BERMUDA HEALTHCARE SERVICES

Phone: 441-236-2810 Fax: 441-236-2835

PATIENT INFORMATION

Today's Date: DD / MM / YY

Patient's Name _____ Preferred Name: _____
Surname First Name Middle Name

Date of Birth: DD / MM / YY Sex: Male / Female

Race: _____ Language: English ( )Yes ( ) No - Other: _____

Mailing Address: _____ Postal Code: _____

Email: _____

Please circle preferred contact phone number below.

Home: _____ Work: _____ Cell: _____

Spouses Name: _____ Spouses Phone for emergencies: _____

Emergency Contact (other than spouse): _____ Phone Number: _____

Who may we discuss your medical condition with? _____ Relationship: _____

How did you hear about our practice? : _____

Pharmacy Choice: _____

I authorize the release of medical information to other physicians and to consultants, if needed, and, as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature _____ **Date** DD / MM / YY

INSURANCE INFORMATION

(Insurance Card, Picture ID, and copayment/patient balance, must be provided at the time of service)

Name of Policyholder: Surname: _____ First Name: _____

Insured's Date of Birth: DD / MM / YY **Relationship to Insured:** (Parent / Spouse)

PLEASE CIRCLE INSURANCE COMPANY:

Insurance Co. ARGUS, ARGUS-HIP, BF&M, COL., COL-HIP, GEHI, HIP, FUTURE CARE, FRIE-BRUC, OTHER _____

Policy Group Number: _____ Certificate Number: _____

I hereby assign, transfer and set over to, Bermuda HealthCare Services, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. Payment is required for all services at the time they are rendered. I agree to the policies, terms and conditions of Bermuda HealthCare Services. I agree that all agency charges, legal costs and other expenses incurred by Bermuda HealthCare Services in attempting to recover overdue amounts will be charged to my account. I understand that unpaid debt will be forwarded for collections after 90 days if no other arrangement has been made.

Patient or Responsible Party Signature _____ **Date** DD / MM / YY

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TODAY'S DATE: DD / MM / YY

Surname: _____ **First Name:** _____ **Middle Name:** _____

DOB: DD / MM / YY **Marital Status:** [ ] **Single** [ ] **Married** [ ] **Divorced** [ ] **Widowed**

Alcohol: [ ] **Never** [ ] **Occasionally** [ ] **Daily**

Tobacco: [ ] **Never** [ ] **NO** [ ] **Yes** [ ] **Occasionally** _____ **packs/day** **Year Stopped** _____ **Cigars/Smokeless**

Have you ever been diagnosed with any of the following medical conditions?

____ Asthma	____Hepatitis/Liver Disease	____Migraines
____Blood Clots/DVT/Phlebitis	____Herniated Disc	____Seizures
____Cancer	____High Cholesterol	____Stroke
____Diabetes	____Hypertension/High Blood Pressure	____Thyroid Disease
____Emphysema/COPD	____Heart Attack	
____Heart Failure	____Kidney Disease	

Please list any other medical diagnoses or problems: _____

_____

Please list any other physicians that you may be seeing: _____

_____

Please list any surgeries or hospital admissions and year of admission(s): _____

_____

Please list any lifetime events: (e.g. children, hysterectomy, etc..) _____

_____

List all prescription medications that you are currently taking:

	Drug	Drug Strength/Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			

List any non-prescription (over-the-counter) medicines (e.g. supplements/vitamins/aspirin) that you take regularly:

_____

_____

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Please list medication allergies and describe any reaction to this medication:

_____

Please list all other allergies and describe any reaction to those allergens:

_____

Please describe the medical history of your immediate family listing any major problems such as heart disease, diabetes, cancer, high blood pressure, stroke, tuberculosis, neurological disease, and whether living or deceased (L/D):

	L / D	Age	Major Medical Problems
Mother			
Father			
Sister(s)			
Brother(s)			
Mt.G-Mother			
Pt.G-Mother			
Mt.G-Father			
Pt.G-Father			
Daughter			
Son			

Please circle any symptoms or problems that you are currently experiencing:

Abdominal/Pelvic Pain
Abnormal Vaginal Discharge
Abnormal Weight Gain
Anxiety
Blood in Urine
Blood in Stool
Black Stools
Breast Mass / Tenderness
Chronic Cough
Chronic Diarrhea
Chronic Constipation
Chest Pain
Depression
Difficulty Hearing
Fatigue
Faintness/Dizziness
Fever/Chills
Frequent Urination
Frequent Nose Bleeds
Headaches
Heart Racing
Heartburn
Impotence
Memory Problems
Muscle/Joint Pain
Nausea
Night Sweats
Numbness in Arms or Legs
Palpitations
Shortness of Breath
Skin Rashes
Swelling of the Legs or Feet
Swollen Glands or Lymph Nodes
Testicular Pain / Mass
Tremor
Trouble Swallowing
Trouble Urinating
Ulcers of the Skin
Unintentional Weight Loss
Vertigo
Vision Problems
Weakness in General
Weakness in Arms or Legs
Wheezing

Patient Signature: _____ **Date:** DD / MM / YY

Name: _____ _____ DD / MM / YY

Completed by: [ ] Patient [ ] Nurse [ ] Caregiver [ ] Friend [ ] Family Member **Signature** **Date**

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FINANCIAL POLICY AND DISCLOSURE

Patient Name: _____ DOB: DD / MM / YY

The Financial Policy and Disclosure is to help Bermuda HealthCare Services provide the most efficient and reasonable health care services. Therefore, it is necessary for us to have a Financial Policy and Disclosure stating our requirements for payment for services provided to patients.

Self-Pay Policy:

- If you are a self-pay patient, you will be required to pay your balance in full at the time of service.

Insurance Policy:

- If you are an insurance patient, we require the coverage to be verified for each patient at each visit.
- If a service is provided that is not covered by your insurance company, or is not covered in full by your insurance company, you will be the responsible party at the time of service.
- Patient co-payments will be collected at the time of service.
- In special cases, we may need your help in contacting your insurance company for the payment of your services, and, therefore, you must agree to fully cooperate in assisting us should that be necessary.

Cancellation / No-Show:

- We require 24 hours notice to cancel your appointment.
- Patient's failing to cancel an appointment without 24 hours notice are subject to a $10.00 missed appointment / no-show fee.
- Payment of any outstanding no-show fees will be required to schedule another office visit.

To help in this policy we ask that you assist us by:

1. Providing us with current and updated information on yourself and your insurance company.
2. Presenting an updated photo identification card and insurance card when changes are made.
3. Making the appropriate payment at the time of service: copay for insured patients, full amount for uninsured patients.

In order to provide the best medical care, we ask that you not discuss your account balance or financial aspects with the physician(s) or medical staff. Please discuss any account information with the check-in or check-out associate, and/or billing coordinator.

Acknowledgements: I acknowledge and agree to the terms and conditions of the Policies described.

_____	_____	DD / MM / YY
Responsible Party's Name	**Responsible Party's Signature**	**Date**

Prescription Policy:

New prescriptions always require an office visit.

Offices visits are required for patients who:

Have not been seen by the doctor in the past year and/or who are requesting new prescriptions and/or antibiotics.

Refill Request outside of an office visit will require payment of a $10.00 (ten dollar) Prescription Refill Fee.

Prescription Refill Request require a minimum of 24 business hours notice for all prescriptions.

Forms:

Completion of forms requires an office visit with the physician.

Completion of TCD forms requires an office visit with the physician if you have not been seen within the past three months.

Expectations:

Patients arriving 15 minutes past their scheduled appointment time will be asked to reschedule their appointment.

Patient phone messages received prior to 2:00pm will be returned before 6:00pm that day, Monday-Friday.

Patient phone messages received after 2:00pm will be returned the following business day no later than 1:00pm.

_____	_____	DD / MM / YY
Responsible Party's Name	**Responsible Party's Signature**	**Date**