



Please complete form in its entirety

Patient Information

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

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): ☐ White ☐ American Indian or Alaska Native ☐ Asian
☐ Hispanic ☐ Black or African American ☐ Native Hawaiian or Pacific Islander
☐ Other ☐ Decline
Ethnicity (please select one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline
Preferred Language (please select one): ☐ English ☐ Spanish ☐ Bosnian ☐ Russian ☐ Indian (including Hindi & Tamil) ☐ Sign Language
Preferred Pharmacy Name & Location: _____

Insurance Information

Primary Medical Insurance	Secondary Medical Insurance
Insurance Company Name: _____	Insurance Company 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 to 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 heartbeat)	DVT (Blood Clot)	Liver Disease	Ulcerative Colitis
Arthritis	GERD (Acid Reflux)	Macular Degeneration	Osteopenia/Osteoporosis
Asthma	Glaucoma	Neuropathy	Peptic Ulcer
Bipolar	Heart Disease	Parkinson's Disease	Psoriasis
Bladder Problems / Incontinence	Heart Attack (MI)	Peripheral Vascular Disease	Pulmonary Embolism (PE)
Bleeding Problems	Hiatal Hernia	High Blood Pressure	Kidney Stones
Cancer:	Headaches	Crohn's Disease	Kidney Disease

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 (written or verbal)? ☐ Yes ☐ No

Current Living Situation (check all that apply): ☐ Single Family Household ☐ Multi-generational Household ☐ Shelter ☐ Homeless ☐ 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	Arthritis	COPD/Emphysema	Dementia	DVT (Blood Clot)
Heart Disease	Kidney Disease	Migraines	Thyroid Disorder	Other:

Mother

Living: Age _____ **Deceased: Age** _____

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

Siblings: _____

List other medical providers you see on a regular basis (e.g. cardiologist, mental health provider, kidney doctor, dentist, etc.):

Patient Signature: _____ **Date:** _____



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) or 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 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: _____ Email: _____

Description of information to be disclosed – I authorize the practice to disclose any and all parts of my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary, and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I also understand a copy of this authorization is as valid as the original, and the provider may not condition treatment on my decision to sign this form. I understand that if the recipient authorized to receive the information is not a covered entity, e.g. an insurance company or health care provider, the released information may no longer be protected by federal and state privacy regulations. My provider cannot withhold treatment if I do not sign this form. A copy of this form is as valid as the original.

Information to be disclosed (please select one): _____ Entire patient record **OR** Treatment date(s): From _____ To _____

If billing is requested, please check here: _____

Purpose of Disclosure: At the request of the individual

(FROM) The following organization is authorized to disclose the information:

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 our practice. Do not designate fax or email as your preferred method if this is a concern to you. This authorization will expire 12 months from the date of this authorization unless otherwise specified by you. You have the right to revoke this authorization at any time by submitting a written request to the practice. Revocation will be effective upon receipt of 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 for obtaining records.*

Signature of patient: _____ Date: _____

If you are not the patient:

*What is your relationship to the patient? _____

*If you are the patient's healthcare decision maker, please provide a Medical Power of Attorney.

*If the patient is deceased and you are the personal representative of the patient's estate, please attach evidence (e.g. Death Certificate).