PATIENT INFORMATION FORM

Patient Name: _____ Date of Birth: _____ Age ___ Gender: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Phone Carrier: _____

Social Security Number: _____ Email Address: _____

Marital Status: ☐ Single ☐ Married ☐ Other

Occupation: _____ Work Phone: _____

Employer: _____ Address: _____

Who is your primary care physician?

Address: _____ Telephone: _____

Other Doctors seen in the last 5 years:

Name: _____

Name: _____

Name: _____

How did you hear about our office? ☐ Internet ☐ Radio ☐ TV ☐ Facebook ☐ Instagram ☐ Patient Referral _____

☐ Other --Please specify _____

PHARMACY INFORMATION

Pharmacy Name: _____ Address: _____

Telephone: _____

EMERGENCY CONTACT

Name: _____

Relationship: ☐ Husband/Wife ☐ Parent/Guardian ☐ Other:

Cell Phone: _____ Home Phone: _____ Work Phone: _____

What procedures would you like to discuss today? _____

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1. Are you allergic to any medications? ☐ No ☐ Yes

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

2. Are you allergic to Latex? ☐ No ☐ Yes Reaction: _____

3. Other allergies? Reaction: _____

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1. Are you pregnant or breast feeding? ☐ No ☐ Yes

2. # Pregnancies _____ # Vaginal Births _____ # C Sections _____

3. Height _____ Weight _____

4. Please Circle any of the following problems which you have now or have had in the past:

Sleep Apnea
Heart Disease
Heart Attack
Heart Murmur
Heart Bypass Surgery
Heart Stents
Other Heart Surgery
Artificial Heart Valve
Pacemaker or Defibrillator
Angina (chest pain)
High Blood Pressure
Stroke
Cancer
Glaucoma
Arthritis
Neck Problems

Gastric Bypass
Gastric Sleeve
Emphysema
Chronic cough/ Bronchitis
Tuberculosis
Asthma or Pneumonia
Loss of Vision
Sinus Problems
Kidney Problems
Stomach Ulcers
Diabetes
Thyroid Disease
Hepatitis A B or C
Liver Disease
Jaundice
Blood Thinners

Pulmonary Embolism
Clotting Problems
Blood Diseases
Anemia
Easy Bruising
Radiation Therapy
Chemotherapy
Seizure Disorder
Fainting or Dizzy Spells
Artificial Joints
Orthopedic Hardware
Excessive Bleeding
Psychiatric Treatment
Blood Transfusions
HIV or AIDS
Cold Sores

Other: _____

_____

_____

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Please list ALL previous surgeries, including Plastic Surgeries

Year	Surgery

1. Do you smoke? ☐ No ☐ Yes, If so, how much? _____
2. Did you smoke previously? ☐ No ☐ Yes, If so, how much? _____
3. How much alcohol do you consume? _____
4. Any other drugs, legal or not (please specify)? _____

Have any blood relatives had any of the following?	Yes	No	Family Relation
1. Clotting Problems (Clots in legs, Embolism to Lungs)	☐	☐	
2. Bleeding Tendency	☐	☐	
3. Abnormal Reaction to Anesthesia	☐	☐	
4. Personal or Family History of Malignant Hypothermia	☐	☐	
5. Increased Temperature Following Exercise	☐	☐	
6. Personal or Family History of Muscle Rigidity	☐	☐	
7. History of Dark/Chocolate Colored Urine	☐	☐	
8. Heart Disease	☐	☐	
9. High Blood Pressure	☐	☐	
10. Cancer	☐	☐	
11. Family History of Breast Cancer	☐	☐	

Have you ever had Genetic Screening for Breast Cancer? ☐ Yes ☐ No

In the past year have you taken prednisone, cortisone or ACTH? ☐ Yes ☐ No

In the past year have you taken Accutane? ☐ Yes ☐ No

Please list, with dosages, ALL medications, including birth control, aspirin, and any over the counter medications, vitamins or Supplements you take: _____

_____

_____

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient Signature: _____ Date: _____

Insurance Company: _____ Ins Co Telephone: _____

ID Number: _____

Policy Holder Name and Relationship _____ Policy Holder Date of Birth: _____

Policy Holder Employer and Address

_____

_____

I _____ have insurance coverage and assign directly 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. I will promptly forward to the doctor all insurance payments sent to me by my insurance company for services performed by the practice.

Signature of Insured / Guardian _____ Date _____

Patient Name: _____

Please mark the ways that you consent to us communicating with you:

- ☐ Work Phone
- ☐ Cell Phone
- ☐ Home Phone
- ☐ Email
- ☐ Email Appt. Reminders
- ☐ Send Text
- ☐ Text Appt. Reminders — if so, list cell carrier:
- ☐ Ok to send Regular Mail

If it is ok to leave a message with another person, please list them:

_____

_____

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Patient Name: _____

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 confidentail 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 confidentiallity 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 of office policy. I understand that this consent shall remain in force from this time forward.

Patient Signature: _____ Signature: _____

Date: _____

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