JOHN DAVID BLANKENSHIP FAMILY PRACTICE **PHONE (256) 534-7235**

PATIENT_____ _____ Date_____

Sex ___DOB ___/___/___ Soc Sec #_____email_____

Address _____City_____ St___ Zip _____

Phone Hm_____Cell_____Bus_____

Marital Status: Never Married ___Married___ Widowed ___Divorced___

Employer_____ Phone_____

Spouse Name _____ _____ ___ DOB: ___/___/___

SpouseEmployer_____Phone_____

Race: Caucasian__ African-American__American- Indian__Asian__Hispanic__Other__
Ethnicity: Unknown____Hispanic/Latino____Non Hispanic/Latino____

EMERGENCY CONTACT:

Name_____Relationship:_____Phone:_____

FINANCIALLY RESPONSIBLE PARTY: SELF SPOUSE PARENT

Name_____ _____ ___ Soc Sec#_____

DOB___/___/____Phone Hm_____Cell_____Bus_____

Address _____City_____ St ___Zip_____

INSURANCE INFORMATION: Subscriber_____Relationship_____

Primary_____Policy#_____Group#_____

Secondary_____ Policy #_____Group#_____

This information is accurate and true to the best of my knowledge. I give my consent to Dr. John David Blankenship to administer medical care and treatment to me and to release my information to my insurance provider for benefits to be paid him for services rendered. I understand that I am responsible to pay for all services, regardless of insurance status, including all fees incurred for collection attempts, should that become necessary. I authorize release of my information to proper authorities for the resolution of any dispute.

Signed_____Date_____

J. D. Blankenship, D.O., LLC
256-534-7235

401 Lowell Drive, Suite 14
Huntsville, AL 35801

NOTIFICATION OF PRIVACY RIGHTS

I, _____acknowledge I have

been advised of my privacy rights and the Notice of Privacy Practices has been made available to me.

(If patient or personal representative is unable or refuse to sign this form, document refusal. This document to be included in patient medical record.)

_____ _____
SIGNATURE OF PATIENT OR REPRESENTATIVE **DATE**

PERMISSION TO DISCUSS MY MEDICAL CONCERNS

J. D. Blankenship, D.O., LLC is authorized to discuss my medical information or needs with the following individuals:

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

_____ _____
SIGNATURE OF PATIENT OR REPRESENTATIVE **DATE**

REQUEST FOR RELEASE OF MEDICAL RECORDS

Name:_____

Date of Birth:_____ Soc Sec#:_____

I hereby authorize release of my medical records from:

Doctor/Practice:_____

Address:_____ City:_____ St____

Phone:_____Fax_____

To: Dr. John David Blankenship, D.O.
401 Lowell Drive, Suite 14
Huntsville, AL, 35801
Phone: 256-534-7235 Fax: 1-877-845-9969

**Please insert documents so

Please indicate if you do not wish any of the following records to be released:

- Mental health treatment records, inclusive dates:_____to_____
- Drugs and/or Alcohol dependency records.
- HIV(AIDS) Antibody test results, test date:_____
- HIV(AIDS) diagnosis/treatment records, inclusive dates: _____to_____

Signature of patient or representative: _____
Date:_____

J.D. Blankenship, D.O. LLC

401 Lowell Drive Suite 14
Huntsville, Al 35801
Phone: 256-534-7235
Fax: 256-534-7265

Dear Patient:

In an effort to provide you with flexible arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS MUST BE MADE AT THE TIME OF YOUR VISIT

Our office is an accredited user of the Visa and MasterCard Health Care Program, and we offer the following payment options, please select the payment method you prefer:

_____ Payment with cash

_____ Payment by check

_____ Payment by credit card (Visa, MasterCard, Discover, Debit, FSA Card)

Please note that we will charge self -pay patients the Blue Cross allowable amount.

Please print and sign your name below confirming that you have read our payment policy, and understand that payment is expected at the time of your visit.

_____

PRINT NAME

_____

SIGN NAME

_____

DATE

Practice Information for Patients

Welcome to the Family Practice of John David Blankenship, D.O. I am truly honored and grateful that you have chosen to trust us with your medical care. This practice has been established to provide individualized care for families in the Huntsville area. While I was raised in Huntsville, I have lived in a number of locations since leaving for college in Nashville in 1988. I graduated from Kirksville College of Osteopathic Medicine in 1997 and finished my Family Practice Residency in Montgomery, AL in 2001. After eight years in a family practice group in Corbin, Kentucky I moved my family back to Huntsville in 2009. I spent three years working in emergency medicine and urgent care clinics in North Alabama. My experiences motivated me to open a solo family practice that combines the best of modern technology with a comprehensive, individualized approach to care in July 2012. This will hopefully produce high quality integrative healthcare with measurable results and improved patient satisfaction. To accomplish this goal, the practice will focus on the principles of access, interaction, reliability and viability. Ultimately, almost all of our decisions are made in order to allow the physician to spend a few more minutes with each patient.

To provide this type of healthcare, it is essential that the practice maintains a low overhead, a manageable volume of patients, leverages technology and empowers patients to participate in all aspects of their healthcare.
Please read carefully:

Appointments

1 For sickness or urgent complaints - we will try to see patients within 24 hrs and will therefore keep close to half of our patient appointments open until a day begins. *Appointments may be requested through the patient portal or by phone*

2. Routine Visits for chronic problems – are only scheduled in a 3 month window. If you are supposed to return more than 3 months later then you will receive a card that reminds you to call us when you leave your appt. *Routine visits may be requested through the patient portal or by phone*. **Bring all medicine bottles. All refills of daily medicines should be handled at the visit. Please make appointments 2 weeks prior to running out of medicines.**

3. Cancellations - please notify us 24 hrs in advance or there may be a $30 charge. Repeated failure to cancel appointments may result in dismissal. *You may cancel an appointment through the patient portal or by phone.*

Medicine Policy

1. If possible, I will prescribe generic medicines and avoid medicines requiring high copays or prior authorization.
2. If a medicine requiring a prior authorization is deemed necessary, - a follow up appointment to complete the application may be required.
3. If medicines need to be changed due to cost or insurance or change in pharmacies - the patient should make an appointment.
4. Refills - should be requested and handled at the office visit. A 1 month's supply will be given for refill requests by phone or portal and an

appointment scheduled. Please allow 48 hrs. or 2 business days for refills. Please schedule visit 2 weeks prior to running out of mail order medicines

5. After hours - I do not call in antibiotics, pain or sleep medicines, or refills of routine medicines

Forms

Please bring all forms that need to be completed by the physician to the office appointment. A $30 charge may be applied to forms completed apart from the office visit. This includes but is not limited to: Short term disability, Life Insurance, All insurance applications, Sports Physical, College Physical, Foster Care, FMLA, Subpoena for lawsuits, Free Medicine Applications, Auto insurance forms**.**

Communication – Phones and Computer Portal

Phones:
4 – Refills
5 – Appointments or to speak to the Receptionist
6 – Medical Assistant
9 – Repeat
After office hours - call is directed to the answering service that will Contact the physician on call

Patient Portal

In order to communicate more effectively with our patients, we have a patient portal, YourHealthFile.com. We appreciate your patience as we strive to improve this tool.
At this time, we prefer to notify patients of

Normal lab values - by the patient portal under messages on the home/ first page

Normal screening tests and tests for non-emergency problems - by portal, i.e. pap smears, dexa scan, Aortic Aneurysm Ultrasound etc

Pre-clinic labs - are discussed at the upcoming visit

Significantly abnormal tests/labs – by phone or both phone and portal

Copies of lab values – are available on the portal under the Documents tabor at your visit. Paper copies of labs are not mailed

Miscellaneous

Co-pays are expected at the time of service.
For patients without insurance, fees are based on the Blue Cross Allowable Amount.
Facebook address: John David Blankenship, D.O.
Website: www.blankenshipfamilymedicine.com

NAME:_____ DOB:_____/_____/_____DATE:_____/_____/20____

Are you allergic to the following?

Drugs with reaction:_____

_____

_____

Any other allergic reactions:_____

_____

_____

Medications:

Drug	Times a Day	Dose

Family History

Condition	Father	Mother	Sister	Brother
Alive				
Heart Disease (explain)				
Cholesterol				
Stroke				
Asthma				
Diabetes				
Clotting Disorder				
Drug Addiction				
Alcohol Addiction				
Depression				
Anxiety				
Cancer (Type)				

Immunizations

Vaccine	Year
Tetanus	
Tetanus/Whooping Cough	
Pneumonia	
Flu	
Shingles	
Hepatitis B	

If under 18, please bring immunization records.

Specialists/Other Doctors

Procedures/Labs

Name	Specialty/Type	What For	Last Seen

Test	Year
AAA Screen	
Cancer	
Cholesterol Panel	
Colonoscopy	
Glucose	
Bone Density	
Heart Cath	
Lung CT	
Upper Endoscopy	
Stress Test	
Women: Pap smear Mammogram	
Men: PSA	
Other	

Signature:_____ Date:_____

NAME:_____ DOB:_____/_____/_____DATE:_____/_____/20____

Medical History

Anemia ☐	Anxiety ☐	Arthritis ☐	Asthma ☐
BPH ☐	Back Problem ☐	Breast Cancer ☐	CAD ☐
CHF ☐	COPD ☐	Cancer ☐ Type:_____	
Cholesterol High ☐	Dementia ☐	Depression ☐	Dermatitis ☐
Diabetes ☐	Epilepsy ☐	GERD ☐	Glaucoma ☐
Gout ☐	HIV ☐	Headache ☐	Hepatitis ☐
Hypertension ☐	MI ☐	Migraine ☐	Pneumonia ☐
Renal Stone ☐	Stroke ☐	Allergies ☐	Ulcer (GI) ☐
Hypothyroid ☐	Hyperthyroid ☐	IBS ☐	

Other:_____

Pregnancies: Live Births:_____ Miscarriages:_____ Stillborn:_____ Menopause Onset: Yes No

Social History

Marital Status:_____ Number of Children:_____ Pets:_____

Do you Smoke? Yes No If so, how many packs per day? _____ Start:_____ Quit:_____

Do you drink Alcohol? Yes No If so, how many/how often? _____ Kind:_____

Please list any recreational drugs used:_____

Religious Preference? _____

Surgeries

Aortic Aneurysm ☐	Appendectomy ☐	Breast Augment ☐	Breast Reduction ☐
ABG ☐	Carotid Endarterectomy ☐	Cataract Extract ☐	C-Section ☐
Colectomy ☐	ESWL ☐	Ectopic Pregnancy ☐	Gall Bladder ☐
Gastric Banding ☐	Heart Valve ☐	Hernia ☐	Hip Fracture ☐
Full Hysterectomy ☐	Partial Hysterectomy ☐	Intestinal By-Pass ☐	Knee Arthroscopy ☐
Knee Surgery ☐	LS Spine Surgery ☐	Lasik ☐	Mastectomy ☐
Oophorectomy Uni ☐	PTCA ☐	Pacemaker ☐	Prostatectomy ☐
Sinusectomy (Nasal) ☐	Splenectomy ☐	Thyroidectomy ☐	Tonsillectomy ☐
Tubal Ligation ☐	Vasectomy ☐	Hip R L	Knee R L

Shoulder R L **Other:**_____

Review of Systems

Please **CIRCLE** any of the following symptoms you have had recently:

General
Fatigue/Daytime sleepiness
Weight loss/gain
Fever, night sweats

Eye
Eye pain
Vision change

Head,Ears,Nose,Throat
Hearing problems
Sore Throat
Runny nose

Endocrine
Excessive thirst
Swelling in neck

Cardiovascular
Chest pain
Palpitations
Shortness of Breath with exertion

Respiratory
Wheezing
Cough
Excessive snoring

Gastrointestinal
Heartburn
Abdominal Pain
Blood in stool
Black tarry stools

Genitourinary
Frequent urination
Discomfort/pain/burning with urination
Women: Hot flashes
Irregular periods
Men: Decreased urine stream
Dribbling urine
Multiple need to urinate at night

Musculoskeletal
Joint or Bone Pain
Back Pain
Neck Pain

Skin
Rash
Change in skin lesion
New skin lesion

Neurologic
Dizzy Spells
Speech problems
Memory Problems
Headaches

Psychiatric
Sad
Irritable
Suicidal

Endocrine
Easy bleeding or Bruising

Other:_____

Signature:_____ Date:_____