BERMUDA HEALTHCARE SERVICES

19 THE LANE, PAGET PG 05 BERMUDA
PHONE: 441-236-2810
FAX: 441-236-5569
EMAIL: INFO@BHCS.BM
WWW.BHCS.BM

PATIENT INFORMATION

Today's Date: DD / MM / YY

Patient Name: LAST NAME / FIRST NAME Preferred Name: _____

Date of Birth: DD / MM / YY Sex: ◯Male ◯Female

Race: _____ Language: English ◯YES ◯NO Other: _____

Mailing Address: _____ Postal Code: _____

Email: _____

Please circle preferred contact phone number below

Home: _____ Work: _____ Cell: _____

Spouse Name: _____ Spouse Phone for Emergencies: _____

Emergency Contact (other thank spouse): _____ Phone Number: _____

Who may we discuss your medical condition with?: _____ Relationship: _____

How did you hear about our practice?: _____

Pharmacy Choice: _____

INSURANCE INFORMATION

(Insurance Card, Picture ID., and co-payment/patient balance, must be provided at the time of service)

Name of Policyholder: Surname: _____ First Name: _____

Insured's Date of Birth: DD / MM / YY Relationship to Insured: _____

PLEASE CIRCLE INSURANCE COMPANY:

Insurance Co: ARGUS, ARGUS-HIP, BF&M, COL, COL-HIP, GEHI, HIP, FUTURE CARE, FRIE-BRUC, OTHER: _____

Policy Group Number: _____ Certificate Number: _____

I hereby assign, transfer and set over to, Bermuda HealthCare Services, all of my rights, title and interests to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. Payment is required for all services at the time they are rendered. I agree to the policies, terms and conditions of Bermuda HealthCare Services. I agree that all agency charges, legal costs and other expenses incurred by Bermuda HealthCare Services in attempting to recover overdue amounts will be charges to my account. I understand that unpaid debt will be forwarded for collections after 90 days if no other arrangement has been made.

I authorize the release of medical information to other physicians and to consultants, if needed, and, as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature: _____ **Date:** DD / MM / YY

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Today's Date: DD / MM / YY

Surname: _____ **First Name:** _____ **Middle Name:** _____

Date of Birth: DD / MM / YY **Marital Status:** ◯ **Single** ◯ **Married** ◯ **Divorced** ◯ **Widowed**

Alcohol: ◯ **Never** ◯ **Occasionally** ◯ **Daily**

Tobacco: ◯ **Never** ◯ **No** ◯ **Yes** ◯ **Occasionally** _____ **packs / day** **Year Stopped** _____ **Cigars / Smokeless**

Have you ever been diagnosed with any of the following medical conditions?

☐ Asthma	☐ Hepatitis/Liver Disease	☐ Migraines	☐ Blood Clots / DVT / Phlebitis
☐ Blood Clots / DVT / Phlebitis	☐ Herniated Disc	☐ Seizures	☐ Cancer
☐ High Cholesterol	☐ Stroke	☐ Diabetes	☐ Hypertension/High Blood Pressure
☐ Thyroid Disease	☐ Emphysema / COPD	☐ Heart Attack	☐ Heart Failure
☐ Kidney Disease			

Please list any other medical diagnoses or problems: _____

Please list any other physicians that you may be seeing: _____

Please list any surgeries or hospital admissions and year of admission(s): _____

Please list any lifetime events: (e.g. children, hysterectomy, etc...) _____

List all prescription medications that you are currently taking:

	Drug	Drug Strength / Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			

List any non-prescription (over-the-counter) medicines (e.g. supplements / vitamins / aspirin) that you take regularly:

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Please list medication allergies and describe any reaction to this medication: _____

Please list all other allergies and describe any reaction to those allergens: _____

Please describe the medical history of your immediate family, listing any major problems such as heart disease, diabetes, cancer, high blood pressure, stroke, tuberculosis, neurological disease, and whether living or deceased (L/D):

	L / D	AGE	MAJOR MEDICAL PROBLEMS
Mother			
Father			
Sister(s)			
Brother(s)			
Maternal G-Mother			
Paternal G-Mother			
Maternal G-Father			
Paternal G-Father			
Daughter			
Son			

Please tick any symptoms or problems that you are currently experiencing:

- ☐ Abdominal / Pelvic Pain
- ☐ Abnormal Vaginal Discharge
- ☐ Abnormal Weight Gain
- ☐ Anxiety
- ☐ Blood in Urine
- ☐ Blood in Stool
- ☐ Black Stools
- ☐ Breast Mass / Tenderness
- ☐ Chronic Cough
- ☐ Chronic Diarrhea
- ☐ Chronic Constipation
- ☐ Chest Pain
- ☐ Depression
- ☐ Difficult Hearing
- ☐ Fatigue
- ☐ Faintness / Dizziness
- ☐ Fever / Chills
- ☐ Frequent Urination
- ☐ Frequent Nose Bleeds
- ☐ Headaches
- ☐ Heart Racing
- ☐ Heartburn
- ☐ Impotence
- ☐ Memory Problems
- ☐ Muscle / Joint Pain
- ☐ Nausea
- ☐ Night Sweats
- ☐ Numbness in Arms or Legs
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Skin Rashes
- ☐ Swelling of the Legs or Feet
- ☐ Swollen Glands or Lymph Nodes
- ☐ Testicular Pain / Mass
- ☐ Tremor
- ☐ Trouble Swallowing
- ☐ Trouble Urinating
- ☐ Ulcers of the Skin
- ☐ Unintentional Weight Loss
- ☐ Vertigo
- ☐ Vision Problems
- ☐ Weakness in General
- ☐ Weakness in Arms or Legs
- ☐ Wheezing

Patient Signature: _____ Date: DD / MM / YY

Name: _____ _____ DD / MM / YY

Completed by: ◯Patient ◯Nurse ◯Caregiver ◯Friend ◯Family Member Signature Date

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FINANCIAL POLICY AND DISCLOSURE

Patient Name: _____ Date of Birth: DD / MM / YY

The Financial Policy and Disclosure is to help Bermuda HealthCare Services provide the most efficient and reasonable health care services. Therefore, it is necessary for us to have a Financial Policy and Disclosure stating our requirements for payment for services provided to patients.

Self-Pay Policy:

- If you are a self-pay patient, you will be required to pay your balance in full at the time of service.

Insurance Policy:

- If you are an insurance patient, we require the coverage to be verified for each patient at each visit.
- If a service is provided that is not covered by your insurance company, or is not covered in full by your insurance company, you will be the responsible party at the time of service.
- Patient co-payments will be collected at the time of service.
- In special cases, we may need your help in contacting your insurance company for the payment of your services, and therefore, you must agree to fully cooperate in assisting us should that be necessary.

Prescription Policy: New prescriptions always require an office visit. Office visits are required for patients who: Have not been seen by the doctor in the past year and / or who are requesting new prescriptions and / or antibiotics. Refill Request outside of an office visit will require payment of a $10.00 (ten dollar) Prescription Refill Fee. Prescription Refill Request require a minimum of 24 business hours notice for all prescriptions. **Form:** Completion of forms requires an office visit with the physician. Completion of TCD forms requires an office visit with the physician if you have not been seen within the past three months. **Expectations:** Patients arriving 15 minutes past their scheduled appointment time will be asked to reschedule their appointment. Patient phone messages received prior to 2:00pm will be returned before 6:00pm that day, Monday-Friday. Patient phone messages received after 2:00pm will be returned the following business day no later than 1:00pm.

Cancellation / No-Show:

- We require 24 hours notice to cancel your appointment.
- Patient's failing to cancel an appointment without 24 hours notice are subject to a $10.00 missed appointment / no-show fee.
- Payment of any outstanding no-show fees will be required to schedule another office visit.

To help in this policy we ask that you assist us by:

1. Providing us with current and updated information on yourself and your insurance company.
2. Presenting an updated photo identification card and insurance card when changes are made.
3. Making the appropriate payment at the time of service: copay for insured patients, full amount for uninsured patients.

In order to provide the best medical care, we ask that you not discuss your account balance or financial aspects with the physician(s) or medical staff. Please discuss any account information with the check-in or check out associate, and/or billing coordinator.

Acknowledgments: I acknowledge and agree to the terms and conditions of the Policies described.

		DD / MM / YY
Responsible Party's Name	**Responsible Party's Signature**	**Date**