Patient Information Today's Date: / /

Patient Tittle: ☐ 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
☐ 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_____

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 lona 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	☐
	(Work) _____	Y | N	☐
	(Cell) _____	Y | N	☐

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 medica0on 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 secute 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 mn 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
(name of facility releasing records)
Information (PHI), including copies of my medical records to, Lowney Medical Associates. INC.
Pug›ase 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 be 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 no 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:_____