Please complete form in its entirety

Patient Information

Patient Information:			
Last Name:	First Name:	M.I.:	Date of Birth:
Mailing Address:		Apt #	
City/State/Zip:			
Home Phone:	Cell Phone:		Work Phone:
Email Address:			Preferred Method of Contact: ☐ Home ☐ Cell ☐ Work ☐ Email
Sex: ☐ Male ☐ Female ☐ Transgender	Social Security #:		
Marital Status: ☐ Divorced ☐ Married ☐ Single ☐ Other____________________	Employer Name:		
Emergency Contact Name and Phone:	Relationship to Patient:		

Additional Information and Responsible Party

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor:		
Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:	Relationship to Patient:	

Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW):			
Race (please select):			Ethnicity (please select one):
☐ White	☐ American Indian or Alaska Native	☐ Asian	☐ Hispanic or Latino
☐ Hispanic	☐ Black or African American	☐ Native Hawaiian or Pacific Islander	☐ Not Hispanic or Latino
☐ Other	☐ Decline		☐ Decline
Preferred Language (please select one):	☐ English	☐ Bosnian	☐ Indian (including Hindi & Tamil)
	☐ Sign Language	☐ Spanish	☐ Russian
Preferred Pharmacy Name & Location:			

Insurance Information

Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Co. Name:	Ins. Co. Name:
Member ID & Group #:	Member ID & Group #:
Policy Holder Name:	Policy Holder Name:
Policy Holder Date of Birth:	Policy Holder Date of Birth:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

Name: ___________________________________ **Allergies** ____

Please list ALL medications you are currently taking, prescribed and or over the counter. Please try and be as specific as possible.

Medication	Dosage	Route	Frequency

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

ADHD	COPD/ Emphysema	High Cholesterol	Rheumatoid Arthritis
Alcoholism	Dementia	HIV	Seizure Disorder
Allergies, Seasonal	Depression	Hepatitis	Sleep Apnea
Anemia	Diabetes: 1 or 2	Irritable Bowel Syndrome	Stroke
Anxiety	Diverticulitis	Lupus	Thyroid Disorder
Arrhythmia (irregular heart beat)	DVT (Blood Clot)	Liver Disease	Ulcerative Colitis
Arthritis	GERD (Acid Reflux)	Macular Degeneration	
Asthma	Glaucoma	Neuropathy	
Bipolar	Heart Disease	Osteopenia/Osteoporosis	
Bladder Problems / Incontinence	Heart Attack (MI)	Parkinson's Disease	
Bleeding Problems	Hiatal Hernia	Peripheral Vascular Disease	
Cancer: ________________	High Blood Pressure	Peptic Ulcer	
Headaches	Kidney Stones	Psoriasis	
Crohn's Disease	Kidney Disease	Pulmonary Embolism (PE)	

Last Menstrual Period	Date: __________	Normal Abnormal
Colonoscopy	Yes/No Date:_____	Normal Abnormal
Mammogram	Yes/No Date:_____	Normal Abnormal
Dexa (Bone Density)	Yes/No Date:_____	Normal Abnormal
Pap	Yes/No Date:_____	Normal Abnormal

Other medical problems not listed above:

____

Surgical History: Please list all prior surgeries and approximate dates performed.

_____________________________________ _____________________________________

_____________________________________ _____________________________________

SOCIAL / CULTURAL HISTORY:

Are there any vision problems that affect your communication? ☐Yes ☐ No

Are there any hearing problems that affect your communication? ☐Yes ☐ No

Are there any limitations to understanding or following instructions (either written or verbal)? ☐Yes ☐No

Current Living Situation (Check all that apply):

☐ Single Family Household ☐ Multi-generational Household ☐ Homeless ☐ Shelter ☐ Skilled Nursing Facility ☐ Other: _________________

Smoking/ Tobacco Use: ☐ Current ☐ Past ☐Never Type:________________Amount/day:__________Number of Years: _________

Alcohol: ☐Current ☐Past ☐Never Drinks/week: __________

Recreational Drug Use: ☐ Current ☐ Past ☐ Never Type: ____

Are you sexually active? ☐Yes ☐No

Are there any personal problems or concerns at home, work, or school you would like to discuss? ☐Yes ☐ No

Are there any cultural or religious concerns you have related to our delivery of care? ☐Yes ☐No

Are there any financial issues that directly impact your ability to manage your health? ☐Yes ☐No

How often do you get the social and emotional support you need?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Comments (Please feel free to comment on any answers marked "yes" above):

____

____

FAMILY HISTORY:

FATHER: Living: Age _____________ Deceased: Age ____________

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: ____________	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: ____

MOTHER: Living: Age _____________ Deceased: Age ____________

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: ____________	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: ____

SIBLINGS:

____

____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

____

____

Patient Signature ________________________________

Health Information Release Form

Please print all the information requested, then sign and date the form at the bottom of the page.

Patient Name:_____________________________________ **DOB**:______________________

The following person(s) have permission for any disclosure of my personal health information and authorization to pick up any medical records pertaining to my health care.

Authorized Person Name	**Relationship**	**Phone Number**
______________________________	___________________	_________________________
______________________________	___________________	_________________________
______________________________	___________________	_________________________

- Expiration or Termination of Authorization: This authorization will remain in effect until terminated by you, your personal representative, or another individual(s) of legal entity authorized to do so by court order or law
- Right to Revoke or Terminate: You have the right to revoke or terminate this authorization by submitting a written request at any time. This can be done in person or by mailing in a request to your office location.

Disclosure: We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.

By signing below, I am indicating I have read the above information and fully acknowledge and understand the risk to my protected health information.

Patient Signature:____ **Date**:____________________

Witness Name:____

Witness Signature:____ **Date**:___________________

Medical Records Request

Patient Name:_________________________________ **DOB**:_________________**Phone**:_________________________

Mailing Address:____

____

Description of information to be disclosed – I authorize the practice to disclose the following protected health information to the entity person, or persons identified below.

Treatment date(s):_____________________________

___ Entire patient record _ Office visits _Lab results _Imaging results

___Immunizations ____Ledger _ Itemized receipt ____Other:_____________

Purpose of Disclosure:

___ Patient Request _ Specialist _ New PCP ____Insurance/FSA _ Taxes

___ Other: ______________________________

Record Retrieval:

___ Mail copies to the address provided _ Fax records to the following:________________________

___ I am planning to pick the copies up, please notify me when ready (can take up to 30 days)

(FROM) The following organization is authorized to make the discloser:

Individual/Entity Name:____

Address:____

Phone:________________________Fax:________________________Email:_____________________________

**I authorize the entity identified above to disclose or provide protected health information about me to the individual/entity listed below.

(TO) Who will be authorized to receive information:

Individual/Entity Name:____

Address:____

Phone:________________________Fax:________________________Email:_____________________________

**Note: Some fax and email transmission methods are not secure and it is possible for your PHI to be compromised during transmission from out practice. Do not designate fax or email as your preferred method if this is a concern to you. This authorization will expire after 12 months unless otherwise specified by you. You have the right to terminate this authorization at any time by submitting a written request. Termination will be effective upon received written notice. We have no control over the person(s) you have listed to receive your PHI. Therefore, your PHI disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice. A fee may apply.

Patient/Authorized Representative Name:___________________________________**Relationship:**_____________________

Patient/Authorized Representative Signature:_____________________________________**Date:**_____________________