NEW PATIENT INFORMATION

PATIENT INFORMATION:

Name of patient____DOB________________Sex_____

Address_______________________________City_________________State______ Zip Code________

Cell phone____________________Home phone ______________________SSN___________________

RESPONSIBLE PARTY INFORMATION: ☐ **SAME AS PATIENT**

Name____DOB__________________

Address_____________________________City_________________State________Zip Code__________

Relationship to patient____

Employer______________________________Cell _______________________Work________________

SPOUSE OR PARENT INFORMATION:

Name____DOB____________________

IF A CHILD: MOTHERS NAME____________________________________DOB_____________________

IF A CHILD: FATHERS NAME_____________________________________DOB_____________________

ADDITIONAL INFORMATION:

Name of nearest relative not living with you__________________________Relationship________________________
Phone__________________________

Who referred you to our office? ____

INSURANCE INFORMATION:

Name of Primary Insurance____

Member Number_______________________________________Group Number_________________

Name of Person who carries the Insurance Policy____

Relationship to Patient_________________________Carriers DOB____________________________

Secondary Insurance____

Member Number______________________________________Group Number__________________

2117 N Kelly Ave, Edmond OK 73003
Office: 405-726-2701 Fax 405-726-2702

Patients Name: ____________________ Date of Birth: ______________

Please check the appropriate boxes below

Ethnicity

Hispanic or Latino ____________

Not Hispanic or Latino _________

Refuse to Report _____________

Language

English____ French____ Japanese _____

Chinese___ German___ Vietnamese ___

Filipino___ Spanish___ Other____

Race

White/Caucasian_____ Black/African American_____

Asian _____ American Indian/Alaska Native______

Multiple____ Native Hawaiian or Other Pacific Islander ____

Email Address____

We understand there are times when you must miss appointments. However when you do not give us 24 hours' notice, you are preventing another patient from getting much needed treatment. As a result we have a policy that you will be charged a $35 NO SHOW FEE. Thank you!

Patient's signature________________________________

Acknowledge of Receipt of notice of Privacy Practices

I acknowledge that I have been provided with the Notice of Privacy Practices ("Notice"):

- The Notice tells me how Vita Health and The Physicians' Group LLC, as applicable (the "Practice"), will use protected health information for the purpose of treatment, payment for treatment, and health care operations.
- The Notice explains in more detail how the Practice may use and share protected health information for other than treatment, payment, and health care operations.
- The Practice will also use and share protected health information as permitted or required by law.
- If I am a patient receiving health services at the Practice, I consent to the Practice using and disclosing my protected health information contained in my treatment records maintained by the Practice for the purposes detailed in the Practice's Notice of Privacy Practices.

Patient's Name (print): ____
Patient's Date of Birth: ____

This form must be signed by either the patient or by the patient's personal representative.

If this form is signed by the patient's personal representative, please provide a copy of the document naming the personal representative and provide a description of the personal representative's authority to act on behalf of the patient:____
____

____ Date: ______________
Signature of Patient or Patient's Personal Representative

Current Contact Information for Patient or Personal Representative signing this form:
Name (print):____
Address: ____
Telephone Number: _____________________________________
Email: ____

For Practice Use Only
I attempted to obtain the signature of the patient or the patient's personal representative on this Acknowledgment but did not because:

______ It was emergency treatment.
______ I could not communicate with the patient.
______ The patient refused to sign.
______ The patient was unable to sign because ______________________________________
______ Other: ____

____ ________________
Signature Practice Staff Member Date
Name: ____
Title: ____

This form should be placed in the patient's medical record.

Authorization for Treatment

I hereby authorize physician (s) in charge of the care of the patient of Vita Health and The Physicians' Group LLC to administer treatment as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

Authorization for Release of Medical Information

I authorize Vita Health and The Physicians' Group LLC to disclose any or all of the information in my medical records to any person, corporation or agency which is or may be liable for all or part of Vita Health's or The Physicians' Group LLC's charge or who may be responsible for determining the necessity, appropriateness, amount or other matter to the physical's treatment or charge including, but not limited to, insurance companies, health maintenance organizations, preferred provider organizations, workers compensation carriers, welfare funds, the Social Security Administration or its intermediaries or carries. **I understand that my medical records may contain information that indicates that I have a communicable disease which may include but is not limited to, disease such as Hepatitis, Syphilis, Gonorrhea or the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS).** With this knowledge, I give my consent to the re-lease of all information in my medical records, including any information concerning identity, and release Vita Health and The Physicians' Group LLC, its agents and its employees from liability in connection with the release of the information contained therein.

Assignment of Insurance Benefits

I hereby authorize payment directly to my physician (s) of the medical insurance benefits otherwise payable to me for services rendered during my visit at Vita Health. I understand I am financially responsible for charges not covered by this assignment.

Waiver of Responsibility of Valuables

I hereby release Vita Health and The Physicians' Group LLC from any claim for responsibility or damages in the event of loss of my property, including money and jewelry.
I understand a photocopy of this document is as valid as the original.

Signed____Date____________________
(Patient)
Or ______________________________________Witness to Signature ___________________
(Nearest Relative or Responsible Party)

____________________________________Policyholder's signature _____________________
(Relationship to Patient)

Notice to Patients: Information in your medical record that you have/may have a communicable or venereal disease is made confidential by law and cannot be released without your permission, except in limited circumstances, including release of persons who had risk exposures, release pursuant to an order of the court of the Dept. of Health, release among health care providers or release for statistical or epidemiological purposes. When such information is released, it cannot contain information from which you could be identified unless release of that identifying information is authorized by you, by an order of the court, or the Department of Health, or by law.

VITA HEALTH
MEDICAL CLINIC

Patient No.______________

Authorization to Release Information via phone/Family/Friends

Patient Name: _______________________________ DOB: _______________

I hereby authorize confidential communications from the physicians or staff of Vita Health and The Physicians' Group, LLC regarding my health, care, treatments, appointments, prescriptions, etc… to be received at any of the numbers given below. I authorize the staff to leave messages on the voice mail or with the individual who answers the phone at any of the below numbers:
(Do not fill in numbers at which you do NOT wish to be contacted)

Home Phone: ______________Cell Phone: _____________ other: ________________

I authorize the following individuals to call the office on my behalf to verify the status of appointments, treatment plan, medications, and account information. These individuals may also pick up prescriptions and/or samples that I have requested:

Name: _________________________________ Relationship: ______________________

Name: __________________________________Relationship:______________________

Name: __________________________________Relationship:______________________

Below is the pharmacy and pharmacy phone number that I will use for all prescriptions:

Pharmacy Name: ________________________Pharmacy Number_______________________

I understand this authorization will remain in effect until I revoke the authorization in writing.

____________________________________ __________________________
Patient Signature **Date**

VITA HEALTH STAFF ONLY:
Documented by: _________ ____________
Initials Date

Authorization to Use or Disclose Protected Health Information

Facility/Provider: ___________________________________

Patient Name: ______________________________________ Date of Birth: ____________________

Recipient & Purpose of Request: I authorize Provider to disclose my protected health information to the following ("Recipient"):

Recipient Name: Vita Health Address**:** 2117 N Kelly Ave, Edmond OK 73003

For the following purpose: ____

I authorize Provider to use or disclose the following protected health information of the Patient described above to Recipient described above in a manner consistent with this authorization (check all that apply):

☐ Entire medical record concerning this patient (excluding psychotherapy notes, if any).

☐ Entire medical record concerning this patient (excluding psychotherapy notes, if any).

☐ Medical record concerning this patient for the following date(s) of service: _________________________

☐ Billing record concerning this patient for the following date(s) of service: __________________________

☐ Other: Lab reports, X-ray reports, Consult Reports, Problem List____________________________________

I understand the following:

- Protected health information is health information that identifies me. The purpose of the authorization is to allow Provider to share my protected health information as set forth above.
- I understand that this authorization is voluntary and that I have the right to refuse to sign this authorization. If I refuse, my protected health information will not be used or disclosed by Provider except as otherwise permit-ted by law. Provider may not condition treatment on my providing this authorization for use or disclosure of my medical information. If I refuse to sign this authorization, I will still be eligible to receive medical services from Provider.
- Subject to certain exceptions, I have the right to revoke this authorization at any time by sending a letter to Provider which gives my name, the date I signed this authorization, and states that I revoke the Authorization to use my protected health information. The letter will not affect any actions taken in reliance of my previous authorization.
- This authorization may result in Provider disclosing my medical information to a recipient who could possibly later use or disclose the information without my authorization. Provider cannot re-disclosure by Recipient.
- I may inspect or copy the information that will be disclosed or used for the purpose set forth in this authorization. I will receive a signed copy of this authorization form and my contact Provider to get a copy if I do not have one.
- **Protected health information authorization for release may include records that indicate the presence of or regarding treatment of HIV/AIDS, sexually transmitted disease, and drug and/or alcohol abuse.**

____ _____________________________________

Signature of Patient or Patient's Representative **Date**

Description of Representative's authority (attach documentation):

☐ Parent of a minor

☐ Power of attorney

☐ Legal guardian

☐ Other:____

____

Printed Name of Patient or Patient's Representative

This authorization is only effective if it is signed and dated. Unless I revoke this authorization prior to expiration, this authorization expires on ____________________________________ (or if this is left blank, one year after the date it is signed).

Financial Policy

Thank you for choosing Vita Health Medical Clinic, Center for Internal Medicine and Pediatrics as your healthcare provider we are dedicated to providing the highest quality, most cost effective care.

In additional to accepting traditional insurance plans and Medicare we are contracted with numerous, Preferred Provider Organizations (PPO) and Health Maintenance Organization (HMO). Because each plan is different and constantly updating providers participation status, please check with your particular-lar plan to make sure we are currently participating in your network. We ask that you assist us in maximizing your insurance coverage by cooperating fully in all referral, prior-authorization and pre-certification process. **Please be aware that all insurance carries do not consider some services rendered a covered benefit. It is important that you are aware of your insurance policy provisions of coverage.**

Accurate, up to date information is the patient's responsibility; please notify our office of any changes in your insurance or personal billing information. Please bring to each appointment your current insurance card, or any other information that is required by your insurance carrier. By maintaining up-dated information this ensures that your medical claims are filed correctly and prevents any unnecessary delays in processing your claim.

Payment for all co-insurance, deductible, and non-covered services are due at the time of service unless special payment arrangements have been made. We do have a payment plan for patients who have financial concerns. Please notify our office at 405-419-8444 to make payment arrangements. **Please be aware that charges for physical therapy, durable medical equipment, laboratory testing, anesthesia, hospital, ambulatory surgery facilities and some radiology services may be billed separately.**

There is a $35.00 charge for any FMLA, disability or accidental form completed. This charge is applicable per form completed and is payable prior to completion.

If you miss your appointment, cancel or change your appointment with less than 24hr notice, you will be charged $35.00. It is important to note that insurance companies do not provide re-imbursement for cancelled appointment.

Again, thank you for allowing Vita Health and The Physicians' Group to participate in your care.
Sincerely,
Vita Health Physicians & Staff

- -

My signature below acknowledges receipt of this Financial Policy:

Signed: ____ Date: _______________
(Signature of the person financially responsible for payment)

Relationship if other than patient: _____________________________________

AGREEMENT FOR LONG TERM CONTROLLED SUBSTANCE PRESCRIPTIONS

Print Patient Name: _______________________________________ DOB: ______________________

The purpose of this Agreement is to prevent misunderstandings about certain medicines the patient will be taking for pain management and/or anxiety management. This is to help both the patient and their provider comply with the law regarding controlled medications.

The use of opioids, benzodiazepines, and stimulants may cause addiction and is only one part of the treatment.

I agree to the following:

- I am responsible for my medicines. I will not share, sell, or trade my medicine. I will not take anyone else's medicine.
- I will not increase my medicine until I speak with my doctor or nurse.
- My medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed.
- I will keep all appointments set up by my doctor.
- I will bring the pill bottles with any remaining pills of this medicine to each clinic visit.
- I agree to come to the office for a pill count at any time if asked by my doctor.
- I agree to give a blood or urine sample, if asked, to test for drug or other medication use. I understand that my insurance company might not cover the test and I will be responsible for the payment. I understand that this test can be very costly.
- I understand that my doctor's office will utilize the Oklahoma of Narcotics Drug Tracking Program.

Refills

- I understand that refills will be made only during regular office hours—Monday through Friday, 8:00AM-4:30 PM. No refills on nights, holidays, or weekends. Advance notice of 3 business days is required.
- I will have my pharmacy fax over a refill request to 405-726-2702. I will not come to the office for my refill until I am called by the nurse to pick up my written prescription.
- I must keep track of my medications. No early or emergency refills may be made.
- I will only use one pharmacy to get my medicine. My doctor may talk with the pharmacist about my medicines.

The name of my pharmacy is____

Prescriptions from Other Doctors

If I see another doctor who gives me a controlled substance medicine (for example, a dentist, a doctor from the Emergency Room or another hospital, etc.) I must bring this medicine to the office in the original bottle, even if there are no pills left. I am not to seek or accept medications from other providers without the permission of my doctor.

Termination of Agreement

If I break any of the rules, if my drug test results are inconsistent with treatment prescribed by my doctors or if my doctor decides that this medicine is hurting me more than helping me, this medicine will be stopped by my doctor in a safe way and no refills will be made. Further, my physician may dismiss me as a patient of the practice and ask me to select another physician.

I have talked about this agreement with my doctor and I understand the above rules.

Patient's signature ____**Date** ______________________

Physician's signature ____

Medical Home Agreement

This Medical Home Agreement Concept is an AGREEMENT between YOU and YOUR PROVIDER, to focus on meeting ALL of your Healthcare Needs.

As your Medical Home Primary Care Provider (PCP), we agree to:

1. Honor your rights as a patient, and treat you with dignity and respect.
2. We will focus on listening to your concerns, educating you on your health care needs and preventive services.
3. Focus on treating you as a whole person: physically, mentally and emotionally.
4. Focus on providing you with ***ongoing, quality*** and ***safe*** medical care, including prevention of future health complications.
5. Work to schedule timely office appointments for your chronic and urgent healthcare needs.
6. Be available to you 24 hours a day, by office appointment, phone calls and/or other electronic communication.
7. Provide you with other healthcare resources when we are absent or unavailable.
8. Provide you with referrals to specialist as deemed ***medically*** necessary by your PCP.
9. Provide you with treatment, medications, equipment and any other resources deemed ***medically*** necessary by your PCP.

As a Medical Home Patient, your responsibility is the following:

1. Work with us, as your ***PCP,*** to meet ***all*** of your health care needs.
2. Communicate with us about all your healthcare concerns and goals.
3. Report ***any*** changes related to your health, treatments, medications, etc.
   This includes use of *all medications* - prescription, over-the-counter, herbal and street drugs.
   This also includes any medical equipment being used or that has been ordered or recommended for use.
4. Call us ***before*** going to the Emergency Room, unless it is life threatening.
5. Notify us ***after*** any Emergency Room, Urgent Care Clinic or Hospital visit.
6. Schedule medical appointments in a timely manner, including ***follow-up*** appointments.
7. Keep appointments as scheduled with us and any appointments scheduled with a specialist.
8. If you cannot keep an appointment call ***before*** your appointment time to cancel or reschedule the appointment.
9. You may be dismissed from your PCP if you repeatedly miss appointments without notice or do not follow the responsibilities listed in the medical home agreement.

Your Healthcare is a TEAM Approach involving BOTH YOU and YOUR PROVIDER.

_______________________________________ _________________________

Patient or Guardian Signature **Date**

_______________________________________ _________________________

Provider Signature **Date**

Patient Name:________________________________ DOB:_____________Entered by:___________

Today's Date:____________________________

Medical History Form

Review of Systems

Are you experiencing any of the following symptoms?

General:
- Allergies
- Chills
- Fatigue
- Fever
- Night Sweats
- Weight Loss
- Weight Gain

Skin:
- Discoloration
- Skin Lesions
- Rash

HEENT:
- Dizziness
- Vision Changes
- Hearing Problems
- Ringing in the Ears
- Nasal Congestion
- Sinus Pressure
- Snoring
- Hoarseness
- Sore Throat

Respiratory:
- Asthma
- Cough
- Coughing Up Blood
- Shortness of Breath
- Wheezing

Cardiovascular:
- Chest Pain
- Difficulty Breathing on Exertion
- Palpitations
- Lower Extremities Swelling
- Edema
- Hypertension

Gastrointestinal:
- Abdominal Pain
- Acid Reflux
- Constipation
- Diarrhea
- Difficulty Swallowing
- Food Intolerance
- Nausea
- Vomiting

Genitourinary:
- Blood in Urine
- Frequency
- Dysuria
- Incontinence
- Difficult Urination
- Urgency

Musculoskeletal:
- Back Pain
- Joint Pain
- Joint Stiffness
- Muscle Pain
- Muscle Weakness
- Neck Pain
- Neck Stiffness

Neurologic:
- Headaches
- Seizures
- Syncope
- Tingling
- Tremor
- Weakness

Psychiatric:
- ADD
- Anxiety
- Bipolar
- Depression
- Trouble Focusing
- Memory Loss
- Sleep Disturbance

Endocrine:
- Diabetes
- Cold Intolerance
- Thyroid Disease
- Hormone Problems

Hematology:
- Cancer
- Lymphadenopathy
- Anemia
- Blood Clots

- **Tobacco User**
- **Former User**
- **Never Smoker**

Patient Name:________________________________DOB:______________Entered by:___________

Past Medical History

Heart
⌋ Heart Attack
⌋ Heart Disease
⌋ High blood Pressure
⌋ High Cholesterol
⌋ Irregular Heart Beat
⌋ Atrial Fibrillation
⌋ Other______________________

Lungs
⌋ Asthma
⌋ COPD
⌋ Emphysema
⌋ Other______________________

Dermatology
⌋ Skin Cancer
⌋ Acne
⌋ Rash

Psychiatric
⌋ Memory Loss/Confusion
⌋ Anxiety
⌋ Depression
⌋ Bipolar

Stomach
⌋ Reflux
⌋ Heartburn
⌋ Ulcers
⌋ Bleeding
⌋ Irregular Bowel
⌋ Diverticulitis
⌋ Liver Disease
⌋ Hepatic Failure
⌋ Other______________________

Musculoskeletal
⌋ Arthritis
⌋ Gout
⌋ Broken Bones
⌋ Other______________________

Urology
⌋ Kidney Stones
⌋ Prostate Issues
⌋ Other______________________

Other
⌋ Anemia
⌋ Sinus & Allergy
⌋ Other______________________

Endocrine
⌋ Diabetes Type I
⌋ Diabetes Type II
⌋ Gestational Diabetes
⌋ Thyroid
⌋ Other______________________

Neurologic
⌋ Stroke
⌋ Headache
⌋ Migraine
⌋ Dementia

Gynecology
⌋ Endometriosis
⌋ HPV

Cancer: List what type
____
____
____

Social History

Tobacco:______Never_____Quit: Year last smoked_______Amt:____pck/day Smoked for:_______years?
Do use a vape?______yes________no

Cigarettes____Yes_____No Amt:_________pck/day Has been smoking for?____________

Smokeless Tobacco ____Yes ____No Amt:_______per day

Cigars_____Yes_____No Amt:_____per day

Children: Secondhand smoke exposure?________Yes________No

Alcohol Use:_____Yes_____No_____# drinks per day / week / occasional / social

Caffeine Use:_____Yes_____No_____# drinks per day / week / occasional / social

Seatbelt Use: _____Yes_____No

Exercise:_____Yes_____No Occupation: ______________________________________

Have you ever used **street drugs**:_____Yes_____No Which ones:________________________________

Are you sexually active (in the last year?)_____Yes_____ No_____Never

If yes check all that apply:_____1 Partner_____Multiple Partner

_____Male Partner (s)_____Female Partner (s) _____5 or More Partners in your lifetime

Which birth control do you use?____None____Condoms____The Pill ____Vasectomy/Tubal____Other______

Is there concern for your safety?____Yes____No____Emotional____Physical____Sexual Abuse

Patient Name:________________________________DOB:______________Entered by:___________

Current Medications: (Please include over the counter medication and food supplements.)
Drug Name:__________________________________Dose:_______________How Often:_______________
Drug Name:__________________________________Dose:_______________How Often:_______________
Drug Name:__________________________________Dose:_______________How Often:_______________
Drug Name:__________________________________Dose:_______________How Often:_______________
Drug Name:__________________________________Dose:_______________How Often:_______________
Drug Name:__________________________________Dose:_______________How Often:_______________
Drug Name:__________________________________Dose:_______________How Often:_______________
Drug Name:__________________________________Dose:_______________How Often:_______________
Drug Name:__________________________________Dose:_______________How Often:_______________
❏ NONE

Pregnancy and Birth

Date of Last Menstrual Period:_____________ Age of First Period:_____________________
# of Days In Flow:______________# of Days Between Cycles:_______________
Are you in Menopausal _____________Age at Onset Of Menopause: ___________________
# of Pregnancies:_________# of Live Births:________# of Abortions_______# of Miscarriages _________
# of Living Children ___________

Past Surgical History

Please check or list all of the SURGERIES you have had:

Type of Surgery	Year
❏ Appendectomy	
❏ Arthroscopy (joint)	
❏ Back Surgery or Neck Surgery	
❏ Cataract Surgery	
❏ Hemorrhoids	
❏ Hernia (Specify)	
❏ Hysterectomy	
❏ Knee Replacement or Hip Replacement	
❏ Mastectomy or Lumpectomy (Specify)	
❏ Polyp Removal (Colon)	
❏ Tonsillectomy or Adenoidectomy	
❏ Tubal Ligation or Vasectomy	
❏ Plastic Surgery (Specify)	
❏ Other (Specify)	
❏ Other (Specify)	
❏ Other (Specify)	

Family History

⌋ Alcoholism ⌋ Father ⌋ Mother ⌋ Sibling ⌋ Other________________________________

⌋ Asthma ⌋ Father ⌋ Mother ⌋ Sibling ⌋ Other________________________________

⌋ Breast Cancer ⌋ Father ⌋ Mother ⌋ Sibling ⌋ Other________________________________

⌋ Colon Cancer ⌋ Father ⌋ Mother ⌋ Sibling ⌋ Other________________________________

⌋ Depression ⌋ Father ⌋ Mother ⌋ Sibling ⌋ Other________________________________

⌋ Diabetes ⌋ Father ⌋ Mother ⌋ Sibling ⌋ Other________________________________

⌋ Elevated Lipids ⌋ Father ⌋ Mother ⌋ Sibling ⌋ Other________________________________

⌋ Heart Attack ⌋ Father ⌋ Mother ⌋ Sibling ⌋ Other________________________________

⌋ Heart Disease ⌋ Father ⌋ Mother ⌋ Sibling ⌋ Other________________________________

⌋ High Blood Pressure ⌋ Father ⌋ Mother ⌋ Sibling ⌋ Other________________________________

⌋ Lung Cancer ⌋ Father ⌋ Mother ⌋ Sibling ⌋ Other________________________________

⌋ Migraines ⌋ Father ⌋ Mother ⌋ Sibling ⌋ Other________________________________

⌋ Osteoporosis ⌋ Father ⌋ Mother ⌋ Sibling ⌋ Other________________________________

⌋ Ovarian Cancer ⌋ Father ⌋ Mother ⌋ Sibling ⌋ Other________________________________

⌋ Prostate Cancer ⌋ Father ⌋ Mother ⌋ Sibling ⌋ Other________________________________

⌋ Skin Cancer ⌋ Father ⌋ Mother ⌋ Sibling ⌋ Other________________________________

⌋ Stroke ⌋ Father ⌋ Mother ⌋ Sibling ⌋ Other________________________________

⌋ Thyroid Disease ⌋ Father ⌋ Mother ⌋ Sibling ⌋ Other________________________________

⌋ Uterine Cancer ⌋ Father ⌋ Mother ⌋ Sibling ⌋ Other________________________________

⌋ Other Cancer ⌋ Father ⌋ Mother ⌋ Sibling ⌋ Other________________________________

⌋ Other Diagnosis ⌋ Father ⌋ Mother ⌋ Sibling ⌋ Other________________________________

⌋ Other Mental Illness ⌋ Father ⌋ Mother ⌋ Sibling ⌋ Other________________________________

List all **ALLERGIES** to any medications and the reactions:__________No Known Drug Allergies

Medication	Reaction

IMMUNIZATIONS: List Dates

Hepatitis A: ____

Hepatitis B: ____

Td– Adult Tetanus Toxoid : ____

Influenza:____

Pneumovax:____

PPD—Tuberculin Skin Test (Include Results):_______________________________________

Gardasil (HPV):____

Zostavax:____

Patient Name:_______________________________DOB:______________Entered by:___________

Health Maintenance

Date of last Mammogram:________________(mo/yr) Date of last Done Density: _________________(mo/yr)

Date of last Colonoscopy:________________(mo/yr)

(Diabetic Patients) Date of last Eye Exam:________________(mo/yr) Where: _________________________

For Women: Date of last Pap Smear:__________________ (mo/yr)

For Men: Date of Last PSA level drawn (Prostate Cancer Screening):

____

Please provide **first and last** names of all other physicians that you currently see and their specialty:

____

____

What is your preferred pharmacy (Please include name and phone number and location:

____

What is your preferred mail order pharmacy (Please include name and phone number):

____