The Family Health Book

Richard Douglas Iliff, M.D., F.A.A.F.P.

On behalf of my staff, we are honored that you would consider joining our practice. We want to provide personalized medical services, both preventative and acute care, to a limited number of patients.

Because of my personal interest in disease prevention, the orientation of this practice is toward fitness and health maintenance. However, I have lost the starry-eyed idealism of my youth; I am well aware that the majority of folks operate on the "breakdown maintenance" philosophy, and for those we'll try to see you promptly and get you back into action as soon as possible.

Please permit me though, to encourage you to schedule a data-base physical exam at least every five years (every two years after the age of 50). That gives me a chance, at least twice each decade, to harass you about all the things you can do to reduce your biological age. I can't do anything about your chronological age, but there is a lot you can do to look and feel younger than your calendar ages says.

If you are interested in participating more fully in your health care, please ask for a Family Health Care Book. This loose-leaf notebook contains the most useful information I could find regarding a number of medical problems, and serves as a repository for the yellow copies of my office records which you will be given at each visit.

Please be sure that the information below is accurate and up-to-date. Remember I work for you, not your insurance company; therefore my bills are ultimately your responsibility. If your insurance will not pay for whatever reason, your signature below acknowledges that you will be responsible for the charges.

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Full Legal Name _____Date of Birth _____Sex_____
(As it appears on your insurance card or other form of identification, INCLUDING middle initial)

Address_____City_____State____Zip_____

Home Phone# _____ Cell Phone# _____ Business Phone#_____

Occupation_____ Last grade completed/Degree_____ Social Security #_____

Spouse Name _____ Spouse Daytime Phone# _____ Spouse Cell #_____

►Primary Medical Insurance Co._____ Policy Holder_____ Date of Birth_____

Policy Holder's Social Security#_____ Relationship to patient _____Policy # _____

►2ndary Medical Insurance Co. _____ Policy Holder _____ Date of Birth_____

2ndary Policy Holders SS#_____ Relationship to Patient_____ Policy #_____

Religious Preference_____ _____Pharmacy Preference _____

Emergency Contact _____ Relationship_____ Daytime Phone# _____Cell Phone#_____

How did you happen to hear about our services? _____

Insurance Co-Pays are due at time of service. If you do not have insurance, payment is expected at time of service, unless prior arrangements are made. Payment can be made by cash or check only.

Signature_____ Date_____