



**PATIENT INFORMATION**

Name \_\_\_\_\_

Date of birth: \_\_\_\_\_ Gender: M / F

Address: \_\_\_\_\_

City: \_\_\_\_\_ state: \_\_\_\_\_ zip: \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_

Marital status: ( ) single ( ) married ( ) widowed ( ) separated ( ) divorced

**Preferred pharmacy name and Location:** \_\_\_\_\_

phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

*Emergency contact*

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address \_\_\_\_\_ Relationship: \_\_\_\_\_

**Where did you hear about us** \_\_\_\_\_

**INSURANCE INFORMATION**

Primary:

Insurance company name: \_\_\_\_\_ Phone: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder Name (if different from patient): \_\_\_\_\_

Policy Holder DOB: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Secondary:

Insurance company name: \_\_\_\_\_ Phone: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

I authorize the release of any medical information necessary process the bill to my insurance company, and request payment of benefits to *Jeremiah Sisay PharmD, MD*. I acknowledge that I am financially responsible for payment whether or not covered by my insurance.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## MEDICAL HISTORY

Previous Physician Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Medical Condition(s):

Hospitalization(s):

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Allergies:

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Childhood Illness:

( ) Chicken Pox    ( ) Measles    ( ) Mumps    ( ) Rubella    ( ) Scarlet Fever

Surgeries

Year

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Women's Health:

Last Menstrual Period: \_\_\_\_\_

Number of Pregnancies: \_\_\_\_\_

Number of miscarriages: \_\_\_\_\_

Number of children: \_\_\_\_\_

Men's health

Last Testicular Exam: \_\_\_\_\_

Last Prostate Exam: \_\_\_\_\_

Last Colonoscopy: \_\_\_\_\_



Last colonoscopy: \_\_\_\_\_

Last mammogram: \_\_\_\_\_

Last bone density: \_\_\_\_\_

Exercise regularly Y/N      Type: \_\_\_\_\_

Frequency: \_\_\_\_\_      Duration \_\_\_\_\_

Tobacco use currently: Y/N      If yes, # of packs per day \_\_\_\_\_      For how many years \_\_\_\_\_

Tobacco use in the past: Y/N      If yes, when did you quit \_\_\_\_\_      How often did you smoke \_\_\_\_\_

Alcohol use: Y/N      If yes, # of drinks per day \_\_\_\_\_      Type of Alcohol \_\_\_\_\_

Alcohol use in the past: Y/N      If yes, # of drinks per day \_\_\_\_\_      Type of Alcohol \_\_\_\_\_

Caffeine use: Y/N      If yes, # of cups per day \_\_\_\_\_      Type of Drink \_\_\_\_\_

### **IMMUNIZATION**

Please check the box (x) next to the disease against which you have been immunized and the date of last booster. "Tetanus or TD booster is due every 10 years." Let the nurse know if you are due for a booster.

- |                              |                                     |
|------------------------------|-------------------------------------|
| ( ) Flu Shot _____           | ( ) Pneumonia _____                 |
| ( ) Tetanus _____            | ( ) Meningitis Vaccine _____        |
| ( ) Zoster Vaccine _____     | ( ) D.T (Diphtheria /tetanus) _____ |
| ( ) Hep A Series _____       | ( ) Covid -19 _____                 |
| ( ) Hepatitis B series _____ |                                     |



### FAMILY HISTORY

Please check the box (x) next to the condition that of you and/or your family member has. Then specify the relation to you after the disease using the abbreviations as followed: (F) Father, (M) Mother, (S) Sister, and (B) Brother

- ( ) Alcoholism\_\_\_\_ ( ) Anemia\_\_\_\_ ( ) Asthma \_\_\_\_ ( ) Arthritis\_\_\_\_ ( ) Heart Disease\_\_\_\_  
( ) Osteoporosis\_\_\_\_ ( ) Colon Polyps\_\_\_\_ ( ) Colon Cancer\_\_\_\_ ( ) Diabetes\_\_\_\_  
( ) Glaucoma\_\_\_\_ ( ) Gout \_\_\_\_ ( ) High blood pressure \_\_\_\_ ( ) Iron Disease\_\_\_\_  
( ) Kidney Disease\_\_\_\_ ( ) Mental Illness\_\_\_\_ ( ) Migraine\_\_\_\_ ( ) Prostate cancer \_\_\_\_  
( ) Seizures \_\_\_\_ ( ) Thyroid Disease\_\_\_\_ ( ) Tuberculosis \_\_\_\_ ( ) Breast Cancer \_\_\_\_

Father:            Living? Y/N            If no, Age of death:\_\_\_\_\_ Cause of death \_\_\_\_\_  
Mother:            Living? Y/N            If no, Age of death:\_\_\_\_\_ Cause of death \_\_\_\_\_



**PRESCRIPTIONS ACKNOWLEDGEMENT**

For refill of prescriptions, please call your pharmacy 5 days in advance, they will notify us by fax. If you need a written prescription you must give 72 hours notice.

For mail in order prescriptions give a 10 days notice.

\_\_\_\_\_  
Patient Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

**MEDICATION LIST**

<u>Name of Medications</u>	<u>Strength or Dose</u>	<u>Frequency</u>



**FINANCIAL AGREEMENT**

- Services are rendered to the patient, not the insurance company. As a courtesy, our office will file your insurance if proper information is furnished.
  - You are responsible for co-pay, deductibles, non-covered services, co-insurance, and items considered “not medically necessary “by your insurance company.
- It is your responsibility to notify our front desk staff of any insurance or address changes.
- You will be responsible for any charges that occur if we are not notified.

**ALL CO-PAYS AND/OR CO-INSURANCES ARE DUE AT THE TIME OF SERVICE UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE.**

**NO INSURANCE – CASH PATIENTS**  
(Please initial if NO Insurance & Sign Below)

\_\_\_\_ I understand that I do not have any insurance and as a cash patient all fees are to be paid today for services rendered.

*WE WILL BE CHARGING \$35 FOR FILLING THE FOLLOWING FORMS: -FMLA PAPERWORK, DISABILITY, MEDICAL RECORDS (LAWYERS, WORK COMP, AND INSURANCE) SCHOOL DOCUMENTS ETC. WE MAY RETAIN THE RECORDS UNTIL FULL PAYMENT IS RECEIVED.*

**MEDICAL FINANCIAL CONSENT FORM**

You agree, in order for us to service our account or to collect any amounts you may owe, our organization’s representatives, ancillary providers, HIPAA business associates, vendors, and the representatives of our debt collection agency, may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. Our organization’s representatives, ancillary providers, HIPAA business associates, vendors, and the representatives of our debt collection agency may also contact you by sending text messages or emails, using any e-mail address you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I/We have read this disclosure and agree that the Lender/Creditor, its ancillary providers, HIPAA business associates, vendors and its debt Collection agents may contact me/us as described above.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



**NOTICE OF PRIVACY PRACTICE/ HIPAA DISCLOSURE**

I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I understand Grace and Joy Medical reserves that right to change their Notice of Privacy Practices and prior implementation will provide an updated copy in the physician's office. I may request a copy of the updated NPP by calling my physician's office or requesting a copy in person at my appointment.

\_\_\_\_\_  
Patient Printed Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient/ Legal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

The following names are of people I would like to be involved in or have access to my Protected Health Information (PHI) on a routine basis. I give permission for Grace and Joy Medical to share my protected health information with:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship



## **MISSED APPOINTMENTS OR LATE CANCELLATIONS**

As part of our ongoing efforts to enhance patient care and improve appointment availability, a **\$25 "NO-SHOW" FEE** will be applied to your account for appointments missed without prior notification or cancellations made less than 24 hours before the scheduled appointment time.

This fee is intended to cover the costs associated with the missed appointment slot and to encourage patients to notify us in advance if they are unable to make their appointment. Please note that this fee will not be covered by insurance and will be due prior to scheduling any future appointments.

By signing below, you acknowledge that you have received and understand this policy regarding the \$25 "no-show" fee at Grace and Joy Medical.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Thank you for calling Dr Sisai's office, if this is emergency please hang up and dial 911. Our office is closed right now. Our office hours are Monday to Friday, 9am to 5pm. If you are an existing patient and you have urgent needs that can not wait until the next business day please email us at [jeremiah@sisaymd.com](mailto:jeremiah@sisaymd.com). If you are calling for appointments, medication refills, authorization or all other requests please leave a detailed voicemail and we will get back with you the next business day. Thank you**