

Patient Information

Today's Date: / /

Patient Title: Mr. Mrs. Ms. Mx. Miss. Dr. Prof. Rev.

First Name _____ Last Name _____

Middle Name _____ Suffix _____

Address 1 _____

Address 2 _____

City _____ State _____ Zip Code _____

Primary Phone _____ Cellphone _____

Email Address _____

Date of Birth _____ Gender Male Female Unspecified

Marital Status (check one) Never Married Married Domestic Partner

SSN _____ Separated Widowed Divorced

Employment Status Employed Unemployed Full-time Student
 Part-time Student Retired Student

Race American Indian or Alaska Native Asian Black or African American
 Hispanic or Latino Native Hawaiian or Pacific Islander White

Ethnicity (check one) Hispanic or Latino Not Hispanic or Latino

Employer _____ Occupation _____

Employer Address _____ Business Phone _____

Spouse's Name _____ Phone Number _____

Emergency Contact _____ Relationship to Patient _____

Cellphone _____ Home Phone _____

Insurance Info: Plan Name _____

Group # _____ ID# _____

Subscriber's Name _____ Date of Birth _____

Relationship to Patient _____ SSN _____

Method of Payment: Cash Check Credit Card

Signature of Patient or Legal Guardian

Date

New Patient Intake Form

Name: _____ DOB: _____

Today's Date: _____ Age: _____

Best phone # to reach you: _____

What pharmacy do you use? _____

It is important that you are aware of your own medical history. Please fill in below and we will review your answers with you.

When was your last Wellness Exam? _____

What other doctors do you see? (Le. Cardiologist, Gynecologist etc) _____

Any drug allergies? _____ Any other allergies? _____

What medications do you take? _____

What medical conditions do you have? _____

What surgeries have you had? _____

What medical conditions run in your family? Specifically your:

Mother: _____

Father: _____

Brothers and Sisters: _____

Your Children: _____

Any one else in the family ever have cancer or a clotting disorder? _____

I am: single / married / divorced / widowed

I am attracted to: Men / Women / Both

Do you have any children? _____

Who lives in your home? _____

Do you currently work or go to school? _____

Do you smoke tobacco? Yes / No

If yes, how many packs per day? _____ How long have you been smoking? _____

Do you drink alcohol? Yes / No How many drinks per week? _____

Do you use marijuana? Yes / No

Do you use any illicit drugs? (ie cocaine, heroin, etc.) Yes / No

When was your last tetanus shot? _____ Flu Shot? _____

Last time you went to the eye doctor? _____ Dentist? _____

(If applicable) Last colonoscopy? _____

(Females only) Last PAP Smear? _____

Mammogram? _____ Dexa (Bone Density Scan)? _____



Lowney Medical Associates, Inc.
1234 Hyde Park Ave. Hyde Park, MA 02136
Tel. 617-364-2420 | Fax: 617-364-1845

HIPPA contract/sharing information consent

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

	May we leave a message and/or medical info?	Which number is primary for messages?
Phone (Home) _____	Y N	<input type="checkbox"/>
(Work) _____	Y N	<input type="checkbox"/>
(Cell) _____	Y N	<input type="checkbox"/>

Do you have an email address? Y/N (if yes, please print clearly):

If so, may our providers contact you at the address, possibly with medically sensitive details? Y/N

Please list all people that we may speak to about you and your medical status:

*Due to HIPPA regulations, we may only discuss health information with people you have listed below (this includes parents and/or spouses)/

NAME	PHONE #:	RELATIONSHIP TO PATIENT
------	----------	-------------------------

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please note this consent will be valid for one year (from date signed). If your contact information changes before the end date, please complete a new form. This may be revoked at any time, in writing. The information is for your protection and we appreciate your cooperation in protecting you and your rights.

Patient (or Guardian) Signature _____ Date _____



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Prescription Policy

Writing prescriptions for medication is considered an extremely important responsibility for the physicians working in this office. When you receive a prescription from Lowney Medical Associates please take the medication as directed. If there are any questions that you may have concerning the proper use of the medicine, please address them during your visit. If you are given a prescription for a pain medicine or a muscle relaxer it is your responsibility to secure that prescription after you have left the office. Lowney Medical Associate doctors will not re-write your prescription for this medication if it is lost or stolen.

Please do not run out of medication that you must take regularly. Our physicians write the prescriptions for your medication anticipating your next visit. You would need to have an office visit at least one or two weeks prior to running out of your medicine for an evaluation and refills. Phone-in refills for medication are not accepted unless there is an unusual circumstance.

Lowney Medical Associate physicians do not write prescriptions for pain medication at night or over weekends. If you have significant pain and need urgent assistance you can call the office "on-call" physician or go to the Emergency Department at your local hospital. No pain medication will be prescribed over the phone.

By signing below you have read the above information agree to Lowney Medical Associates "Prescription Policy."

Print your name

Sign your name

Date



Lowney Medical Associates, Inc.

Charles W. Lowney, D.O.,FACFP, FAANaOS-C

Jeremiah J. Lowney, D.O.,FACP, MMS

Michael P. Lowney, D.O.

1234 Hyde Park Ave. Hyde Park, MA 02136

Tel. 617-364-2420 | Fax: 617-364-1845

STATEMENT OF UNDERSTANDING

ASSUMPTION OF FINANCIAL RESPONSIBILITY FOR MEDICAL SERVICES

I acknowledge that I voluntarily sought the services of Lowney Medical Associates, a participating provider. I accept full responsibility for paying for services provided by Lowney Medical Associates that are not covered by my health insurance plan. I understand that my insurer will not pay the provider nor reimburse me for the cost of services rendered here, or for any subsequent or ancillary services which the provider may order on my behalf, if this insurance is not truly in effect, or if the provider is not considered my primary care physician. I further acknowledge that it is my responsibility and not the provider's to know what services are covered by my insurer. I accept full responsibility for paying for services provided if they are not covered by my insurance.

Patient's Name

Date of Birth

Patient's Insurance ID Number

Responsible Party's Signature

Today's Date



Lowney Medical Associates, Inc.
1234 Hyde Park Ave. Hyde Park, MA 02136
Tel. 617-364-2420 | Fax: 1-877-515-5073

Authorization for release of protected health information

I authorize _____ to release my Protected Health Information (PHI), including copies of my medical records to, Lowney Medical Associates. INC.
Purpose of records:

*medical treatment *legal matter *personal

Include treatment dates from _____ to _____

Information to be released, (please check all that apply)

- immunization radiology reports ekg reports
 medical progress notes laboratory test results last physical
 other, (please specify) _____

I understand that my records may contain some highly confidential information.

By initialling, I am specifically authorizing its release.

- STD's substance abuse mental/psychiatric treatment
 HIV testing/treatment genetic testing sexual/domestic abuse

I understand that I can withdraw my authorization for release of my PHI information at anytime by indicating in writing to the Medical Records Manager, as long as action has not already been taken in releasing it.

I understand that the PHI requested via this authorization may be released by the recipient/receiver to another party and may no longer be protected by the privacy rules.

I understand that if I refuse to sign this form, I will not be refused treatment and my payment, health plan enrollment or eligibility will not be affected.

I have carefully read and understand the above and therefore authorize disclosure of my protected information to the person or agency indicated above.

This authorization is good for one year from date of signature or until expiration indicate.

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

Parent or legal guardian if minor: _____