

TOTAL CARE 280

AMY ILLESCAS, MD

Today's Date _____

Last Name _____

First Name _____

WHAT IS THE PURPOSE OF YOUR VISIT TODAY?

Annual Exam Only- I am here for my "Annual wellness examination" which will include a physical exam and may include a pap smear. I require no further testing or evaluation other than a renewal of my current birth control or hormone replacement therapy which have been prescribed here in the past if applicable.

Annual Exam & Other Reason- I am here for my "annual wellness examination" but I also have a problem, complaint or issue that I need to have evaluated/discussed, or I may require a new prescription or refill. I understand that my insurance will require a co-pay for any of these additional evaluations or where a prescription is given other than birth control or hormone replacement therapy.

Office Visit- I am not here for my "annual wellness examination" but for a specific problem, complaint, or recheck that I need evaluated, or I am requesting a new prescription. I understand that my insurance will require that co-pay be made for these services.

I currently have of the following symptoms Cough, Congestion, Sore throat, Fever, Vomiting?

Yes No (If unsure please go to your car and call.)

What is the most important issue we must discuss during our time here today?

1.) _____

Signed _____

Date _____

**TOTAL CARE 280
AMY BENTLEY ILLESCAS, MD
10 MEADOWVIEW DR.
HOOVER, AL 35242**

PATIENT INFORMATION

Date: _____ email address: (PRINT!) _____

Patient Name: _____

Date of Birth: _____ Age: _____ Sex: M F Marital Status: _____

SS#: _____ Preferred Language: _____

Race: ___ African Am ___ Am Indian ___ Asian ___ Native Hawaiian ___ White ___ Other

Ethnicity: ___ Hispanic/Latino ___ Non Hispanic/Latino

Phone: Home: _____ Work: _____ Cell: _____

PLEASE PROVIDE AT LEAST 2 TELEPHONE NUMBERS FOR US TO REACH YOU. FAILURE TO DO SO MAY RESULT IN DELAYS IN COMMUNICATING TEST RESULTS, ETC WITH YOU.

Address: _____

_____ ZIP: _____

Occupation: _____

Employer: _____

Who referred you to us? _____

Primary Insurance: _____

Policy #: _____

Group #: _____

Who is the insured: _____

Relationship to patient: _____

Insured's date of birth: _____

Secondary Insurance: _____

Policy #: _____

Group #: _____

Who is the insured: _____

Relationship to patient: _____

Insured's date of birth: _____

Pharmacy name: _____

Address: _____

Telephone Number: _____

PLEASE COMPLETE THIS PAGE & RETURN WITH INSURANCE CARD & DRIVER'S LICENSE – THEN COMPLETE ADDITIONAL PAGES

SOUTHERN CARE INTERNAL MEDICINE, PC
Amy L. Illescas, MD

**The following people have my permission to obtain or have discussed
with them my Protected Health Information (PHI):**

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

_____ I do not wish to list anyone. I do not want any information to be released.

I understand that you may be transmitting my medical records electronically to other doctors and authorize you to do so. If another party receives them in error, I absolve Total Care 280 (Amy Bentley Illescas, MD) of any and all liability to such submission of said records.

**AUTHORIZATION TO LEAVE MESSAGES WITH OTHER PERSONS OR ON
ANSWERING MACHINES/VOICE MAIL**

I, the undersigned, authorize Southern Care Internal Medicine, PC to leave messages containing medical information, test results, doctor's recommendations on an answering machine/voice mail at the following phone number: _____

I the undersigned, authorize Southern Care Internal Medicine, PC to discuss my medical condition with the following person(s), which may include leaving a message with this person(s) regarding medical information, tests results or doctor's recommendations.

NAME	PHONE NUMBER	RELATIONSHIP
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Patient Signature: _____ Date: _____

SOUTHERN CARE INTERNAL MEDICINE, PC

Amy Bentley Illescas, MD

10 MEADOWVIEW DR.

HOOVER, AL 35242

(205)547-2323

Patient Name _____

Patient's Date of Birth: _____

ASSIGNMENT AND RELEASE

I, the undersigned, authorize my insurance carrier/worker's compensation, including Medicare, to pay benefits directly to Southern Care Internal Medicine, PC and furthermore authorize the release of any and all information required to process my claim to my insurance carrier, including the Centers for Medicare and Medicaid Services (CMS).

I understand I am responsible for all non-covered services, deductibles and co-pays. In the event of a nonpayment or denial of payment by my insurance carrier/workers compensation carrier, I agree to pay all amounts due within 30 days. If I fail to pay the balance due on my account, I will assume all costs of collections, including reasonable attorney's fees as well as the legal rate of interest on the account until paid in full.

CONSENT FOR TREATMENT

Knowing that I (or the patient indicated on the top of this form) desire evaluation and/or treatment at Southern Care Internal Medicine, PC, I voluntarily consent to such care. I consent to routine diagnostic procedures, including but not limited to x-rays, blood draw, laboratory tests, administration of medication and to medical treatment by physicians and staff members of Southern Care Internal Medicine, PC. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of my examination or treatment at Southern Care Internal Medicine, PC. Patients at Southern Care Internal Medicine, PC will be treated regardless of race, color, age, national origin, disability or religion. Notwithstanding the above, Southern Care Internal Medicine, PC reserves the right to refuse care to any individual who may have an unpaid balance, exhibits rude or disruptive behavior or any other reason at the discretion of the office.

This consent shall remain in force until such time as it is specifically revoked.

Patient Name (please print)

Date

Patient Signature/Guardian

Witness

COMPREHENSIVE PATIENT MEDICAL HISTORY FORM

Your answers on this form will help your clinician understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details or date. Thank you!

PERSONAL INFORMATION:

Preferred Name: _____ DOB: _____ Date: _____

Current Health Concerns: _____

MEDICATIONS: (Prescription and non-prescription medications, vitamins, birth control pills, herbs and supplements.)

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY

Drug Allergies or Reactions to Medications / Foods / Other Agents: Yes No Please list: _____

PERSONAL MEDICAL HISTORY: Do you have any of the following?

- | | | |
|------------------------------------------------------------------------------------------|----------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Acid Reflux (heartburn) | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Allergies (environmental) |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Asthma | <input type="checkbox"/> Atrial Fibrillation |
| <input type="checkbox"/> Cancer (list below) | <input type="checkbox"/> Cholesterol Problem | <input type="checkbox"/> Coagulation (bleeding) Problem |
| <input type="checkbox"/> Chronic Low Back Pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Gout | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Heart Disease (explain below) | <input type="checkbox"/> Migraines | <input type="checkbox"/> Osteopenia / Osteoporosis |
| <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Thyroid Problems | |
| <input type="checkbox"/> Other Chronic or Recurring Medical Problems (Please list below) | | |

Patient Name: _____ Date: _____

PRIOR SURGERIES AND HOSPITALIZATIONS: Yes No (Please list all prior operations and hospitalizations)

DATE	SURGERY OR HOSPITALIZATION	DATE	SURGERY OR HOSPITALIZATION

Have you received a blood transfusion? Yes No When? _____

FAMILY HISTORY: Please indicate with a check any family members who have had any of the following conditions:

Check here if you don't know your family history

MEDICAL CONDITION	M	D	B	S	D	S	OTHER CLOSE RELATIVES	MEDICAL CONDITION	M	D	B	S	D	S	OTHER CLOSE RELATIVES
	O	A	R	I	A	O			O	A	R	I	A	O	
Alcoholism								Genetic Diseases							
Anemia								Glaucoma							
Anesthesia Problem								Allergies							
Arthritis								High Cholesterol							
Asthma								Heart Disease (Heart attack, stent or bypass surgery)							
Birth Defects								High Blood Pressure							
Cancer, Breast								Kidney Disease							
Cancer, Colon								Migraine Headaches							
Cancer, Melanoma								Osteoporosis							
Cancer, Other Skin								Rheumatoid Arthritis							
Cancer, Ovary								Seizures							
Cancer, Prostate								Strokes							
Cancer (other list below)								Thyroid Disorders							
Colon Polyps								Tuberculosis							
Depression								Other:							
Diabetes, Type 1															
Diabetes, Type 2															

Immunizations: Please check any immunizations you were given and your best estimate of the month and year it was given.

Tetanus: Y N _____ Pneumonia: Y N _____ Chicken Pox: Y N _____ Hepatitis A: Y N _____
Hepatitis B: Y N _____ HPV (genital warts): Y N _____ Shingles: Y N _____

Patient Name: _____ Date: _____

SOCIAL HISTORY:

Tobacco Use

Please check one

- I have never smoked
- I have smoked, but rarely
When was the last time? _____
- I have quit smoking. Quit Date: _____
How many packs/day? _____ How many yrs? _____
- I currently smoke _____ pack(s)/day.
How many yrs. _____

Other Tobacco: pipe cigar snuff chew
Are you interested in quitting? Y N

Sexual History

Are you sexually active? Y N Not currently
Current sexual partner(s) is/are male female
Birth control method: _____
Have you ever had any sexually transmitted diseases (STD's)? Y N Date: _____ Which STD? _____
Are you interested in being screened for sexually transmitted diseases? Y N

Exercise

Do you exercise? Y N How often? Daily 4 - 6x a week 1 - 3x a week less than one time a week
What form of exercise? (e.g., jogging, cycling, swimming) _____

Safety

Do you use seat belts consistently? Y N
Is violence at home a concern for you? Y N
Are you currently in a relationship? Y N
If yes, do you feel safe in this relationship? Y N
Other concerns? _____

Socioeconomics

Marital Status: single married separated divorced widow
Occupation: _____
Education completed: grade school high school college graduate school
Number of children: _____ Who lives at home with you? _____
Frequent foreign travel? Y N Where? _____

Alcohol Use

Do you drink alcohol? Y N
 never occasionally regularly
Average # drinks/week? 5 oz. wine _____
12 oz. beer _____ 1.5 oz. hard liquor _____
Is alcohol use a concern for you or others? Y N

Drug Use

Do you use recreational drugs? Y N
Have you ever used needles? Y N