

**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 \$20 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 _____