



PRIMARY MEDICINE
ASSOCIATES

1171 Gatewood Drive Bldg 101

Auburn, AL 36830

334-821-2708 * pma@eamc.org

Circle Preferred Provider (if any):

Andrew Jones, M.D. Mallory Willis, D.O Brian Wood, M.D. Katherine Winchester, P.A First Available

Name: _____ DOB: _____

SSN: _____ Birth Sex: Male / Female

Address (please list bldg./apt no): _____

City _____ ST: _____ Zip: _____

Phone: _____ (alternate): _____

E-MAIL: _____

Emergency Contact (name/relationship/phone number): _____

Last Primary Physician: _____ Last Seen: _____

Insurance Company: _____ Member ID: _____

If you have a BCBS policy that requires a Primary Care Physician, please call your insurance company when your appointment is made and change Primary Care Provider.

Any Concerns you may have at this time: _____

**PMA PHYSICIANS DO NOT WRITE PRESCRIPTIONS FOR PAIN MEDICATION
AND OTHER CONTROLLED SUBSTANCES.**

**IF YOU HAVE MEDICAID INSURANCE, YOU WILL BE DIRECTED TO THE HEALTH DEPT. FOR YOUR
IMMUNIZATIONS AND BLUE CARDS.**

Patient's Name: _____ date of birth: _____

Please list **ALL MEDICATIONS** you are currently taking
(Prescription and over the counter) If none, please specify.

Medications	Dosage	Frequency

Please List **ALL** Allergies
If none, please specify

Allergies

Type of Reaction

Pharmacy Name: _____

Patient's Signature: _____ Date: _____

Patient's Name: _____ date of birth: _____

Complete Medical History Form

Past medical history

A. Current Medical Diagnosis (Hypertension, Diabetes, etc.): _____

Surgeries/Procedures dates:

T&A (tonsils): _____ Appendectomy date: _____ Gallbladder: _____

Hysterectomy: _____ Ovaries removed: Yes No (circle) Vasectomy _____

Other surgeries: _____

Colonoscopy: _____ mammogram: _____ PAP _____

B. Injuries/Fractures: (type, date, and how injured): _____

Family history

Mother: Age (if living) _____ Age (at death) _____ Cause of death: _____

List any medical problems she has had: _____

Father: Age (if living) _____ Age (at death) _____ Cause of death: _____

List any medical problems he has had: _____

Brother(s) ages and any medical problems he/they have had: _____

Sister(s) ages and any medical problems she/they have had: _____

Any other blood relatives with: (mother=M, father=F, brother=B, sister=S, mother's mother= M/M, mother's father=M/F, father's mother=F/M, father's father=F/F, aunt=A, uncle =U)

Diabetes: _____ High Blood Pressure: _____

Heart Attack: _____ High cholesterol: _____

Stroke: _____ Tuberculosis: _____

Alzheimer's: _____

Cancer (please list): _____

Patient's Signature: _____ Date: _____

Lifestyle History

A. Alcohol Intake:

What do you usually drink? _____ how much? _____ how often? _____
_____ Do not drink alcohol

B. Tobacco: _____ vape _____ current smoker _____ ex-smoker _____ never

Current-Number of packs, pipes, cigars, dips per day? _____

When did you start smoking? _____ If ex-smoker, when did you quit? _____

C. Drugs/Substance Abuse: Type: _____ Frequency: _____

Still using: _____ yes _____ no

D. Work/Education:

Current occupation or school(year/major): _____

Any work related injuries? _____

E. Marital status: _____ single _____ married _____ divorced _____ widowed

F. Have you ever been pregnant or do you have any children? ____yes ____no ____N/A

If yes, how many pregnancies/births/children? _____

G. Diet: Any special Diet? _____ number of meals per day? _____

Number of times per week you eat "fast food"? _____

H. Exercise: Do you exercise regularly? _____

What Activity? _____

How often and for how long? _____

I. Are you current on vaccinations (childhood, yearly, etc) _____ yes _____ no

List any current specialists (Name, Practice name, reason, and location): _____

Patient's Signature: _____ Date: _____

1. Are you receiving Black Lung Benefits? Yes No
 2. Are the services to be paid by a government research program? Yes No
 3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for your care at this facility? Yes No
 4. Was the illness/injury due to a work-related accident/condition? Yes No Not Applicable
 5. Was illness/injury due to a non-work-related accident? Yes No Not Applicable
 6. Are you entitled to Medicare based on Age? Yes No
- Are you currently employed? Yes No
7. Date of retirement _____
 8. Do you have a spouse who is currently employed? Yes No
 9. Are you entitled to Medicare based on Disability? Yes No
 10. Are you entitled to Medicare based on ESRD? Yes No

Patient/Representative Signature: _____ Date: _____

Please fill this form out if you have records from a previous physician that you wish to have sent to us. Include all information including fax number.

PLEASE PRINT



PRIMARY MEDICINE
ASSOCIATES

Phone: 334-821-2708 * Fax: 334-528-5420

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AUTHORIZATION TO DISCLOSE / RELEASE OR OBTAIN MEDICAL RECORDS

All disclosures are in compliance with federal and state laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), governing the use and disclosure of Protected Health Information (PHI)

I hereby authorize Primary Medicine Associates to _____ Send to _____ Receive Records from _____

Name of Person or Organization Telephone Fax

Address City State Zip

INFORMATION REQUESTED: I hereby agree to this authorization and understand that it must contain personally Identifiable Information and PHI as defined by HIPAA to ensure accuracy. I understand I have the right to limit the type of information released and to revoke this authorization by submitting a notice, in writing, to the Privacy Officer. Unless revoked, this authorization will expire three months for date of signature or on the following date: _____.

If I choose to limit the information released, I understand Primary Medicine Associates (PMA) may inform the requestor that portions of the record have been withheld. I understand the information disclosed may be subject to re-disclosure by the recipient and no longer be protected by PMA. PMA and its staff are hereby released from any legal responsibility or liability for disclosure of the below information to the extent indicated and authorized.

_____ PARTIAL medical records; please specify parts and dates to be released: _____

_____ ALL medical records without exception. Please include: most current labs, most current imaging (mammogram, CT, ultrasound, MRI), most current colonoscopy, most current specialist notes, last 2 office notes, and immunization record.

For the purpose of: _____

I authorize the release of my medical records as indicated above.

Signature of patient or legal guardian Date

Printed Name Date of Birth Social Security Number

Address City, State Zip Telephone Number

Witness Date

Note to recipient: This information has been disclosed to you from records whose confidentiality is protected by Federal and State Laws (including HIPAA) and prohibits you from further disclosure without written consent of the person to whom it pertains. Charges may apply for copies of medical records.

_____ Faxed _____ Copies Left for pt _____ Mailed _____ Date _____

Patient Policies at Primary Medicine Associates

We are here to be your Medical Home and to provide you better ways to take care of yourself.

This page is for you to keep.

- All copays are due at the time service is rendered. Patients that are unable to pay their copays can speak to the manager about their situation. New Self-pay patients are required to pay \$181.50, and all return visits are \$169.40. This price does not include anything other than the office visit.
- So that we can offer you the best care possible, we appreciate you turning your cell phones off when entering the back office and for the duration of your appointment.
- All refills will be completed within 24-48 hours after you have notified us of the need for a refill. Please call us when you get down to 4-5 days left of your medication, with the exception of mail order pharmacies (or anything not local). These will need a 2 week minimum.
- **Primary Medicine Associates works very hard to minimize wait times for our patients. Please arrive on time for your appointments. If you arrive more than 10 minutes after your appointment time, we will have to reschedule your appointment to another day or you may have an extended wait to be seen, it will also count as a no show.**
- **When you do not show or call to cancel your appointment, you are preventing other patients from being treated. A NO SHOW is when you make an appointment and do not show up or call to cancel the appointment. We have a policy of allowing no more than 3 NO SHOWs for our patients. If you cannot come to your appointment, you must call 2 hours in advance or as soon as possible before your appointment, so that we will not count you as a NO SHOW.**
- We will call, send a letter, or send a message via the patient portal detailing your lab results for labs that were performed here within 10 days. IF you do not get a letter, call, or message from us after that time, please call us.
- We are committed to getting your outside test or consult scheduled as quickly as we can and we will send you a letter or call you with the details of the scheduled appt within 10 business days. If you do not hear from us within 10 business days regarding your test or consult appointment, please call us.
- We also have to maintain a good relationship with other facilities and doctors in the area. Therefore, if we schedule an appointment for you with a specialist or arrange for you to have tests done and you do not show up or call to cancel that appointment four or more times, the physicians here may dismiss you as a patient.