Airport Clinic, Inc. **New Patient Information** **Date:** ____/____/____

Name: _____ DOB: ____/____/____
Last First Middle

Address: _____
Mailing address City State Zip Code

Social Security#: ___-___-____ Male__ Female__ Race: _____ Primary Language: _____

Single___ Married___ Divorced__ Widowed__ Separated ____ Live with a partner_____

Occupation, description: _____ Highest Level of Education? _____

Primary Phone #_____ Work #_____ Cell#_____

Emergency Contact:_____ Relation: _____ Phone# _____

Personal Email address:(optional) _____

Do you have a personal physician/specialist? No___ Yes__ If yes, Physician's name/phone _____

Reason for visit. (If injured, describe in detail): _____

1. Check whether you have had these conditions and describe in detail at on line #2.

Asthma		Immune Disease		Depression		Sinus Problems	
COPD		Hepatitis		PTSD		Menstrual Problems	
Heart or vascular disease		Chronic Pain		Substance or Alcohol Abuse		DVT	
High Blood Pressure		Fibromyalgia		Diabetes		Lung Blood Clots	
High Cholesterol		Stroke		Thyroid Disease		Kidney Disease	
Arthritis		Epilepsy		Intestinal Problems		Sleep Apnea	
HIV		Anxiety		Skin Disease		Allergies	

2: Details or other Conditions? _____

3: Place a check mark by any surgeries you may have had (if not listed please write in Other slot.

Appendectomy		Hysterectomy		Other	
Cardiac Bypass		Joint Replacement		No Surgery	
Cardiac Stent (s)		Tonsillectomy/Adenoidectomy		Colonoscopy- Year	Mammogram- Year
Gallbladder Removal		C-Section		Hospitalizations (reason/year):	

Family History: Please CIRCLE any diseases that run in your Immediate family and the family member who had them **Adopted** ____

High Cholesterol	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Brother	Sister	Kids	Oth
Diabetes	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Brother	Sister	Kids	Oth
Rheumatoid Arthritis/Osteo Arthritis	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Brother	Sister	Kids	Oth
Cancer (Kind?)	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Brother	Sister	Kids	Oth
Heart Disease	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Brother	Sister	Kids	Oth
Thyroid Disease	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Brother	Sister	Kids	Oth
Alcoholism/Drug Abuse/Bipolar Disorder/Anxiety/ Depression	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Brother	Sister	Kids	Oth

List any other family medical history you are aware of:

Do you use tobacco products	Y	N	What Kind?	Packs per day?
Former Smoker	Y	N	Amount per day?	How Many Years?
Do you drink alcohol	Y	N	Do you drink, on average, 2 drinks a day? Y or N	Drink more than 5 drinks within 2 hours? Y or N
Do you do illicit drugs?	Y	N	If yes, what kind:	Former Drug User? Y or N

AIRPORT CLINIC, INC.
704 Gil Harbin Industrial Blvd Valdosta,
Ga 31601
Phone: 229-242-9003
Fax: 229-242-0490
Website: www.airportclinicinc.com

PATIENT INSURANCE INFORMATION

Primary Medical Insurance

Insurance Name: _____ **Policy #** _____

Group# _____

Subscriber's Name: _____ **DOB:** ____/____/____

SSN#_____-_____-_____

SECONDARY MEDICAL INSURANCE

Insurance Name: _____ **Policy #** _____

Group# _____

Subscriber's Name: _____ **DOB:** ____/____/____

SSN#_____-_____-_____

Self-pay patient circle: Yes or No

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PATIENT IMMUNIZATION INFORMATION

Date: _____

Patient Name: _____

DOB: _____

Type	Received (YES OR NO)	Year
Td/TDAP		
Covid 1		
Covid 2		
1st Covid Booster		
2nd Covid Booster		
Flu		
Pneumovax		
Shingrix 1		
Shingrix 2		
Hep A 1		
Hep A 2		
Hep B 1		
Hep B 2		
Hep B 3		

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Patient Medication Sheet

Date: _____

Name: _____ DOB: ____/___/_____

Name of Pharmacy: _____

Pharmacy Phone & Address: _____

_____

List all drug or latex allergies & type of reaction, if any:

Name of Drug:	Type of Reaction:
_____	_____
_____	_____
_____	_____

PLEASE LIST BELOW ALL PRESCRIBED MEDICINES INCLUDING INHALERS, BREATHING MACHINE SOLUTIONS, ASA, OVER-THE-COUNTER MEDICINES (NASAL INHALERS, EYE DROPS, ETC) & ANY SUPPLEMENTS, VITAMINS, & MINERALS.

Name of Medication	Dosage	Times/Day	Reason for Taking Medication

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HIPAA Release Form:

Patient Name: _____ Date of Birth: _____

I, _____, do not want to authorize anyone to receive my medical information.

OR

I, _____, hereby authorize Airport Clinic, Inc. to release Any or all medical information and test results that pertain to me under the Health Information Portability and Accountability Act of 1996 (HIPPAA), to the following Individuals:

Name	Phone	Relationship

I authorize Airport Clinic Inc to contact the individual(s) listed above to convey any pertinent information to me, in the event that I am unable to be reached or in case of emergency by the clini

I understand that I may revoke/cancel this authorization by notifying Airport Clinic Inc in writing of my intent to revoke authorization or change the name(s) of the individuals to whom information is to be released.

_____ _____

Signature of Patient Date

_____ _____

Guardian Signature (needs Power of Attorney or Guardianship Documentation) Date

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Payment Policy

To our private insurance patients:

If you have a yearly deductible on your health insurance policy that you have not met, payment for your visit will be due at the time of service. We will file your claim with your insurance company and apply your billed amount to your deductible. If you do not know that amount of your deductible or do not know if you have one, we will be glad to check with your insurance provider. Your patient during this process is appreciated. If we cannot verify the amount of your deductible, your insurance will be billed for the cost of the office visit. Any amount not paid by your insurance will be billed to you separately. Thank you for your cooperation in this matter.

To our cash/uninsured patients;

You must have means of payment available to you at the time of service. If you cannot afford to pay a minimum fee at the time of service, you may seek care in the emergency room. The hospital receives government support to assist low income patients.

To our Medicare Patients:

Under some conditions Medicare may not pay for services, procedures, or medications given in the office. Under these circumstances you may be billed separately for these services. You must sign a waiver for this to occur and will be informed of the treatments which may not be covered at the time of service.

To Our Medicaid Patients:

If your Medicaid is assigned to another physician or medical office, we may need a referral number from the to treat you. A referral number lets your primary physician know what is being done for you and by whom. Under some conditions we may be unable to collect a referral number from your physician. If this occurs you may elect to wait and be seen at a later time by your primary doctor, have your Medicaid primary medical office changed to our facility or seek medical care in the emergency room.

Any payment denied by your financial institution will be assessed a $25.00 service fee in addition to original fees.

Please ask if you would like to arrange a payment plan for any amounts you will be billed. We will be happy to work with you.

Print Patient Name	Patient(guardian) Signature	Date

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Medical Release Form

Date: _____

Records requested from:

_____

_____

_____

_____

I, _____**, hereby authorize and request that you relase the following information:**

_____

_____

_____

Release records to: **Airport Clinic, Inc**
704 Gil Harbin Industrial Blvd
Valdosta, Ga 31601
Phone: 229-242-9003
Fax: 229-242-0490

_____ _____
Patient Signature **Date of Birth**

_____ _____
Social Security # **Witness Signature**

Please contact our office with any questions
229-242-9003