

PATIENT INFORMATION

PATIENT FULL NAME: _____ PREFERRED LANGUAGE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

DOB & AGE: _____ RACE: _____ ETHNICITY: NOT HISPANIC OR LATINO HISPANIC OR LATINO

SSN: _____ GENDER: _____ EMAIL ADDRESS: _____

WHO IS YOUR PRIMARY CARE PHYSICIAN? _____ CLINIC NAME: _____

WHAT PHARMACY DO YOU USE: _____

PLEASE MARK THE WAYS THAT YOU CONSENT TO US COMMUNICATING WITH YOU:

CALL CELL PHONE OK TO LEAVE VOICEMAIL YES NO

CALL HOME PHONE OK TO LEAVE VOICEMAIL YES NO

SEND EMAIL SEND REGULAR MAIL SEND TEXT MESSAGE

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP: SPOUSE PARENT/GUARDIAN OTHER: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

MAY WE SPEAK TO THIS PERSON CONCERNING YOUR CARE? YES NO

PRIMARY INSURANCE

NAME: _____ POLICY #: _____ GROUP ID: _____

SECONDARY INSURANCE

NAME: _____ POLICY #: _____ GROUP ID: _____

ASSIGNMENT AND RELEASE

I HAVE INSURANCE COVERAGE AND ASSIGN ALL MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS.

SIGNATURE OF INSURED / GUARDIAN _____

DATE _____

SURGERY AND ANESTHESIA HISTORY

1. HAVE YOU EVER HAD SURGERY? NO YES, PLEASE DESCRIBE:

2. DO YOU HAVE A BLOOD RELATIVE WHO HAD ANESTHESIA COMPLICATIONS OF ANY KIND? NO YES, PLEASE DESCRIBE:

SPECIFIC MEDICAL HISTORY

1. ARE YOU PREGNANT? NO YES

HEIGHT: _____ WEIGHT: _____

HAVE YOU OR DO YOU STILL HAVE:

	YES	NO	DESCRIPTION
2. ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. EMPHYSEMA	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. HEART TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. HEPATITIS OR LIVER TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. KIDNEY TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. EPILEPSY OR SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. STROKE	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. PROBLEM SCARRING	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. HAVE YOU BEEN ADVISED TO OR HAD PSYCHIATRIC CARE?	<input type="checkbox"/>	<input type="checkbox"/>	_____
13. OTHERS NOT LISTED: _____			
14. DO YOU SMOKE? <input type="checkbox"/> NO <input type="checkbox"/> YES, HOW MUCH? _____			
15. DO YOU DRINK? <input type="checkbox"/> NO <input type="checkbox"/> YES, HOW MUCH? _____			
16. DO YOU HAVE CHILDREN? <input type="checkbox"/> NO <input type="checkbox"/> YES, HOW MANY? _____			

MEDICATIONS

ARE YOU TAKING ANY MEDICATIONS, VITAMINS OR HERBAL SUPPLEMENTS? NO YES, PLEASE LIST:

ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS: NO YES

COUMADIN, WARFARIN, IBUPROFEN, FULL STRENGTH ASPIRIN, NAPROXEN (CIRCLE ANY YOU HAVE TAKEN IN THE LAST 10 DAYS)

ALLERGIES AND SENSITIVITIES

ARE YOU ALLERGIC TO ANY MEDICATIONS OR LOCAL ANESTHESIA? NO YES, PLEASE LIST:

I HAVE READ THIS QUESTIONNAIRE AND DISCLOSED MY MEDICAL HISTORY TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE: _____

DATE: _____

HIPAA INFORMATION AND CONSENT FORM

PATIENT NAME: _____ DOB: _____

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

SIGNATURE: _____

DATE: _____