

Patient Information (Please PRINT)		
	Patient	Responsible Party
Name: (Last, First MI)		
Date of Birth:		
Sex:		
Street:		
City:		
State, ZIP:		
Home Phone:		
Alt. Phone:		
SS#:		
Driver License:		
Marital Status:		
Employer:		
Occupation:		
Work Phone:		
In Case of Emergency—Notify:		
Name (Relationship):		
Contact Phone (Where):		
Alt. Phone (Where):		
Insurance Information		
	Primary:	Secondary:
Insurance Company:		
Street:		
City, State, ZIP		
Contact Phone:		
Policy:		
Group:		
Other Information		
Referred By:		
*** I agree to pay for appointments that I miss if I do not cancel 24 hours in advance. *** I authorized this office to release any information to my insurance carrier necessary to process my claim. *** I understand that payment is my obligation, regardless of insurance of other third party involvement.		
Signature:		Date:

Informant: <input type="checkbox"/> Self <input type="checkbox"/> Patient's father <input type="checkbox"/> Patient's mother <input type="checkbox"/> Other – _____	
Chief Complaint: (Please explain why you are here for this visit)	
History of Present Illness: (Please describe your chief complaint with regards to following aspects) (Mode of onset, Duration, Frequency, Location, Character, Severity, Aggravating/alleviating factors, Exacerbation, Remission)	
Allergies: (Food, medication, pollen etc.) (Please describe symptoms of allergy. Ex. Penicillin—rash)	Past Medical History: (Please list all of injuries, illnesses, and chronic diseases that you have encountered in following order-- type, date, outcome, & any complications)
Current Medications: (Prescriptions, OTC, supplements, vitamins, & minerals) (Please list as follows: Name of the medication, Dosage of medication, Frequency of taking medication)	
	Past Surgical History: (Operation-date-reason-outcome-complications)
Family History: (marked = yes, blank = no) If yes to any of following conditions, please describe the	Social History: (marked = yes, blank = no)

<p>person's relationship to you.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Alcohol abuse- <input type="checkbox"/> Anemia- <input type="checkbox"/> Asthma- <input type="checkbox"/> Cancers- <input type="checkbox"/> Depression- <input type="checkbox"/> Diabetes- <input type="checkbox"/> Epilepsy/ seizures- <input type="checkbox"/> Heart attacks- <input type="checkbox"/> Hypertension- <input type="checkbox"/> Strokes- <input type="checkbox"/> Other conditions- 	<p>Do you currently...</p> <ul style="list-style-type: none"> <input type="checkbox"/> drink Alcohol- <input type="checkbox"/> drink Coffee- <input type="checkbox"/> drink Tea- <input type="checkbox"/> drink Soda- <input type="checkbox"/> have Stress- <input type="checkbox"/> used Illicit drugs- <input type="checkbox"/> chew or smoke Tobacco- <input type="checkbox"/> crave Sweets- <input type="checkbox"/> eat Snacks- <input type="checkbox"/> become irritable or tired if your mealtime is delayed- <input type="checkbox"/> take Artificial sweeteners- <input type="checkbox"/> Salt your food- <input type="checkbox"/> have Sexual problems / difficulties- <input type="checkbox"/> Exercise-
<p>Review of System (marked = yes, blank = no)</p>	

General:

- fatigue weakness
 fever/ chills weight change

Skin:

- itching rashes
 lumps sores
 moles

HEENT:**Head-**

- headache trauma

Eye-

- blurriness glaucoma
 cataract scotoma
 eye pain visual loss
 glasses / contact lenses

Ear

- discharge tinnitus
 hearing loss vertigo

Nose

- congestion / stuffiness rhinorrhea (running nose)
 epistaxis (nose bleed) sneezing
 itching sinusitis

Throat/Mouth-

- bleeding gums sore throat
 hoarseness swollen neck

Chest / Breasts:

- breast discharge history of cancer
 breast pain lumps / masses

Respiratory:

- asthma pneumonia
 bronchitis shortness of breath
 cough w / o sputum tuberculosis
 emphysema wheeze
 hemoptysis (coughing blood)
 last chest x-ray _____

Cardiovascular:

- angina / chest pain heart murmurs
 blood claudication high cholesterol
 dyspnea on exertion hypertension
 edema (swollen) orthopena
 heart attack palpitations
 heart failure varicose veins
 paroxysmal nocturnal dyspnea

Gastrointestinal:

- abdominal pain indigestion
 appetite change jaundice
 constipation nausea
 diarrhea ulcer
 dysphagia vomiting
 hepatitis

GI Bleeding-

- hematemesis hemorrhoids
 hematochezia melena

Urinary:

- discharge incontinence
 dysuria increase frequency
 hematuria nocturia
 hesitancy stones
 frequent infection urgency

Genital:**Male-**

- inguinal hernia testicular pain or masses
 penile discharge or sores

Female-

- dysmenorrhea pain/bleeding with intercourse
 flushing / menopause vaginal discharge
 hot flashes vaginal itching
 irregular menstrual period vaginal sores
 premenstrual tension (PMS) – if yes, do you have:
 pain cramps fluid retention moodiness
 pregnancies – if yes, please indicate number of :
pregnancies _____ live birth _____
miscarriages _____ abortions _____

General-

- sexual transmitted diseases using contraception

Musculoskeletal:

- arthritis motor vehicle accident
 gout spasms
 fractures / broken bones trauma

Muscle/joint

- decrease range of motion stiffness
 instability swelling
 pain weakness
 redness

Neurologic:

- blackouts stroke
 fainting tremors
 paralysis vertigo
 paresthesia (numbness) weakness
 seizures

Hematologic:

- anemia petechiae
 easily bleeding of the gums purpura
 easy bruising transfusions

Endocrine:

- diabetes polydipsia
 heat/cold intolerance polyphagia
 hyperthyroid polyuria
 hypothyroid

Psychiatric:

- anxiety mood changes
 depression psy tx/hospitalization
 hallucinations tension
 memory loss

Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____ Signature _____ Date _____

Compliance assurance notification for our patients

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.