



Primary Medicine Associates

1171 Gatewood Dr. Bldg #101

Auburn, AL 36830

Phone: (334) 821-2708

Fax: (334) 528-5420

Email: pma@eamc.org

Please select your preferred provider:

- ☐ Dr. Andrew Jones ☐ Dr. Mallory Willis ☐ Dr. Brian Wood ☐ Dr. Reagan Elkins
☐ Katherine Winchester, PA ☐ First Available

Patient Name: _____ Date of Birth: _____

Preferred Name: _____

Social Security Number: _____ Birth Sex: ☐ Male ☐ Female

Address: _____ Apt./Unit (if applicable): _____

City: _____ State: _____ Zip: _____

Primary Phone #: _____ ☐ Work ☐ Home ☐ Cell

Alternate Phone #: _____ ☐ Work ☐ Home ☐ Cell

Email: _____

Emergency Contact: _____ Relationship: _____

Phone: _____

Last Primary Care Provider: _____ Last Appointment (if known): _____

Insurance Company: _____ Member ID: _____

Please list any concerns you would like to discuss with your provider: _____

Helpful information before your appointment:

- Our providers do not typically prescribe controlled substances on a routine basis. Please discuss any controlled substance medications with your scheduled provider.
- If you have Medicaid, please note that our office is unable to administer vaccines, but you can still receive them at the Lee County Health Department
- If your BCBS or Viva Medicare policy requires a PCP designation, please contact your insurance company **before your appointment** to update it. If it is not updated before your visit, your insurance company may not cover the appointment.
- Our office is currently out of network with Aetna HMO, UHC HMO, and AmBetter insurance policies. If you are unsure whether your provider is in network, please contact your insurance company before your appointment.

Patient Name: _____ Date of Birth: _____

Medications and Allergies

Please list **all medications** you currently take, including prescriptions, supplements, and over-the-counter medications. If you are not currently taking any medications, please check the box below.

☐ I am not currently taking any prescriptions, over-the-counter medications, or supplements.

Medication Name	Strength (mg, mcg, etc.)	Frequency daily, weekly, as needed
		☐ Daily ☐ Weekly ☐ Other: _____
		☐ Daily ☐ Weekly ☐ Other: _____
		☐ Daily ☐ Weekly ☐ Other: _____
		☐ Daily ☐ Weekly ☐ Other: _____
		☐ Daily ☐ Weekly ☐ Other: _____
		☐ Daily ☐ Weekly ☐ Other: _____
		☐ Daily ☐ Weekly ☐ Other: _____
		☐ Daily ☐ Weekly ☐ Other: _____
		☐ Daily ☐ Weekly ☐ Other: _____
		☐ Daily ☐ Weekly ☐ Other: _____
		☐ Daily ☐ Weekly ☐ Other: _____

Please list any medication, environmental, or food allergies below, including the reaction you experienced. If you do not have any allergies, please write "None."

Allergy	Reaction	Severity
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe

Preferred Pharmacy: _____

Pharmacy Location: _____

Patient Signature: _____ Date: _____

Medical and Surgical History

Patient Name: _____ Date of Birth: _____

Please list all current medical problems you are being treated for below.

Current Medical Problems (High blood pressure, Diabetes, Cancers, Heart Disease, Depression, Anxiety, etc)	Please list the specialist treating your condition below (if applicable)
	☐ Previous PCP ☐ Specialist

Please list any previous surgeries/procedures you have had and approximate dates (if known).

Type of surgery Please include: hysterectomy, tonsillectomy, gallbladder, joint surgeries, etc.	Approx Date/Year

Family History

Please check any conditions that apply to your immediate family history and list the affected family member(s), if known.

Condition	None	Parent	Sibling	Child	Other
Diabetes	☐	☐	☐	☐	☐ _____
Heart attack	☐	☐	☐	☐	☐ _____
Stroke	☐	☐	☐	☐	☐ _____
High blood pressure	☐	☐	☐	☐	☐ _____
High cholesterol	☐	☐	☐	☐	☐ _____
Alzheimer's disease	☐	☐	☐	☐	☐ _____
Cancer	☐	☐	☐	☐	☐ _____
Other: _____	☐	☐	☐	☐	☐ _____
Other: _____	☐	☐	☐	☐	☐ _____
Other: _____	☐	☐	☐	☐	☐ _____

Patient Name: _____ Date of Birth: _____

Social History

Please complete the section below so your provider can better understand your lifestyle and health history.

Alcohol use	# of drinks per episode: _____ Frequency: ☐ None ☐ Rarely (<4 times/yr) ☐ Monthly ☐ Weekly ☐ Daily
Tobacco use	☐ Never ☐ *Former ☐ Current Type: ☐ Cigarettes ☐ Vape ☐ Smokeless Packs/day: _____ Frequency: ☐ None ☐ Rarely (<4 times/yr) ☐ Monthly ☐ Weekly ☐ Daily *If you are a former smoker, please list how many years you smoked and packs per day below. # of years smoked: _____ # of packs per day: _____
Drug/substance use	☐ None ☐ Former ☐ Current Please list substance(s), if applicable: _____
Employment	Occupation/Employer: _____
Marital status	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered ☐ Prefer not to answer
Pregnancy history	Currently pregnant? ☐ No ☐ Yes ☐ Not applicable Number of pregnancies: _____ Number of births: _____
Children	Number of children: _____
Diet	☐ Regular ☐ Low sodium ☐ Diabetic ☐ Vegetarian/Vegan ☐ Other: _____
Exercise	☐ None ☐ 1–2 days/week ☐ 3–4 days/week ☐ 5+ days/week Type: _____

Health Maintenance

Please list the approximate date of your most recent preventive screening, if applicable.

Mammogram: _____ ☐ Not applicable ☐ Unsure

Colon cancer screening: _____ Type: ☐ Cologuard ☐ Colonoscopy ☐ FIT test ☐ Not applicable ☐ Unsure

Pap smear : _____ ☐ Not applicable ☐ Unsure

Diabetic eye exam: _____ ☐ Not applicable ☐ Unsure

Patient Name: _____ Date of Birth: _____

Medicare as Secondary Payer Questionnaire

Please only answer the below questions if you are currently covered by a Medicare or Medicare Advantage Plan.

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:** _____

Patient Name: _____ Date of Birth: _____

Primary Medicine Associates Policies

Welcome to Primary Medicine Associates! We are glad to serve as your medical home and partner with you in your health care. Please review the following office policies.

- Copays are due at the time of service. If you are unable to pay your copay, please ask to speak with the office manager. Please note that these fees cover the office visit only and do not include labs, testing, procedures, or other services. Prices are listed in the table below for your reference.

New Patient Visit	\$181.50
Subsequent Visits	\$169.40

- To help us provide the best care possible, please silence or turn off your cell phone while you are in the clinical area.
- Please request medication refills when you have 4–5 days of medication remaining. Most refills are completed within 24–48 hours.
- We kindly ask that you arrive on time for your appointment. While we understand that instances may arise that are beyond your control, if you arrive more than 10 minutes after your appointment start time, your appointment may need to be rescheduled.
- If you cannot keep your appointment, please call at least 2 hours before your appointment time, or as soon as possible. Missed appointments without notice are considered no-shows. Patients acquiring 3 or more no-shows within a rolling 24 month period, may be dismissed from the clinic.
- For lab work completed in our office, we will contact you by phone, letter, or patient portal message within 10 days. If you do not hear from us after 10 days, please call our office.
- For outside tests or consults, you will be contacted by the referred office with scheduling details within 10 business days.