

**SCHOLL – FARMER – SHORE  
INTERNAL MEDICINE**

Jean Scholl, M.D. Cheryl Farmer, M.D. Pamela Shore, M.D.

**Welcome to the office of Drs. Scholl, Farmer and Shore.**

**What you can expect:**

We try to return phone calls promptly. We sometimes return calls in the evening, after the practice is closed. A physician is on call for our practice 24 hours a day, 7 days a week. If you have an urgent problem, you will be able to speak with an on call physician who will direct you as to the next steps in your care.

If you need a prescription refill, please have your bottle in front of you when you call and give us the following: your name, the name of the medicine, the dosage, how many pills you take a day and the number of your pharmacy. We will call in your prescription within 24 hours.

**Your responsibilities:**

Insurance co pays and balances need to be paid at the time of your visit.

If your insurance requires a referral for visits to a specialist, we need 5 days notice before your appointment with the specialist to process the referral.

If you have missed two appointments (without 24 hours notice) you will be charged \$25 for any subsequent missed appointments, and \$50 if the appointment was for a complete physical exam.

There is a charge of \$35 for each form filled out by the physician, and a charge of \$75 (depending on chart size) for copies of chart records. Please fill out the form as completely as possible and sign for release of information prior to submitting the form.

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Dear Patient;

I would appreciate it if you could fill out the enclosed form before you are to come in for your physical exam. I find that it helps us to use time better if the form is completed, and I can review it in person during your appointment. If you have filled out this form before, please disregard it and let me know when you come in.

Please arrive 15 minutes prior to your appointment time on the day of your exam, and give the receptionist the form when you sign in. This gives us time to update your chart with your current information. Thanks for taking the time to complete these forms before your appointment.

Sincerely,  
Pamela Shore, M.D.

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**PLEASE PRINT CLEARLY**

Today's Date: \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_  
Last First Middle

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Marital Status \_\_\_\_\_ Social Security Number \_\_\_\_\_

SAINT JOSEPH HOSPITAL REGISTRATION NUMBER \_\_\_\_\_

Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

List a Contact Person to call if we CANNOT REACH YOU at your residence >

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

DO YOU HAVE MEDICAL INSURANCE COVERAGE THROUGH YOUR EMPLOYER? \_\_\_\_\_

Who is responsible for paying this bill, if other than patient?

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Social Security Number \_\_\_\_\_

Medicare:

Claim Number \_\_\_\_\_ Effective Date \_\_\_\_\_

Blue Cross Blue Shield:

Contract Number \_\_\_\_\_ Group Number \_\_\_\_\_

Coverage Codes \_\_\_\_\_ Plan Code \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Effective Date \_\_\_\_\_

Patient Relationship to Subscriber \_\_\_\_\_

Other Insurance Carrier:

Insurance Carrier's Name \_\_\_\_\_

Carrier Address \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

Effective Date \_\_\_\_\_ Co-Pay \_\_\_\_\_

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Authorization to release information and pay benefits to physicians: I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment for insurance purposes. I understand I am responsible for payment of all services unpaid by my insurance carrier and for negotiating a settlement on a disputed claim. I hereby authorize payment directly to Scholl-Farmer-Shore, PLLC.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Sex \_\_\_\_\_ Date \_\_\_\_\_

Please list any problems of concerns you would like to discuss today:

1. \_\_\_\_\_ 3. \_\_\_\_\_  
2. \_\_\_\_\_ 4. \_\_\_\_\_

Allergies (please list reaction) for example, Penicillin (hives):

Medication Allergies \_\_\_\_\_  
Other Allergies \_\_\_\_\_

Current Medications (please include vitamins, herbal, homeopathic and over the counter medications):

	Medication	Dose	Frequency
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____

Adult Illnesses (please note any details or complications of these illnesses):

\_\_\_\_\_ Diabetes Since \_\_\_\_\_ (year)  
\_\_\_\_\_ Asthma  
\_\_\_\_\_ Arthritis  
\_\_\_\_\_ High Blood Pressure  
\_\_\_\_\_ Cancer Type \_\_\_\_\_  
\_\_\_\_\_ Liver Disease  
\_\_\_\_\_ Kidney Disease  
\_\_\_\_\_ Heart Disease  
\_\_\_\_\_ Stroke  
\_\_\_\_\_ Seizures  
\_\_\_\_\_ TB  
\_\_\_\_\_ Others: \_\_\_\_\_

Operations (including tonsils, vasectomy, gallbladder, appendix, etc):

Operation	Year	Operation	Year
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	7. _____	_____
4. _____	_____	8. _____	_____

Hospitalization (please include reason and year, do not list normal pregnancies):

1. _____	5. _____
2. _____	6. _____
3. _____	7. _____
4. _____	8. _____

Major accidents or injuries (please include year):

1. _____
2. _____

Immunizations (please list year):

_____	Influenza	_____
_____	Pneumonia	_____
_____	Hepatitis B	_____
_____	Tetanus	_____

Women (please note any pregnancy complications):

Number of Pregnancies _____	Number of Abortions _____
Number of Miscarriages _____	Number of Living Children _____

Social and Personal History (please circle all that apply)

You are: In relationship   Married   Single   In a relationship   Separated   Divorced   Widowed  
Type of work you do \_\_\_\_\_ Disabled   Retired   Out of Work

Smoking: Never Smoked   Current Smoker   Number of packs daily \_\_\_\_\_ Age you started \_\_\_\_\_  
Former smoker   Year you quit \_\_\_\_\_ If a current smoker, any interest in quitting? Y or N

Alcohol: Do you drink? Y or N If yes, please answer the following:

How much do you drink per week? \_\_\_\_\_

Have you ever had anyone recommend that you cut down? Y or N

Do you become annoyed with others, or they with you, when you drink? Y or N

Do you ever feel guilty when you drink? Y or N  
Do you take an eye opener in the morning? Y or N

Recreational Drugs:

Have you used street drugs currently or in the past? Y or N  
Which? \_\_\_\_\_

Do you use your seat belt? Y or N  
What do you do to relieve stress? \_\_\_\_\_  
What are your hobbies and interests? \_\_\_\_\_

Family Health

Have any of your blood relatives had any of the following illnesses? If so, please indicate the relationship (mother, grandmother, father, etc.)

Diabetes \_\_\_\_\_  
Cancer \_\_\_\_\_  
Arthritis \_\_\_\_\_  
Asthma \_\_\_\_\_  
High Blood Pressure \_\_\_\_\_  
Heart Disease \_\_\_\_\_  
Alcoholism \_\_\_\_\_  
TB \_\_\_\_\_  
Stroke \_\_\_\_\_  
Mental Illness \_\_\_\_\_  
Other \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_  
\_\_\_\_\_

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Date: \_\_\_\_\_

Dear \_\_\_\_\_:

We are writing to remind you that your annual complete physical exam is scheduled for \_\_\_\_\_ at \_\_\_\_\_ a.m./p.m. You will be asked to fill out a short questionnaire about your recent health at the time of your visit. Please bring all your medications with you for this visit.

**Unfortunately, Medicare and many commercial insurance companies do not pay for routine preventative services, such as a complete physical.** Payment for these services would then be your responsibility. If you are unsure whether your insurance pays for routine physical exams, immunizations, or other care, you should call your insurance representative prior to your visit.

We do feel that preventative health care is very important, and hope that these issues will not pose a problem or discourage you from having your regular physical. Routine preventative health care including physicals, mammograms, and blood tests are the very best way to detect illnesses early when there is the best potential for effective treatment. Please do not hesitate to call the office if you have any questions or concerns.

Sincerely,

Jean Scholl, M.D.  
Cheryl Farmer, M.D.  
Pamela Shore, M.D.

Please sign below and bring this letter to your appointment so that we can verify that you have received the above information. Thank you for your participation and we look forward to addressing your health care needs in the future.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_