We strive to provide our patients with accountable patient care. Accountable care means that we take responsibility for quality, safety, cost, and your experience of care. It also means that we are focused on preventing disease, promoting and maintaining health, and intervening early when illness threatens.

Our commitments to YOU

- Availability of same-day appointments
- Availability of telephone and portal care
- Hospitals, admitting privileges, and the use of hospitalists

Copays
All copays are due at time of service. This charge is the responsibility of the patient along with coinsurance/deductibles.

Forms
There is a $25 fee associated with form completion. This includes FMLA, Work Comp and etc. This does not include new patient paperwork.

Insurance Cards
Insurance cards are required to be present at the time of your appointment. You are responsible for any insurance changes, co-payments, co-insurance, deductibles or non-covered services.

Late & No Show Appointments
Please call ahead if you are running late and we can make you aware if accommodations can be made for you. If you are greater than 15 minutes late for your appointment you are considered a late arrival. Late arrivals will be offered the next available appointment. All patients are responsible for a $25.00 No Show Fee for not canceling appointments 24 hours prior to appointments.

Medications
Please request medication refills or renewals directly from your pharmacy. Bring a complete list of all your medications with you to every office visit.

Referral requests
If you feel you need to see a specialist, please call our office first. We may be able to provide the service you need. In the event that a specialist is needed, we will provide a referral.

Again, welcome to our practice. We look forward to getting to know you and helping you with all your medical needs.

AMG Patient Code of Conduct

Anderson Medical Group is committed to providing personal, convenient, and quality healthcare. Our Patient Code of Conduct helps us meet this goal.

Our expectation is that all visitors, patients, and family members refrain from unacceptable behaviors that are disruptive and pose a threat to the rights or safety of our patients and staff.

Examples of these include:

- Physical or verbal threats and assaults
- Offensive comments about others' race, accent, religion, gender, sexual orientation, or other personal traits
- Sexual or vulgar words or actions
- Possessing firearms or any weapons on our premises
- Damaging business equipment or property
- Making threats of violence through phone calls, letters, voicemail, email, or other forms of written, verbal, or electronic communication
- Disrupting another patient's care or experience
- Audio and/or video recording of staff during care or treatment. Please be courteous with the use of your cell phone and other electronic devices.

Some violations of this Code may lead to patients being asked to make other plans for their future non-emergency care. Anderson Healthcare has a zero-tolerance policy for aggressive behavior. Anderson Medical Group leadership supports team members in pressing charges for aggressive behavior directed by patients against our staff. Aggressive behavior may result in removal from the facilities and could lead to an arrest.

If you witness or are the target of any of these behaviors, please report it to a member of your care team.

Everyone following a shared Code of Conduct is essential and we thank you for allowing us to serve you.

ANDERSON MEDICAL GROUP

PATIENT REGISTRATION & DEMOGRAPHICS

Last Name ________________________ First Name __________________________Middle Initial ____

Date of Birth_____________ SS# ______________________ Sex: Female, Male, or Undifferentiated

Address ____

City____ State _____ Zip __________________

Home Phone ________________Cell Phone _______________ Work Phone ___________________

Marital Status ______________ Preferred Language _______________ Race__________________

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Decline to Provide

Interpreter Needed? ___ Yes ___ No

Email Address for Patient Portal____

Optional: Preferred Pronouns ____

Primary Insurance:

Insurance Name ____

Policy#_______________________________________Group#______________________________

Subscriber Name __________________________________ Date of Birth____________________

SS# _________________________ Patient Relationship to Subscriber___________________

Secondary Insurance:

Insurance Name ____

Policy#_______________________________________Group#______________________________

Subscriber Name ________________________________ Date of Birth____________________

SS# _________________________ Patient Relationship to Subscriber____________________

Responsible Party/Guarantor:

Person financially responsible for payment on the patient account. Usually the patient if over 18 years of age.

Is the Patient also the Guarantor? ___Yes___No If Yes, skip to the *Emergency Contact* Section

Guarantor Name: _________________________ Date of Birth: __________SS#___________________

Address__________________________________City__________________State_____Zip ___________

Relationship to Patient:____________________________

Emergency Contact: ☐ Appointment ☐Clinical ☐Financial Information

Name:_________________________ Phone:_________________Relationship to Patient:______________

Signature of Patient/Authorized Person | Relationship to Patient | Date

ANDERSON MEDICAL GROUP

Health History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient Last Name ____________________ First Name ____________________ DOB _____________

Gender: □Male □Female □Other

Marital Status: □Single □Partnered □Married □Separated □Divorced □Widowed

Living arrangements: □Alone □Family □Friends □Roommate

Previous or Referring Dr. _______________________ Date of last Physical Exam ____________

Do you have an Advance Directive or Living Will? □Yes □No

Employer/School _______________________________ Occupation _____________________

Medication List:

List your prescribed drugs, inhalers and over-the-counter drugs and vitamins.

Name of Drug	Strength	Frequency

List of Allergies and Reaction to Medications:

____
____
____

List Surgery & Year:

____

Chronic Health Problems – Check all that apply

□Allergies
□Asthma
□Anemia
□Anxiety
□Arthritis
□Blood Clots
□Cancer
□Coronary Artery Disease
□Congestive Health Failure
□COPD
□Crohns/Colitis
□Diabetes
□Gallbladder Disorder
□GERD/Acid Reflux
□Headache/Migraine
□Heart Attack
□Heart Disease
□Hepatitis
□Hyperlipidemia
□Hypertension
□Irritable Bowel Syndrome
□Kidney Disease
□OSA
□Osteoporosis
□Seizures
□Stroke
□Thyroid Disorder
□Ulcers
□Other ______________

Family Medical History:

	Father	Mother	Sibling	Child	Maternal GP	Paternal GP
Alcoholism						
Asthma						
Cancer (Type)						
Diabetes						
High Blood Pressure						
Depression/Anxiety						
Heart Problems						
Stroke						
Thyroid Disorder						
Other (Describe)						

Female Patients Only:

Are you pregnant? □ Yes □ No
Number of pregnancies: _____ Miscarriages: _____ Terminated Pregnancies: ___ Live Births: ____
Date of last menstrual cycle: _______ Usual length of cycle: _______ Days of flow: _______
Usual menstrual cycle: Regular Irregular Painful/Cramps
Birth Control Method: ____
If menopausal, do you experience any symptoms? □Yes □No
Date of last PAP test: ____________________________ Normal Abnormal
Date and Facility of last Mammogram: ___________________ Normal Abnormal
How often do you perform Self Breast Exams? ____________

Male Patients Only:

Any urinary complaints? (hesitation in starting urine stream, decrease in force or flow, dribbling)
How many times per night do you awaken to urinate? ____________________
Any difficulty in getting or maintaining an erection? □Yes □No
Have you had a PSA blood test? □Yes □No Date of PSA: ___________ Normal or Abnormal
Males over 50 Prostate Exam: □Yes □No Date of Prostate: __________________

Health Maintenance:

	Yes	No	Date
Flu Vaccine			
Tetanus Vaccine			
Pneumonia Vaccine			
Dexa Scan			
Adults over 20 - Cholesterol			
Adults over 50 - Colonoscopy			
Have you ever had a blood transfusion?			
Would you accept blood if needed?			

Health Habits and Safety:

Do you currently use recreational or street drugs? □Yes □No
Have you ever given yourself street drugs with a needle? □Yes □No
Do you eat a healthy diet and exercise regularly? □Yes □No
If you are over the age of 65, do you experience frequent falls? □Yes □No
Are you sexually active? □Yes If yes, are you trying for a pregnancy? □No
□Yes □No
If not trying for a pregnancy, list contraceptive or barrier method used: _________
Do you fear for your safety or have a history of abuse? □Yes □No

Caffeine None □Coffee □Tea □Cola ___ # of cups or cans per day?

Alcohol Do you drink alcohol? Yes □No
If yes, what kind? _______________ Amount and frequency _______
Are you concerned about the amount you drink? □Yes □No

Tobacco Do you use tobacco? □Yes □No
□ Cigarettes pks./day ________ □Chew - #/day __ □Pipe - #/day _____ □Cigars - #/day ______
□ Vaping ______ # of years. Tried to quit? □Yes □No Year quit__________

Pharmacy Name: _____________________________ Secondary Pharmacy: ___________________________

Signature:____ Date: ___________________