MEDICAL RECORD SUMMARY

Name_____ Today's Date_____

Street_____ City, State, Zip_____

Telephone (Home)_____ Cell Phone_____

Birth Date_____ Age_____ Sex_____ Race_____ Marital Status: **M S W D O**

SS Number_____-___-_____ Ethnicity **Hispanic Non Hispanic Other** Family Physician_____

Language_____ Email Address_____ Referred By_____

Employer_____Occupation_____Work Phone_____

If Retired, Previous Occupation_____ Religious Preference (if any)_____

Spouse's Name & Birth Date_____ (Needed for Insurance)

Current Pharmacy & Location_____(Needed for Electronic Prescribing)

Family History:
Place a check mark below if anyone in your family has or had any of the following medical conditions:

Mother	**Father**	**Brothers**	**Sisters**
____Allergies	____Allergies	____Allergies	____Allergies
____Anemia	____Anemia	____Anemia	____Anemia
____Asthma	____Asthma	____Asthma	____Asthma
____Cancer (Type?)	____Cancer (Type?)	____Cancer (Type?)	____Cancer (Type?)
____Colon Polyps	____Colon Polyps	____Colon Polyps	____Colon Polyps
____COPD	____COPD	____COPD	____COPD
____Depression	____Depression	____Depression	____Depression
____Diabetes	____Diabetes	____Diabetes	____Diabetes
____Kidney Disease	____Kidney Disease	____Kidney Disease	____Kidney Disease
____Substance Abuse	____Substance Abuse	____Substance Abuse	____Substance Abuse
____Thyroid Disease	____Thyroid Disease	____Thyroid Disease	____Thyroid Disease

Father's Age____ Deceased? Yes No Cause? _____
Mother's Age____ Deceased? Yes No Cause?_____

Present Illness: List any present symptoms that you are having at this time related to this visit:

_____
_____
_____
_____

Past Medical History: Place a check mark below if you have or had any of the medical conditions listed:

__AIDS/HIV
__Anemia
__Anxiety
__Arthritis
__Asthma
__Blood Transfusion (Year?)
__Cancer (Type?)
__Colon/rectal polyps
__COPD
__Depression
__Diabetes – Type I
__Diabetes – Type II
__GERD
__Glaucoma
__Heart Attack (Year?)
__Heart Disease
__High Cholesterol
__Hypertension
__Hyperthyroidism
__Hypothyroidism
__Insomnia
__Kidney Disease
__Migraines
__Osteopenia
__Osteoporosis
__Rheumatoid Arthritis
__Seasonal Allergies
__Sleep Apnea (CPAP?)
__Stroke (Year?)
__Suicide Attempt
Other_____

Surgical History: List all minor/major surgeries including both In-patient and Out-patient surgical procedures:

Type of Surgery	Year	Hospital	Doctor

Social History:

Do you currently smoke? Yes No If yes, how much? _____
If no, have you ever smoked? Yes No If yes, quit when? _____

Do you drink alcoholic beverages? Yes No If yes, how much?_____
Do you have a history of sexually transmitted disease? Yes No If yes, what kind?_____
Do you use LSD, Marijuana or other drugs? Yes No If yes, what kind?_____

I understand that I am entering into a contractual relationship with Darell Covington, M.D. for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Darell Covington, M.D., I and/or my representative agree not to advance, directly or indirectly, any false, meritless and/or frivolous claim(s) of medical malpractice against Darell Covington, M. D.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I and/or my representative agree to use ABMS board-certified expert medical witness (es) in the same or similar specialty as Darell Covington, M.D. I agree that these expert witnesses will adhere to the guidelines and/or code of conduct defined by the specialty society (ies) for expert witnesses in the area(s) of medicine that would typically have the background and experience to opine on such a case. In further consideration of this, I, Darell Covington, M.D., agree to the same stipulations.

I consent to examination plus any/all medical treatment deemed advisable by Darell Covington, M. D. in the exercise of his best judgment. I understand that I am responsible for providing full, complete and accurate information concerning my present symptoms, changes in my condition, injuries, past illnesses, hospitalizations, medications and other matters relating to my health to Darell Covington, M.D. I hereby authorize Darell Covington, M.D., F.A.C.S. to release any information acquired in the course of my examination or treatment for insurance claims, and authorize payment directly to Darell Covington, M.D. of the surgical and/or medical benefits, if any, otherwise payable to me for their services. I understand that I am financially responsible for all charges not covered by this authorization and guarantee payment of this account.

We do not release confidential information to unauthorized persons, however, it has been our policy to leave messages on answering machines when possible, fax reports to your physicians and insurance companies, and we send office recalls via postcards. (For your treatment, payments of claims and health care operations) Should you have any objections to these policies or any special requests for communicating your information, please check here ____ *and we will speak to you about this and document your wishes in your chart.*

SIGNED_____

REVIEW OF SYSTEMS

Patient Name: _____

Circle yes or no for each of the following:

General:			**Musculoskeletal:**		
Weight gain?	Yes	No	Back or neck pain?	Yes	No
Weight loss?	Yes	No	Joint pain?	Yes	No
Fatigue?	Yes	No	Stiffness?	Yes	No
			Muscle weakness?	Yes	No
Eyes:			**Skin:**		
Blurred vision?	Yes	No	Rashes?	Yes	No
Double vision?	Yes	No	Itching?	Yes	No
Irritation?	Yes	No	Dryness?	Yes	No
Eye pain?	Yes	No			
ENT:			**Central Nervous System:**		
Earaches?	Yes	No	Seizures?	Yes	No
Ringing or buzzing in the ears?	Yes	No	Recently blacked/lost consciousness?	Yes	No
Nosebleeds?	Yes	No	Tremors?	Yes	No
Sore throat or hoarseness?	Yes	No	Spells of dizziness?	Yes	No
Cardiovascular:			**Psychiatric:**		
Chest pain?	Yes	No	Depression?	Yes	No
Palpitations?	Yes	No	Anxiety?	Yes	No
Shortness of breath on exertion?	Yes	No	Memory loss?	Yes	No
Swelling of feet or ankles?	Yes	No	Thoughts about suicide?	Yes	No
Respiratory:			**Genitourinary:**		
A constant or bothersome cough?	Yes	No	Burning or pain when you urinate?	Yes	No
Shortness of breath?	Yes	No	Blood in the urine?	Yes	No
Coughing up blood?	Yes	No	Urinary frequency?	Yes	No
			Urinary hesitancy?	Yes	No
Gastrointestinal:			**Hematological:**		
Nausea?	Yes	No	Bleeding tendency?	Yes	No
Vomiting?	Yes	No	Bruising tendency?	Yes	No
Diarrhea?	Yes	No	Anemia?	Yes	No
Constipation?	Yes	No	Blood transfusion? Year:_____	Yes	No
Change in bowel habits?	Yes	No			
Abdominal pain?	Yes	No	**Women Only:**		
Black or tarry stools?	Yes	No	Possibly pregnant?	Yes	No
Rectal bleeding?	Yes	No	Vaginal discharge?	Yes	No
Length of time for any of these_____			Date of last menstrual period:_____		

Reviewed By: _____ **Date:** _____

MEDICATION LIST

Patient Name: _____ **Today's Date:**_____

Please List ALL Medications Including Anything Over-The-Counter

Medication, Vitamin, or Supplement	Dosage	How Taken	How Often

I Have Had Reactions to the Following Drugs:

Drugs	Reaction

I Take No Medications_____

FINANCIAL POLICY

APPOINTMENT REQUIREMENTS: Upon arrival we need your insurance information, copay, and a photo ID. If you arrive at the office for your appointment without these requirements, you have two options:

(1) Reschedule your appointment.
(2) Pay for your visit in full at the time of service.

PARTICIPATING INSURANCE PLANS: As a courtesy to our patients, insurance forms will be filed by our office. We must emphasize that our relationship is with the patient, not the insurance company. If we do not receive payment from your insurance carrier within 90 days, payment becomes the responsibility of the patient. It is the patient's responsibility to determine if our office is in network with your insurance plan. We participate with a number of plans, but because of our tri-state location, some plans consider us out of network. Our office is not responsible for charges if your insurance company only covers screenings. If any symptoms are noted by you, the colonoscopy cannot be billed as a screening. Please call your insurance prior to your visit to get this information.

MANAGED CARE PLANS (HMOs): If your plan requires a referral, you MUST have the insurance referral from your primary care physician at the time or your appointment. If you do not have the referral, you have the same two options listed above.

RESPONSIBILITY FOR PAYMENT: If you have an open balance for previous services in collections or owe a bad debt, you must pay this amount prior to being seen by Dr. Covington in the office again.

RESCHEDULING FEES: Due to abuse of our scheduling procedures, we can no longer provide the service of continuing to reschedule colonoscopies for our patients. Constant rescheduling causes hardships for the facilities, our office staff, and other patients. We will, however, allow ONE courtesy reschedule of a procedure for a VALIDATED EXCUSE ONLY such as a medical problem or a genuine family emergency. If you must reschedule for other reasons, there will be a $25.00 charge assessed, which must be paid prior to the performance of your procedure. We also require 48 hours notice for this cancellation or reschedule.

ADDITIONAL OFFICE CHARGES: Our office charges $15.00 for the completion of disability forms. Finance charges of 1 1/2 % will be applied monthly to unpaid balances over 60 days old. Charges for patient medical records are reasonable and cost-based and will include postage, if mailed.

When you schedule any procedure with Dr. Covington, we call your insurance company to verify benefits. If they inform us that your deductible has not been met and/or you participate with a high-deductible plan, this office requires a $250.00 deposit, which MUST BE PAID before your procedure can be scheduled.

I have read, understand and agree to the above financial policy:

Patient Signature_____ **Date**_____