons involved in my medical care may transfer/transmit/receive my health information to such affiliated health professionals as deemed necessary by Credo Family Medicine for the purposes of fulfilling the administration of my medical care.
- _____ I hereby acknowledge that I have been offered the opportunity to review Credo Family Medicine's Notice of Privacy Practices.

Patient Name: ____

Patient Signature: ____

Parent/Legal Guardian Signature: ____

Guardian's Relationship to Patient: ______________________________ Date: _____/_____/______



CREDO
FAMILY MEDICINE

Patient History Form

Patient Name: ____

Date of Birth: _____/_____/_______ **Age:** ______ **Sex:** ___M ___F **Birthplace:**_________________

Previous Primary Physician: ________________________________ **Last Visit:** _________________

Social History

1. Marital Status:	Single: _______ Married: _______ Separated: ______ Widowed: ______ *Spouse Name:*______________ *or* *Partner Name:*_______________
2. Race/Ethnicity:	
3. Primary Language:	
4. Who lives in the home?	
5. Pets in the home?	
6. Occupation:	
7. Religious Preference:	
8. Alcohol Use:	Never: ____ Current: ____ Former: ____ *Amount per week:* ______________________ *If Former, how long ago was last use?* ______________________
9. Drug Use:	Never: ____ Current: ____ Former: ____ *Type used:* ____________________________ *If Former, how long ago was last use?* ______________________
10. Smoking Use:	Never: ____ Current: ____ Former: ____ Secondhand:____ *Amt per day:* ___________ *Total years smoking:* ________ *If Former, how long ago was last use?:* ______________________
11. Living will/POA?	Yes: ___ No: ___
12. Healthcare Proxy Name:	
12. Will you accept emergency blood transfusions?	Yes: ___ No: ___

Medical History

Preventative Care			
When was your last?	Date	Abnormal	Normal
Colonoscopy			
PAP Smear			
Mammogram			
Bone Density Scan			
Lung Cancer Screening			

Medical Diagnosis/Problems – *Please indicate medical diagnosis and date of diagnosis*					
Diagnosis	**Yes, Type?**	**Date**	**Diagnosis**	**Yes, Type**	**Date**
Alcoholism			High Cholesterol		
Anemia			HIV/AIDS		
Aneurysm			Infertility		
Anxiety/Depression			Kidney Disease/Stones		
Arrhythmia			Liver Disease/Hepatitis		
Arthritis			Migraines/Headaches		
Asthma			Osteoporosis		
Bleeding/Clotting Problems			Pacemaker		
Cancer			Prostate Enlargement		
Colon Problem/Polyps			Psychiatric Illness		
Diabetes; Type			Pulmonary Embolism		
Dialysis			Skin Problem		
Emphysema/COPD			Sickly Cell Anemia		
Epilepsy/Convulsions			Sexually Transmitted Disease		
Eye Problems			Stroke		
Gall Bladder Disease			Suicide Attempts		
Gout			Thyroid Problems		
Heart Disease			Ulcers		
Heartburn/Reflux			Urination Problems		
Other, please specify:					

Drug Allergies	**Date**	**Reaction**
1)		
2)		
3)		

Surgeries/Hospitalizations	**Date**	**Reason**
1)		
2)		
3)		
4)		

PEDIATRIC PATIENTS ONLY – BIRTH HISTORY					
___Vaginal	*___ C-section*	*___Preterm*	*___ Full Term*	*___Shoulder Dystocia*	*___NICU Admit*
Pregnancy Complications (i.e. diabetes, hypertension)?					

FEMALE PATIENTS ONLY – OBGYN HISTORY							
Age of First Menses:		Duration of bleeding:		Cycle Length in Days:			
Menopause Status:	___ Pre ___ Peri ___ Post			Age of Menopause:			
Natural family planning or birth control? What kind?							
Total Pregnancies	Number of Full Term	Number of Preterm	Number of Miscarriages	Number of Abortions	Ectopic Pregnancies	Multiple Births	Number Living
Comments or complications?							

Vaccination History

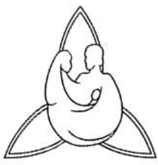
Are you up to date with vaccinations?	Yes: _____ No:_____ Unsure: ______ Refused: _____

Medication List

Medication	Dosage/Frequency	Diagnosis
1)		
2)		
3)		
4)		
5)		
6)		

Family History

Family Health Status					
	Alive	Health Status/Medical Diagnosis	Deceased	Cause of Death	Age Died
Father					
Mother					
Maternal Grandmother					
Maternal Grandfather					
Paternal Grandmother					
Paternal Grandfather					



Vaccination Schedule Form

PEDIATRIC PATIENTS ONLY

I, ____, the parent/legal guardian of

____

born on _______________ _________ of ______________ choose to have the following vaccination schedule for my child. Credo Family Medicine has informed me that the standard of care is the CDC recommended vaccination schedule, which they recommend. I understand the benefits of vaccinating and the potential consequences of not vaccinating my child using the recommended schedule and am aware that the benefits of vaccination and the potential consequences of not vaccinating are also available at www.cdc.gov/vaccines/pubs/vis/default.htm. As the parent/legal guardian, I want my child to receive:

- ☐ CDC Schedule (Recommended)
- ☐ Other (please specify) ____

In the event I choose a vaccination schedule outside the recommended CDC vaccination schedule listed above, I have been informed and I understand that I may be putting my child or others at risk of serious illness if such diseases are contracted by my child that otherwise could have been prevented through vaccination on a regular schedule.

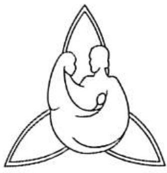
Please provide brief reasoning for your selection above:

____

____

Parent/Legal Guardian Name: ____

Signature: ____ Date: ______/______/_______



CREDO
FAMILY MEDICINE

Medical Records Release Form

Name: ____

Patient Account No.: ____________________

Date of Birth: _______/________/_________

I, ______________________________, hereby grant permission for Credo Family Medicine to disclose, in complete form, my medical records to the parties listed below. By signing this authorization I understand that this release includes all protected health information including any information pertaining to: substance abuse, sexually transmitted diseases, HIV/AIDS, and treatment for psychiatric disorders.

- I am aware there is no requirement to sign this authorization form in order to receive treatment from Credo Family Medicine.
- If this authorization is exercised, I am aware that any protected health information disclosed to the authorized parties listed below will no longer be protected under the privacy obligations of Credo Family Medicine as the actions of these parties are beyond our control.
- I am aware that I may revoke this authorization at any time by providing a signed written request to Credo Family Medicine.

Please fill in the appropriate fields below:

Relative/Representative: ____

Relationship/Role: ________________________ Phone Number: (_____)__________________

Relative/Representative: ____

Relationship/Role: ________________________ Phone Number: (_____)__________________

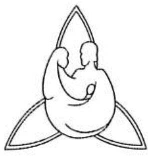
Relative/Representative:____

Relationship/Role: ________________________ Phone Number: (_____)__________________

Date: _____/______/_______

Patient/Guardian Signature: ____

Printed Name: ____



CREDO
FAMILY MEDICINE

Medical Records Request Form

Patient Full Name: ______________________________

Address: ______________________________

Phone Number: (____)______________________ Date of Birth: ______/______/______

I, ______________________________, (Patient/Guardian) hereby grant permission for:

Clinic Name/Physician to Be Requested: ______________________________

Address: ______________________________

Fax Number: (_____)______________________ to release my health information to:

Credo Family Medicine
10050 Auburn Park Dr.
Fort Wayne, IN 46825
Phone: (260) 432-6459 / Fax: (260) 240-5284

For office use only

- ☐ Entire Record, including all categories below ______________________________
- ☐ Hospital Notes ______ **Last year** ______
- ☐ Emergency Reports ______________________________
- ☐ Office Notes ______ **Last 2 notes** ______
- ☐ Lab Results ______ **Last year** ______
- ☐ Imaging and Other Test Results ______ **All** ______
- ☐ Nursing Home/Home Health/Hospice/Other Physician Records ______________________________
- ☐ Financial History Report ______________________________
- ☐ Other: ______________________________

Purpose of release of information: ______ **Transfer of care** ______

I understand that this authorization may remain valid for 1 year post signing of this document. I further understand that I may revoke this authorization by writing to the contact for Credo Family Medicine at any time, except to the extent that this authorization has already been exercised. Credo Family Medicine cannot refuse me treatment based on my refusal to sign this form. I also hereby hold harmless the releasing party from any legal liability that arises from the release of my health information.

I hereby grant permission for Credo Family Medicine to keep a copy of my medical records for their own records.

Patient/Guardian Signature: ______________________________

Printed Name: ______________________________

Relationship to Patient: ______________________________ Date: _____/_____/______