Ebenezer Medical Outreach, Inc.

Welcome to Ebenezer Medical Outreach, Inc. (EMO). We appreciate your choosing us for your health care needs, and we are committed to doing our best for you. Our goal is to provide you with high-quality, affordable health care.

Thank you for choosing us for your medical care.
PATIENT INFORMATION

Patient Name ______________________________________________________________________________________

DATE OF BIRTH ___________________ SEX: □ M □ F

MARRITAL STATUS: □ Single □ Married □ Divorced □ Widowed

SOCIAL SECURITY NUMBER ___________________________ EMAIL ADDRESS _______________________________________

PREFERRED LANGUAGE: □ Arabic □ English □ Hindi □ Spanish
□ Chinese □ German □ Russian □ Other: ________________________________

RACE:
□ African American □ Asian □ Hispanic/Latino □ Pacific Islander
□ Alaska Native □ Caucasian/White □ Native American □ Declined

ETHNICITY:
□ Hispanic/Latino □ Non-Hispanic/Latino □ Declined

Are you a US Citizen? □ Yes or □ No

PATIENT ADDRESS ____________________________________________________________________________________

STREET       COUNTY
_____________________________________________________________________________________

CITY       STATE       ZIP

DRIVER'S LICENSE NUMBER ___________________________ STATE

HOME PHONE _______________________ WORK PHONE ____________________ MOBILE PHONE _____________________

EMPLOYER NAME _____________________________________________________________________________________

EMPLOYER ADDRESS ___________________________________________________________________________________

STREET
___________________________________________________________________________________________

CITY       STATE       ZIP

PRIMARY CARE PROVIDER ____________________________________________

If under 18, who is parent or legal guardian?

GUARDIAN NAME ___________________________________________ DATE OF BIRTH ___________________________

RESPONSIBLE PARTY (PERSON WHO WILL BE RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE)

__________________________________________ DATE OF BIRTH ___________________________

RELATED PARTY TO PATIENT __________________________

SOCIAL SECURITY NUMBER ___________________________ DATE OF BIRTH ___________________________

ADDRESS _______________________________________________________________________________________

STREET
___________________________________________________________________________________________

CITY       STATE       ZIP
Home Phone _____________________ Work Phone _____________________ Mobile Phone _____________________

Employer Name ____________________________________________

Employer Address

STREET

CITY   STATE   ZIP

Spouse’s Name/Other Parent is under 18 ________________________________________________

Employer Name ____________________________________________  Work Phone _____________________

In case of an emergency, notify (friend or relative not in your home):
Name ____________________________________________  Phone _____________________

Relationship to Patient ________________________________________

INSURANCE INFORMATION
Primary Medical Insurance ______________________________________  Phone _____________________

Policy Holder Name __________________________________________  Date of Birth ________________

Address ______________________________________________________

STREET

CITY   STATE   ZIP

ID Number ___________________________________  Group Number ________________
Plan Number ___________________________  Effective Date ________________  Expiration Date ________________

Secondary Medical Insurance ______________________________________  Phone _____________________

Policy Holder Name __________________________________________  Date of Birth ________________

Address ______________________________________________________

STREET

CITY   STATE   ZIP

ID Number ___________________________________  Group Number ________________
Plan Number ___________________________  Effective Date ________________  Expiration Date ________________

Other Medical Insurance (Worker’s Comp., Medicare Supplement, Etc.)
Medical Insurance ____________________________________________  Phone _____________________

Policy Holder Name __________________________________________  Date of Birth ________________

Address ______________________________________________________

STREET

CITY   STATE   ZIP

ID Number ___________________________________  Group Number ________________
Plan Number ___________________________  Effective Date ________________  Expiration Date ________________
PATIENT’S AGREEMENT

Pease Read Carefully

I consent to care and treatment

I consent to examination, treatment and testing as advised by the physicians and other providers of Ebenezer Medical Outreach, Inc. (EMOI). I give permission for health care professionals in training to observe and participate in my care and treatment under the supervision of licensed health care providers. In addition, I consent to the use or disclosure of my protected health information by EMOI to diagnose and treat me, to obtain payment for my bills and to conduct its health care operations and business.

I acknowledge that I have received or was offered a copy of EMOI Notice of Privacy Practices which tells how my health information may be used and shared. I understand that EMOI reserves the right to revise the notice at any time, and that I can always get the current copy by asking for it.

All patients accepting care at Ebenezer must:

- Maintain an accurate address, contact telephone number, current proof of income and notification of any receipt of medical insurance, which includes Medicaid, Medicare, VA benefits or private insurance.
- Show up at the clinic on time or cancel by telephone at least one workday (24 hours) prior to the scheduled appointment time. In those situations when special tests or follow up is required for the clinic, failure to obtain required tests/follow up will result in the clinic appointment being rescheduled at a later date.
- The patient must follow the instructions given for the recommended follow up for care such as: keeping additional appointments, obtaining special tests or lab work.

I agree that payments can be made to University Physicians and Surgeons, Inc.

EMOI has contracted with University Physicians and Surgeons, Inc. (UP&S) DBA Marshall Health. I allow University Physicians and Surgeons, Inc. (UP&S) to directly bill and collect payment from Medicaid. I assign my right to receive payment of any insurance to UP&S.

I agree to have EMOI complete any enrollment process, which includes providing financial information, for available patient assistance programs sponsored by pharmaceutical companies to secure my prescribed medication.

If you have any questions about this document, please ask someone at the front desk for assistance.

I have read this form and I fully understand what I am agreeing to. (The patient or another responsible party on behalf of the patient must sign this Agreement. Upon signing, the responsible party assumes all liability for the consents, authorizations and financial responsibility discussed above.)

_________________________  ____________________________
Date          Signature of Patient or Legal Representative

STATEMENT OF PATIENT’S LEGAL REPRESENTATIVE OR AGENT

I give the consents and authorizations made above on behalf of the patient and I have the authority to do so. The patient did not sign because he or she is (check one):

_____ Mentally or physically unable to understand or sign
_____ Other (describe): __________________________________________________________

I am authorized to sign for the patient because: (for example, having medical power or attorney) ______________________________
**NEW PATIENT HISTORY FORM**

Name: __________________________________ Date: __________ Date of Birth __________

Marital Status: S M W D  Allergies: ________________________________________________

Recent Medical problems: _______________________________________________________

________________________________________________________________________________

**Review of Body Systems:** (Check all that apply to you)

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Current Medications and Doses: ________________________________________________

_________________________________________________________________________
**Past History**

Illnesses: 

Surgeries (when): 

Other hospitalizations (when): 

Last Pap Test____ Mammogram____ Last Rectal Exam____ Last Dr. visit____

**Personal History:** (Circle all that apply) Do you.....

Regularly exercise? Now Past Never Use Illegal Drugs? Now Past Never

Wear Seatbelt? Now Past Never Use Alcohol? Now Frequently Now some Past Never

Do you do self Breast exam?____ Self Testicular Exam?____

**Family History**

Mother: Alive Deceased  Father: Alive Deceased Cause of Death: Cause of Death:

Brothers and Sisters: Number Living: Number Deceased:

Cause of Death: 

Medical Conditions: 

**Family History: Mother Grandmother Grandfather Father Grandmother Grandfather Bro/Sister**

Cancer _____ _____ _____ _____ _____ _____ _____

Diabetes _____ _____ _____ _____ _____ _____ _____

Heart Disease _____ _____ _____ _____ _____ _____

High Blood Pressure _____ _____ _____ _____ _____

Stroke _____ _____ _____ _____ _____ _____

Thyroid Disease _____ _____ _____ _____ _____

Other Medical conditions in family: 

________________________________________________________________________________

________________________________________________________________________________
Authorization for Release of Medical Records

___________________________________    ____________________________
(Print Patients Full Name)       Birth Date (mo/day/yr)
___________________________________    ____________________________
(Street Address)        (Social Security Number)
___________________________________    ____________________________
(City, State, Zip)        (Phone – Home)

At the request of the individual, I ______________________________, do hereby authorize ________________________
(Name of Doctor that you have seen)

Dates of

____ Discharge Summary _____ Pathology Reports       Emergency Reports
____ History and Physical _____ Laboratory Reports       X  All Records
____ Progress Notes _____ RadioLOGY Reports       Other ______________________
____ Operative Reports _____ ECG/EEG/Cardiac Cath

I do _____ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV
(Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug
abuse.

I give my permission for any confidential information to be released verbally to:

________________________________________   _________________________
(Name)        (Relationship)

Information Release to

________________________________________

________________________________________

________________________________________

Purpose of Disclosure:

____ Referral to Specialist _____ Insurance       _____ Workers Comp
____ Change of Physician _____ Legal Investigation       _____ Disability Determination
____ Personal _____ x  Continuity of Care       _____ Service Management
____ Other

I hereby authorize disclosure of the health information for the above needed patient. This authorization is valid for 12 months from the date of signature. I understand
that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the
information used or disclosed may be subject to re-disclosure by the person or the class of persons or facility receiving it, and would then no longer be protected by
federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign
authorization.

___________________________________   ______________________________
Signature of individual or guardian or personal representative of patients’ estate       Date
EBENEZER MEDICAL OUTREACH, INC.

We do not provide:

**NARCOTICS OR ANY CONTROLLED MEDICATION**

(Including anti-anxiety medication such as Xanax, Valium, Ativan, Ultram, Neurontin or Klonopin)
NEW PATIENT HISTORY FORM

Name: ___________________________ Date: _______ Date of Birth________

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Do you do self Breast exam?_______     Self Testicular Exam?______

Family History

Mother: Alive  Deceased  Father:  Alive  Deceased
Cause of Death: ______________  Cause of Death: ______________

Brothers and Sisters:  Number Living: __________
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Diabetes          _____     _____     _____     _____     _____     _____     _____
Heart Disease     _____     _____     _____     _____     _____     _____     _____
High Blood Pressure_____     _____     _____     _____     _____     _____     _____
Stroke          _____     _____     _____     _____     _____     _____     _____
Thyroid Disease  _____     _____     _____     _____     _____     _____     _____
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(Print Patients Full Name) ____________________________
Birth Date (mo/day/yr) ____________________________

(Street Address) ____________________________
(Social Security Number) ____________________________

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(Phone – Home) ____________________________

At the request of the individual, I ____________________________, do hereby authorize ____________________________ (Name of Doctor that you have seen) to release:

Dates of

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