Valley Internal Medicine and Pediatrics

Name_________________DOB_____________ ☐Female ☐Male
Address_____________________________
City, State, Zip_______________________
Phone______________________________
Phone______________________________
Email______________________________

Pharmacy___________________
Emergency Contact:
Name______________________
Phone______________________
Relationship_________________

☐Yes ☐NO I authorize VIMP contact me by phone or text to discuss personal health information at the phone numbers provided.
☐Yes ☐NO I authorize the disclosure of personal health information to certain individuals other than myself as listed below:
Name___________________ Relationship___________ Phone__________________
Name___________________ Relationship___________ Phone__________________
Name___________________ Relationship___________ Phone__________________

Insurance Information:
☐Self-Pay

Primary___________________________
Member ID________________________
Group#___________________________
Policy Holder______________________
DOB_________Relationship_________

Secondary_________________________
Member ID__________________________
Group#_____________________________
Policy Holder________________________
DOB_________Relationship___________

The above information is true to the best of my knowledge: I hereby authorize my insurance benefits to be paid directly to the practice. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize Valley Internal medicine and pediatrics to release information necessary to secure the payment and benefits. I authorize the use of my signature on all insurance submissions.

Printed Name_________________ Sign___________________ Date______________

Valley Internal Medicine and Pediatrics

Financial/ office policy's: (please initial)

_____ All copays/deductibles/balance due at time of visit
_____ If payment plan needs to be set up, please ask
_____ All return checks $35 charge
_____ No Show Appointments $35
_____ Late appointments $25 after 15 min grace period
_____ Phoned in medication refill not obtained at visit $15
_____ Blue cards not obtained at office visit $5
_____ All FMLA paperwork $25
_____ PA's for medications, have to be requested by patient and these are $25
_____ Allow 5-7 business days for all referrals to be complete
_____ We refer out for any pain or psychiatric management

ROS (-) Please **CIRCLE** all **CURRENT** positive findings

Weight loss	Blurry vision	Chest pain	Coughing up blood
Fevers Chills	Eye pain or discharge	Palpitations	History of Tuberculosis
Poor appetite	Eye redness	Heart Murmur	Nausea
Fatigue	Double vision	Poor Circulation	Diarrhea
Weight gain	Sore throat	Edema	Constipation
Insomnia	Hoarseness	Short of breath	Heartburn
Night sweats	Ear Pain	Chronic Cough	Acid Reflux
Trouble swallowing	Blood in stool	Trouble with urination	Rash
Hives	Nail Changes	Mole Changes	Hair loss
Joint pain	Leg cramps	Weakness	Drug dependence
Suicidal thoughts	Anxiety	Depression	Panic Disorder
Alcohol dependence	Blood transfusion	Seizure	Stroke
Tremors	Dizziness	Loss of balance	Slurred speech
Easy bruising	Blood clots	HIV positive	Hepatitis

I authorize that I have read the above office policy's and know that I have access to Notice of privacy practice/HIPPA and I agree to the authorization to treat.

Printed Name_________________ Sign___________________ Date______________

Valley Internal Medicine and Pediatrics

Medical Information:

Allergies____

Past Medical History: ____

____

Surgical History: ____

____

Medications____

____

____

____

Marital Status_________________ Occupation_______________________

Tobacco Use__________________ How many pack per day_________________

Alcohol Consumption____

Family History: (please list any known medical problems) Circle one

Father: Alive or Deceased. Age_______ Medical hx_________________________

Mother: Alive or Deceased. Age______ Medical hx_________________________

Siblings: Alive or Deceased. Age______ Medical hx________________________

Siblings: Alive or Deceased. Age______ Medical hx________________________

Siblings: Alive or Deceased. Age______ Medical hx________________________

Your Children: How Many? _________

Health Maintenance: (Please list month and year)

Routine Labs______________ Prev 13_______________________

Flu Vaccine_______________ Pneumovax_____________________

Shingles Vaccine___________ COVID 19 Vaccine______________

Colonoscopy______________

Mammogram______________

Bone Density______________

Pap Smear________________

Prostate Exam_____________

PSA labs__________________

Printed Name________________ Sign__________________ Date____________

Medical Records Release Authorization

I hereby authorize and request you to release a medical records needed to:

Valley Internal Medicine and Pediatrics
708 Will Halsey Way Suite A
Madison, Al 35758
Ph: (256) 325 7425
Fax: (256) 325 2765

Patient Full Name___________________________ DOB______________________

If not patient: Name_________________________ Relationship________________

Name of physician from whom we are requesting records:

____

Purpose for disclosing records____

Records Needed____

Patient signature ____

Parent or guardian signature____

Date___________________________________