PHYSICIANS HOME VISITS
COMPREHENSIVE QUALITY HEALTHCARE

PHYSICIANS HOME VISITS
3069 Trenwest Dr., Suite 200
Winston-Salem, NC 27103
Phone: 336.993.3146
Fax: 336.992.3930
www.myhomevisits.com

Patient Questionnaire

Date: ___/____/____

Patient Name: ______________________________ Date of Birth: / /
(LAST) (FIRST) (MIDDLE)

Address: ______________________________

City: ______________________ State: __________ Zip: ______________

Home Phone #: ( ) - ______________ Cell #: ( ) - ______________

SSN: - - ______________ Patient Email address: ______________________

Is Patient currently residing at a community? ☐ Yes ☐ No

If so what communty? ______________________ ☐ Independent Living ☐ Assisted Living ☐ Memory Care

Race: ☐ Asian ☐ African-American ☐ White ☐ American Indian/ Alaskan Native ☐ Native Hawaiian/ Other Pacific Islander

Ethnicity: ☐ Hispanic ☐ Not Hispanic Spoken Language: ______________________

Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Widowed

If married, spouse name: ______________________ Children: ____Sons ____Daughters

Emergency contact name: ______________________________

Relationship: ______________________ Email: ______________________

Cell Phone #: ______________________ Home Phone #: ______________________

Emergency contact name: ______________________________

Relationship: ______________________ Email: ______________________

Cell Phone #: ______________________ Home Phone #: ______________________

Contact Information to schedule appointments if different than patients' information

Name: ______________________________ Phone #: ( ) - ______________

Mailing Address: If bills and other communications from **Physicians Home Visits** should be sent to a different address than patient address above, please provide mailing address here:

Name: ______________________________ Relationship: ______________________

Address: ______________________ City: ______________ State: ______ Zip: __________

Phone: ______________ Cell Phone: ______________ Email: ______________________

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Insurance Information

Please provide copies of all insurance cards

Primary Insurance Information

Insurance Company ____________ Name of Policy Holder ____________

Relationship to patient: ____________ Policy Holders DOB ______/____/______

Policy Holders SSN: ______-______-______ Policy Number: ____________

Group Number: ____________ Insurance Phone #: (   )   -

Submit claims to address: ________________________

City: ____________ State: ____________ Zip: ____________

Secondary Insurance Information

Insurance Company ____________ Name of Policy Holder ____________

Relationship to patient: ____________ Policy Holders DOB ______/____/______

Policy Holders SSN: ______-______-______ Policy Number: ____________

Group Number: ____________ Insurance Phone #: (   )   -

Submit claims to address: ________________________

City: ____________ State: ____________ Zip: ____________

Outside services

- Name of pharmacy: ____________ Phone #: (   )   -

  Pharmacy Address: ________________________

- Do you currently have a Home Health Agency? ☐ Yes ☐ No

If yes, please provide the name of the agency: ____________

- Do you currently have Hospice Services? ☐ Yes ☐ No

If yes, please provide the name of the agency: ____________

- Do you currently have a Patient Companion Agency? ☐ Yes ☐ No

If yes, please provide the name of the agency: ____________

- Preferred Hospital: ____________

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Health Information

Gender: ☐ Male ☐ Female Age: ________ Height: ________ Weight: ________

Education

High School or GED Technical/Professional: ____________________

College (years or degree(s): ____________________

Tobacco use

Does the patient smoke or use tobacco in any form? ☐ Yes ☐ No

Is there a history of tobacco use in the past? ☐ Yes ☐ No

Alcohol use

Does the patient drink alcoholic beverages? ☐ Yes ☐ No

Is there a history of alcohol use in the past? ☐ Yes ☐ No

Recreational Drugs use

Does the patient use recreational drugs? ☐ Yes ☐ No

Is there a history of recreational drugs use in the past? ☐ Yes ☐ No

Allergies ☐ NONE (If yes, please list)

☐ Drugs			
☐ Latex			
☐ Foods			

Your Medical History (check all that apply)

___ Alcoholism
___ Arthritis
___ Anxiety/Depression
___ Autoimmune Disease
___ Bladder/Kidney
___ Cancer
___ Chronic Pain
___ Digestive Issues
___ Diabetes
___ Eczema/Skin Issues
___ Emphysema/Asthma
___ Epilepsy/Seizures
___ Eye Issues
___ Headaches
___ Heart Disease
___ High Blood Pressure
___ HIV/AIDS
___ Intestinal Issues
___ Muscle Problems
___ Repiratory Issues
___ Scarlet Fever
___ Stroke
___ Swallowing Issues
___ Other: ________

Please list any specialist ____________________
Doctors and contact info: ____________________

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Immunizations

Please check all that apply:

☐	Pneumonia vaccination	Date of vaccination	______
☐	Zoster (shingles) vaccination	Date of vaccination	______
☐	Influenza vaccination	Date of vaccination	______

CURRENT MEDICATIONS - (or attach FL-2 and MAR)

Please list all medications that you are taking, including vitamins and over the counter:

	Medication	Dose	Frequency
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

SURGERIES OR HOSPITALIZATIONS

Please list any prior surgeries or hospitalizations:

	Surgery	Date	Location
1			
2			
3			
4			
	Hospitalizations	**Date**	**Location**
1			
2			
3			
4			

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Code Status

Regarding the patient's wishes concerning response to sudden severe change in health condition (also referred to as Code Status), does the patient have either of the following:

☐ Do Not Resuscitate *and/or* ☐ MOST form

Does the patient have a living will/Advanced Directive? ☐ Yes ☐ No

Does the patient have a health care and/or financial POA? ☐ Yes ☐ No

If yes, Name of health care power of attorney: ______________________

If yes, Name of the financial power of attorney: ______________________

Functional Status (or attach FL-2)

How does the patient get around?

☐ Walks independently ☐ Walks with a cane ☐ Walks with a walker
☐ Wheelchair (self-propelled) ☐ Wheelchair (powered)

Does the patient require assistance with any of the following?

☐ Eating ☐ Dressing ☐ Toileting ☐ Bathing

Is the patient continent of bladder? ☐ Yes ☐ No ☐ Sometimes

Is the patient continent of bowels? ☐ Yes ☐ No ☐ Sometimes

Family Medical History

What are the major medical problems, if any, of your parents, grandparents, siblings?

(Check all that apply)	M=Mother, F=Father, S=Sister, B=Brother								
☐ Heart Disease	M	F	S	B	☐ COPD	M	F	S	B
☐ Diabetes	M	F	S	B	☐ Cancer	M	F	S	B
☐ High Blood Pressure	M	F	S	B	☐ Stroke	M	F	S	B
☐ Other:					☐ Other:				

Mother

Is your mother still living? ☐ Yes ☐ No

Date of Birth: ___/___/______

If not, age at death: ______________

Cause of death: ______________

Father

Is your father still living: ☐ Yes ☐ No

Date of Birth: ___/___/______

If not, age at death: ______________

Cause of death: ______________

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How did you hear about ***PHYSICIANS HOME VISITS?*** ________________________________

Thank you for your time and attention to this material. The information you gave will help us to provide care for you and your loved one.

Name of person filling out form if other than patient: ____________________________

Signature: ________________________ Today's Date: ____________________________

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"). I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used for the following:

To conduct, plan and direct my treatment and follow-up among the multiple health-care providers who may be involved in that treatment directly and indirectly. Obtain payment from third-party payers. Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Physicians Home Visits has the right to change its Notice of Privacy Practices from time to time and that I may contact Physicians Home Visits at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Signature: ______________________________ Date: ______________________

Other Signature: ______________________________ Relationship to Patient: ______________________

PHYSICIANS HOME VISITS APPRECIATES THE OPPORTUNITY TO SERVE YOU.

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Compound Authorization

Patient: ____ **DOB:** ____________________

__________ I authorize the release of my medical records to ***PHYSICIANS HOME VISITS*** upon its request, including all examinations, diagnoses, laboratory and imaging studies, and treatments for the past two years.
Release from:

____
(Current or previous physician or facility releasing information)
Address:____
City: ________________________ State: __________ Zip:_________
Phone: (______)______-_______ Fax: (______)______-_______

__________ I authorize payment of my medical benefits to ***PHYSICIANS HOME VISITS*** for services rendered.

__________ I authorize ***PHYSICIANS HOME VISITS*** to give my insurance company any information about services rendered to me as necessary to process claims.

__________ I understand and agree that I am financially responsible for all charges for services rendered to me, including balances owed after insurance payments.

__________ I authorize ***PHYSICIANS HOME VISITS*** to discuss my Medical Care, etc, with the following individual(s):____________________________,
_______________, __________________, ____________________.

Note: ***PHYSICIANS HOME VISITS*** will check all patient's medication histories.

____
Signature of patient or patient's Power of Attorney **Date**

____
(Please print name above) **Date**

*Physicians Home Visits* Patient Portal

We now offer your medical information online, any time, through the *Physicians Home Visits* Patient Portal. The Patient Portal is located on our website www.myhomevisits.com. First, you must contact us by phone, 336-993-3146, to request your username and password and then log on to our website. Be prepared with patient date of birth and your email address so we can assign your login.