Salem Family Primary Care

Patient History

Beth Israel Deaconess HealthCare®

Lawrence General Hospital

Today's Date:

Patient Name: Date of Birth:

Marital Status: Married Widowed Separated Divorced Single

Height: Weight:

Employment Status:

Do you have any health concerns presently?

Please indicate whether you have had any of the following:

| | | | | | |
|---|---|---|---|---|---|
| YES | NO | Anemia or Sickle Cell Disease | HIV Infections/AIDS | YES | NO |
| YES | NO | Arthritis or Back problems | Heart Attack or Heart Failure | YES | NO |
| YES | NO | Asthma | Heart Murmur that requires antibiotics before dental work | YES | NO |
| YES | NO | Bleeding tendencies | Heart Rhythm Abnormalities/Pacemaker | YES | NO |
| YES | NO | Blood Transfusions | Hepatitis, Liver Disease, or Cirrhosis | YES | NO |
| YES | NO | Clotting Problems | High Blood Pressure | YES | NO |
| YES | NO | Bowel Problems | Kidney Disease | YES | NO |
| YES | NO | Bronchitis, Pneumonia, or TB | Seizures or Epilepsy | YES | NO |
| YES | NO | Emphysema/COPD | Stomach Ulcers | YES | NO |
| YES | NO | Cancer, Type | Stroke or Mini-stroke | YES | NO |
| YES | NO | Chest Pain | Thyroid Abnormalities | YES | NO |
| YES | NO | Depression | Fibromyalgia | YES | NO |
| YES | NO | Diabetes | Blood clots/DVT | YES | NO |
| YES | NO | Elevated Cholesterol | | YES | NO |

Please list any other medical problems other doctors have diagnosed:

Please list any other doctor or specialist that you are currently seeing:

32 Stiles Road • Salem, NH 03079
603.870.5452

Salem Family Primary Care

Beth Israel Deaconess HealthCare®

Lawrence General Hospital

# Patient History

Name/address of the lab that you currently use for blood work:

Please list the medications you are currently taking:

| Medication Name | Strength | Times per Day |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Name/address of the pharmacy you use:

Please list any allergies you have to medications, food, etc.:

| Allergen | Reaction/Side Effect |
|---|---|
| | |
| | |
| | |
| | |
| | |

Have you ever had an adverse reaction to anesthesia?

32 Stiles Road • Salem, NH 03079
603.870.5452

Salem Family Primary Care

Beth Israel Deaconess HealthCare®

Lawrence General Hospital

Patient History

Surgical History:

| Procedure | Date | Hospital/Doctor |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Do you have a Health Care Proxy? Yes No If so, who is it?

---

Please indicate family medical history:

| Medical Condition | Relative | YES | NO |
|---|---|---|---|
| Alcohol/Drug Abuse | | | |
| Asthma | | | |
| Bleeding Problem | | | |
| Cancer, Type | | | |
| Depression/Psychiatric Illness | | | |
| Diabetes | | | |
| Allergies | | | |
| Heart Attack | | | |
| High Blood Pressure | | | |
| High Cholesterol | | | |
| Liver Disease | | | |
| Kidney Disease | | | |
| Anesthetic Problems | | | |
| Stroke | | | |
| Epilepsy (Seizures) | | | |
| Other | | | |

## Social History

How many children do you have?

What are their ages?

Who lives at home with you?

Do you use seatbelts consistently?

Do you use a bike helmet regularly?

Do you use sunscreen or protective clothing?

Do you use insect repellant?

Are you a cigarette smoker?

If so, how many packs do you smoke per day?

How many years have you been a smoker?

Are you interested in quitting?

Do you drink alcohol?

If so, how many drinks do you have per week?

Do you drink coffee, tea, and/or caffeinated soda?

If so, how many cups per day?

Do you currently use recreational or street drugs?

Do you exercise regularly?

If so, what exercise and how often?

Are you on a diet?

If so, please describe.

Are you concerned about your weight?

In the past month, have you often:

Felt little interest or pleasure in doing things?

Felt down, depressed, or hopeless?

Beth Israel Deaconess HealthCare®

# Patient Financial Responsibility Guidelines

*Beth Israel Deaconess Healthcare (BIDHC) is pleased you have chosen our practice for your medical care. Quality care is a first priority among our providers. To reduce confusion and keep costs of your care to a minimum, BIDHC requests that you please read the following guidelines to understand your financial responsibility and requirements.*

## Patients with Health Insurance

- Please bring your insurance card to each visit so that the office staff can verify your eligibility.
- Not all services may be covered by your insurance plan therefore the obligation to understand what services are covered remains with you. Please contact your insurance carrier regarding covered services.
- If your insurance requires a referral to see one of our MDs for specialty care, please contact your PCP's office. The referral will need to be in place prior to your visit.

## Co-Payments

- Co-payments will be expected on each date of service when required by your insurance.
- Please understand co-payments may be required when problems are addressed during your annual physical visit.
- If you have questions regarding your co-pay amount, please call your health plan directly.

## Worker's Compensation (WC) / Motor Vehicle Accident (MVA) Visits

- Please inform both the scheduling and check-in staff that your visit is due to either a work-related injury or a motor vehicle accident.
- WC and MVA insurance carriers require related forms to be filled out in order for reimbursement of your claims to occur. Please bring your employer, worker's compensation, auto insurance carrier and/or attorney information to your office visit.
- Patients will be billed directly if the above information requested is not provided to our offices.

**Billing: (617) 754-0730 ♦ Mon-Fri 8:00am-4:00pm**

Beth Israel Deaconess HealthCare®

# Patient Financial Responsibility Guidelines

## Establish PCP with your Health Insurance

- If your health insurance requires the selection of a Primary Care Physician (PCP), please make sure this is in place prior to your appointment.
- Patients may be responsible for the visit if the PCP has not been established with your health plan.

## Self-Pay Patients

- A deposit for services provided in the physician office is expected at the time of your visit. Any remaining balance will be billed to you.

## No Shows

- We require 24 hour cancellation notice if you are unable to keep your appointment.
- Please understand that you may be charged a No Show fee for missed appointments.

## Billing Questions

We realize that special circumstances may arise and will assist you in every way we can to resolve your outstanding balances. Financial hardship discounts are available. To apply please contact our Billing department.

Please understand we reserve the right to transfer delinquent accounts to a collection agency after all efforts have been exhausted to obtain payment from you.

Statements sent to you from BIDHC are for the physician's portion of the visit. Hospital, laboratory and radiology services may be billed to you separately from those facilities. Please call them directly when bill questions arise.

Please feel free to contact our Billing department with any questions at **(617) 754-0730** between the hours of **8:00am-4:00pm, Mon – Fri** or email askapg@bidmc.harvard.edu at your convenience.

**Billing: (617) 754-0730 ♦ Mon-Fri 8:00am-4:00pm**

# Beth Israel Deaconess HealthCare℠

Welcome to your first visit with Beth Israel Deaconess HealthCare. In order to better understand how you learned about our services, please check all answers which apply to you and return this form to the front desk. Thank you!

**The Physician I am seeing today is: _____**

**How did you hear about Beth Israel Deaconess HealthCare?** (check all that apply)

**I Was Referred By**

- ☐ Find-A-Doc Team at Beth Israel Deaconess Medical Center
- ☐ Friend or Family Member
  His/Her Name (optional): _____
- ☐ Health Insurance Handbook, Call Center or Website
- ☐ Physician not Affiliated with Beth Israel Deaconess

**Online**

- ☐ Angie's List
- ☐ Beth Israel Deaconess HealthCare Website (bidmc.org/pcpnow)
- ☐ Online Advertisement, Website: _____
- ☐ Online Google Advertisement
- ☐ ZocDoc
- ☐ Other Online Source _____

**Beth Israel Deaconess Network**

- ☐ Former Patient, Returning to Practice
- ☐ Patient of Beth Israel Specialties, Physician Name: _____

**Beth Israel Deaconess Network Employee**

- ☐ I am an Employee
- ☐ My Spouse is an Employee
- ☐ I am a Former Employee

**Advertisement**

- ☐ Print Advertisement
  ☐ Billboard ☐ Bus ☐ Newspaper ☐ Subway Station ☐ Other
- ☐ Radio Advertisement
- ☐ Television Advertisement

**Community Outreach**

- ☐ Community Event/Fair
- ☐ Speaking Engagement

**Other**

- ☐ Exterior Signage at Practice
- ☐ Newspaper article
- ☐ Mailing to Your Home
- ☐ None of the Above (please explain):

  _____