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:	SEE INSURANCE CARD	SEE INSURANCE CARD
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: ☐ **Self** ☐ **Patient's father** ☐ **Patient's mother** ☐ **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)

Current Medications:
(Prescriptions, OTC, supplements, vitamins, & minerals)
(Please list as follows: Name of the medication, Dosage of medication, Frequency of taking medication)

Past Medical History:
(Please list all of injuries, illnesses, and chronic diseases that you have encountered in following order-- type, date, outcome, & any complications)

Past Surgical History:
(Operation-date-reason-outcome-complications)

Family History: (marked = yes, blank = no)
If yes to any of following conditions, please describe the person's relationship to you.

- ☐ Alcohol abuse-
- ☐ Anemia-
- ☐ Asthma-
- ☐ Cancers-
- ☐ Depression-
- ☐ Diabetes-
- ☐ Epilepsy/ seizures-
- ☐ Heart attacks-
- ☐ Hypertension-
- ☐ Strokes-
- ☐ Other conditions-

Social History: (marked = yes, blank = no)

Do you currently…

- ☐ drink Alcohol-
- ☐ drink Coffee-
- ☐ drink Tea-
- ☐ drink Soda-
- ☐ have Stress-
- ☐ used Illicit drugs-
- ☐ chew or smoke Tobacco-
- ☐ crave Sweets-
- ☐ eat Snacks-
- ☐ become irritable or tired if your mealtime is delayed-
- ☐ take Artificial sweeteners-
- ☐ Salt your food-
- ☐ have Sexual problems / difficulties-
- ☐ Exercise-

Review of System (marked = yes, blank = no)

General:
- ☐ fatigue
- ☐ fever/ chills
- ☐ weakness
- ☐ weight change

Skin:
- ☐ itching
- ☐ lumps
- ☐ moles
- ☐ rashes
- ☐ sores

HEENT:

Head-
- ☐ headache
- ☐ trauma

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

Ear
- ☐ discharge
- ☐ hearing loss
- ☐ tinnitus
- ☐ vertigo

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

Throat/Mouth-
- ☐ bleeding gums
- ☐ hoarseness
- ☐ sore throat
- ☐ swollen neck

Chest / Breasts:
- ☐ breast discharge
- ☐ breast pain
- ☐ history of cancer
- ☐ lumps / masses

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

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

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

GI Bleeding-
- ☐ hematemesis
- ☐ hematochezia
- ☐ hemorrhoids
- ☐ melena

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

Genital:

Male-
- ☐ inguinal hernia
- ☐ penile discharge or sores
- ☐ testicular pain or masses

Female-
- ☐ dysmenorrhea
- ☐ flushing / menopause
- ☐ hot flashes
- ☐ irregular menstrual period
- ☐ 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 _____
- ☐ pain/bleeding with intercourse
- ☐ vaginal discharge
- ☐ vaginal itching
- ☐ vaginal sores

General-
- ☐ sexual transmitted diseases
- ☐ using contraception

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

Muscle/joint
- ☐ decrease range of motion
- ☐ instability
- ☐ pain
- ☐ redness
- ☐ stiffness
- ☐ swelling
- ☐ weakness

Neurologic:
- ☐ blackouts
- ☐ fainting
- ☐ paralysis
- ☐ paresthesis (numbness)
- ☐ seizures
- ☐ stroke
- ☐ tremors
- ☐ vertigo
- ☐ weakness

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

Endocrine:
- ☐ diabetes
- ☐ heat/cold intolerance
- ☐ hyperthyroid
- ☐ hypothyroid
- ☐ polydipsia
- ☐ polyphagia
- ☐ polyuria

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

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_________

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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.