New Patient Registration

PATIENT INFORMATION

Last Name: ______________________________ First Name: ____________________ M. Initial: ___

DOB: ____________ Sex: ☐ Female ☐ Male Social Security Number: ______-______-______

Marital Status: ____________________ email: ______________________________

Address: ______________________________

City: ______________________________ State: ______ Zip: ____________

Home Phone: ____________________ Cell Phone: ____________________

PHARMACY NAME & PHONE NUMBER: ______________________________

PARENT OR GUARDIAN INFORMATION *(Only fill out if the patient is under the age of 18)*

Last Name: ______________________________ First Name: ____________________ M. Initial: ___

Address: ______________________________

City: ______________________________ State: ______ Zip: ____________

DOB: ____________ Social Security Number: ______-______-______

Home Phone: ____________________ Cell Phone: ____________________

EMERGENCY CONTACT INFORMATION

Name: ______________________________ Relationship: ____________________

Home Phone: ____________________ Cell Phone: ____________________

EMPLOYER: ______________________________

PRIMARY INSURANCE INFORMATION Insurance Plan Name: ____________________ Subscriber ID: ____________

POLICY HOLDER NAME *(if other than patient)*: ______________________________

DOB: ____________ Sex: ☐ Female ☐ Male Relationship to Patient: ____________________

SECONDARY INSURANCE INFORMATION Insurance Plan Name: ____________________ Subscriber ID: ____________

POLICY HOLDER NAME *(if other than patient)*: ______________________________

DOB: ____________ Sex: ☐ Female ☐ Male Relationship to Patient: ____________________

The information below is being collected pursuant to the requirements of the TN Department of Health in compliance with Tennessee state law.

RACE: ☐ White ☐ Black ☐ American Indian ☐ Eskimo or Aleut ☐ Asian or Pacific Islander ☐ Other Race ☐ Unknown Race

ETHNICITY: ☐ Hispanic Origin ☐ Not Hispanic Origin

Please check the appropriate box in answer to the following question. Have you executed an Advanced Health Care Directive, A Living Will or a Power of Attorney? ☐ Yes ☐ No

DO YOU WANT ANYONE TO HAVE ACCESS TO YOUR PHI? IF SO, WHO? NAME: ______________________________

Signature: ______________________________ **Date:** ____________

Relationship to Patient: ______________________________

Patients' Rights

The patient's rights include:

- The right to receive a copy of the Notice of Privacy Practices
- The right to request confidential communications
- The right to request a restriction on the use and disclosure of PHI
- The right to know that the covered entity is not required to agree with the requested restriction unless the request is for a restriction of information to the health plan for a service or item which the patient pays for out of pocket, with no health plan involvement
- The right to inspect and copy the PHI
- The right to request amendments and corrections to the PHI
- The right to request an accounting of PHI disclosure
- The right to be treated with respect and dignity.
- The right to voice complaints or grievances about your managed care organization or the medical care provided.

These are included in the Notice of Privacy Practices. Most require the patient to express their requests in writing. Forms for those requests are in this section of the manual. Providers have the authority to deny certain requests based on professional judgment.

Confidential Communications
Patients may request that the covered entity communicate with them through a method different than normally used, or to an alternate address or phone number, or through electronic means. However, the covered entity may require the patient to provide an effective means of contact, such as an address, phone number, or e-mail address, and may require the patient to explain how any additional costs to the practice will be paid. If the patient is unable to provide this information, the practice may deny the request.

If the patient prefers or requests electronic communications, he or she should be reminded that the PHI may not be secure. They should use the Electronic Communication Form to acknowledge the risk involved in this communication format.

Restrictions
Patients may request restrictions on how their PHI may be used. However, covered entities are not required to agree to the requested restriction. Patients may not request restrictions for uses required by law or for workers' compensation purposes. If the provider, using professional judgment, determines that agreeing to the restriction would not be in the best interest of the patient, the request may be denied.

Covered entities are required to grant a request for a restriction disclosure to the patient's health plan for a service or item for which the individual pays for totally out of pocket. This request must be made in writing. Another individual, such as a friend or family member, may pay for the service or item, but the patient cannot have another plan contribute toward the payment.

Inspect and Copy
Patients have the right to access, inspect, or copy routine PHI. However, they do not have the right to access, inspect, or copy psychotherapy notes or records restricted by another law, such as CLIA. The right to access PHI is suspended during participation in clinical trials. The patient usually agrees to this prior to the participation, and access is restored at the end of the trial.

Access may be denied to personal representatives if the provider, using professional judgment, has reason to believe that the access would not be in the patient's best interest, especially if the provider suspects that the patient may be subject to domestic violence, abuse, or neglect, or if the access may in any way endanger the patient or another individual. Access will also be denied to individuals other than the patient if the patient has requested a restriction and that request has been granted. In the case of inmates, access may be denied if it may endanger anyone there or if it might compromise the work of the facility.

A request for access must be acted upon within 30 days. If the records are not easily accessible (stored off-site, for example), the practice may have 30 more days to allow the access.

If the request is denied, this must be documented and communicated to the patient. The patient may appeal. This information must be added to the patient's medical record.

We are required to provide the information in electronic format if available. The format (examples: e-mail, disk, flash drive) must be acceptable to the requesting individual. We cannot use media provided by the patient due to security risks, and cannot require the patient to purchase media from us.

We will charge the patient the allowable rate for providing copies in any format.

Amendment
Patients may request an amendment to their medical record. The provider must review this request to determine whether the amendment is appropriate. The request may be denied -

- If the provider determines that the records are complete and accurate, the request may be denied
- If the correction does not apply to information in the designated record set
- If the information was not created by that covered entity (unless the provider who created the record is no longer available to make the correction)
- If it is part of a designated record set that is not available for access

The covered entity must act upon this request within sixty days. If it is unable to meet that response to the patient requesting the amendment, a copy of that response becomes part of the designated record set.

If the covered entity agrees to the amendment, the amendment must be made part of the designated record set and must be provided to any other agency or individual who was provided with the original information.

If the provider denies the amendment, the covered entity must communicate this information to the patient. The patient may submit a letter of disagreement and may request that the letter become part of the designated record set.

Accounting of Disclosures
Patients have the right to request an accounting of disclosures – incidents involving the use of their protected health information. At this time, the changes proposed in 2011 (and in the HITECH rule) were not incorporated. However, we are following those at this time, as they are the most current guidelines available.

For paper charts, this excludes disclosures for the purposes of treatment, payment, and health operations. The request may go back as far as six (6) years from the date of the request. The report must include -

- The date of the disclosure
- The name and address (if available) to whom the information was disclosed
- A description of the PHI disclosed
- The purpose of the disclosure

The report must be provided to the requesting individual within sixty days of the request. A one-time extension is allowed if the situation prevents a timelier reporting, but the practice must explain in writing the reason for the delay.

If the accounting includes multiple disclosures to the same entity or individual, a summary log may be used. If the disclosure is for research involving more than fifty individuals, the accounting must include the research protocol or activity, a description and criteria of the activities or protocols, a description of the PHI disclosed and the date of the disclosure, the name and address of the sponsor and the researcher, and a statement that the information could not be used for any additional purpose.

For electronic health records, the accounting includes disclosures for the purposes of treatment, payment, and health operations. This request may go back only three (3) years from the date of the request. For practices using electronic health records prior to January 1, 2009, the compliance date is January 1, 2014. For those acquiring electronic health records after January 1, 2009, but before January 1, 2011, the compliance date is January 1, 2011. For practices that implement electronic health records after January 1, 2011, compliance is required upon installation. However, the Secretary of HHS may delay these compliance dates.

At the time this document was developed, the Secretary of HHS had not yet published the required information to be included in the accounting.

The following disclosures are exempted from all accounting reports.

- Incident to a permitted or required disclosure
- Pursuant to a signed authorization
- To people involved in the patient's care
- For purposes of national security or intelligence
- To correctional institutes or law enforcement agencies
- Limited data sets
- Prior to the covered entity's compliance date
- With a written statement from an agency requesting information for health oversight or law enforcement that states that including the disclosure would impede their activities

Notice Of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

Patient Name or Legal Guardian: ______________________________

Signature: ______________________________

Date: ______________________________

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date: ____________________ Initials: ____________________

Reason: ______________________________

____

General Consent For Treatment

As the patient, you have the right to be informed about your conditions and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify appropriate treatment and/or procedure for any identified condition(s).

I request and authorize medical care as my provider, his assistant or designees (collectively called “the providers”) may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, and routine medical and nursing care.
I authorize my provider(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient) care is directed by my provider(s) and that other personnel render care and services to me (the patient) according to the provider(s) instructions.

I understand that I have the right and the opportunity to discuss alternative plans of treatment with my provider and to ask and have answered to my satisfaction any questions or concerns.

In order to maintain an accurate and up to date medical record we request permission to query outside resources to obtain a list of your medications. _______ **(initial)**

In the event that a healthcare worker is exposed to my blood or bodily fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus or hepatitis C, I consent to the testing of my blood and/or bodily fluids for these infections and the reporting of my test results to the healthcare worker who has been exposed. _______ **(initial)**

I HAVE READ OR HAD READ TO ME AND FULLY UNDERSTAND THIS CONSENT; I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAD THESE QUESTIONS ADDRESSED.

Name of Patient: ____

Signature of Patient: ______________________________________ Date: ____________

☐ Consent of Legal Guardian, Patient Advocate or Nearest Relative **if patient is unable to sign**

☐ Consent Caregiver **if patient is unable to sign**

Name of Legal Guardian, Patient Advocate, Nearest Relative or Other: ______________________________

Relationship: ______________________________________ Telephone: _______________

Address: ____

Signature of the above: ________________________________ Date: ___________ Time: ___________

Signature of Witness: ______________________________________ Date: ____________

Patient Financial Policy

This is an agreement between AdvancedHEALTH, as creditor, and the Patient/Debtor named on this form and indicated by patient/debtor signature below.

In this agreement the words "you", "your" and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us" and "our" refer to AdvancedHEALTH. By executing this agreement, you are agreeing to pay for all services that are rendered.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. A copy of your signed financial agreement will be provided to you.

HEALTH INSURANCE - It is YOUR responsibility to:

- Ensure we have been provided with the most current insurance information relative to filing your claim including insurance card, ID number, employer, birth date and patient address. This information will be located on our patient registration form.
- Ensure we are contracted with your insurance carrier to receive maximum benefits.
- Pay your co-payment or patient portion at the time of service.
- Inform us of any insurance changes made after this signed agreement/date of service. Insurance carriers have specific timely filing guidelines and pre-authorization requirements for certain services. If revised insurance information is not provided to us within your insurances' timely filing limits, you will be required to pay for services in full. If prior authorization was required for services already received and your claim is denied for lack of authorization, you will be required to pay for services in full.
- Contact your insurance company if no correspondence is received by you within 45 days of the date of service.

It is OUR responsibility to:

- Submit a claim to your health insurance carrier based on the information provided by the patient/debtor at the time of service or as updated information is provided.
- Provide your health insurance carrier with information necessary to determine benefits. This may include medical records and/or a copy of your insurance card.
- Provide MVA patients a courtesy health insurance claim form for their records upon request.

PAYMENT OPTIONS: Per our contracted agreement with your insurance carrier, we are required to collect your co-payment on the day of service. If you do not have insurance, you are required to pay for treatment at the time of service unless other arrangements have been formally made. A separate self-pay financial agreement will be provided to you. Our office collects all copays plus estimated coinsurance and deductibles at the time of service

We accept the following: Cash Check Credit Card ***(Visa, MasterCard, Discover, American Express)***

A twenty-five dollar ($25.00) returned check fee will be assessed to the patient account per incident.

For convenience, payments may be made online at **www.ePayItOnline.com.** To utilize this service you will need your account number, access code, and Code ID. This information can be found on the patient statement you will receive reflecting your balance.

PENDING APPROVALS FOR SERVICES: In the event we are unable to obtain approval for services and you wish to proceed, we will not bill your insurance. Services will be reduced to the in-network insurance allowable amount and will apply to the patient's responsibility.

__________ Initials

Patient and/or Debtor Signature: ____ Date ______/_______/_______

Additional financial explanations are continued on the back side of this page

WORKERS' COMPENSATION INJURIES: Written approval/authorization by your employer and/or workers' compensation carrier prior to your initial visit is needed. We will contact your case manager and/or supervisor to confirm your workers' compensation injury. If this claim is denied, for any reason by your employer or your employer's workers' compensation carrier, you will be responsible for payment in full. If denial is made by workers' compensation, health insurance can be filed for these denied services and you will be held responsible for the account.

MOTOR VEHICLE ACCIDENTS (MVA's) – Yes, I was involved in a MVA on ______/ _____/ _______. Unless prior agreement has been reached or I am a Medicare recipient, my **health insurance** will be filed for services related to this accident. In the event I do not provide insurance information upon initial visit, I understand insurance denials may occur depending on type of service(s) received or carrier specific filing requirements. I agree, as the patient or patient's guardian, I am ultimately responsible for all balance(s) due to this facility and/or its physician(s) for services rendered regardless of insurance denial(s) or unfavorable case outcomes. If I have chosen an attorney to oversee my case, this financial agreement will serve as a Letter of Protection to my attorney. I further understand my account may be handled by an outside entity that specializes in attorney lien accounts at the facilities discretion.

_____ Yes, I have chosen to retain an attorney. Signed: ______________________________ Date: _____/_____/_____

Attorney Name: ____ Phone: _________________________________

BILLING INFORMATION

STATEMENTS: A statement of account will be provided to you if insurance has paid leaving a patient portion, denied or no response is received. Due to the type of service we provide, you may receive billing from more than one practice, otherwise known as split billing. The balance on your statement is due and payable within 30 days of receipt unless other arrangements are made with our billing department. The statement will be sent to the address provided at the time of service. In the event your mailing address changes after your service date and your account has not been paid in full, you are required to notify our billing office of this change by email at Billing@OurAdvancedHEALTH.com or call 615.239.2018. In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child at time of service will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, court documentation is required for any guarantor address changes, otherwise, it is the authorizing/custodial parent's responsibility to collect from the other parent. Any account with a credit balance of less than <$5.00> will not be refunded without specific request from the patient/debtor.

DELINQUENT ACCOUNTS: We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing.

If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If you fail to pay on time and we refer your account(s) to a third party for collection, a collection fee will be assessed and will be due at the time of the referral to the third party. The fee will be calculated at the maximum percentage permitted by applicable law, not to exceed 18 percent. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances.

CONSENT TO CONTACT: I grant permission and consent to AdvancedHEALTH and its agents, assignees, and contractors (which may include third party debt collectors for past due obligations): (1) to contact me by phone at any number associated with me, if provided by me or another person on my behalf; (2) to leave messages for me and include in any such messages amounts owed by me; (3) to send me text message or emails using any email address I provided or any phone number associated with me, if provided by me or another person on my behalf; and (4) to use prerecorded/artificial voice messages and/or an automated telephone dialing system (an auto dialer) as defined by the Telephone Consumer Protection Act in connection with any communications made to me as provided herein or any related scheduled services and my account. I understand that my refusal to provide the consent described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services.

WAIVER OF CONFIDENTIALITY: You understand if your account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

MEDICAL RECORDS: You will be required to request in writing or sign a medical authorization form for the release of your medical records to any organization or physician. We charge a **$20 flat rate** for 1-5 pages plus .50 per additional page and postage.

- If age 18 years and over, you should contain documentation of whether a medical advance directive has been executed for Medicaid/Medicare members. A copy should be on file within the office.
- Please notify the office if you have a Living Will or Power of Attorney.

No Show/Cancellation Policy

Thank you for trusting your medical care to Midstate Internal Medicine. When you schedule an appointment with Midstate Internal Medicine we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, or no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for appointments or work-ins. Please see our No Show/Cancellation Policy below:

- Effective August 1, 2023, any established patient who no shows more than once to appointment will be subject to no show fee of **$50.00.**
- If a third No Show with no 24-hour notice should occur will be subject to dismissal from Midstate Internal Medicine practice. Numerous cancellations or reschedules will also be subject to dismissal.
- The fee will be charged to the patient and NOT the insurance company and **due at the time of the next office visit.**
- Any New patient who fails to show for their initial visit will not be rescheduled with practice.
- As a courtesy, our office gives appointment reminders calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

Our practice does understand there may be unforeseen circumstances, and emergencies that occur. Please call our office immediately to speak to office manager to waive that No show fee. Our office can be reached at the numbers listed below for both our locations.

I have read and understand the No Show/Cancellation Policy and agree to its terms.

______________________________ ______________

Signature Date

Release Of Medical Information

NAME *(Please print)*: ______________________________ DOB: ______________

By Signing Below, I Authorize AdvancedHEALTH To Release My Medical And Billing Information To:

RELATIONSHIP			**NAME OF DESIGNATED PERSON**
SPOUSE	☐ YES	☐ NO	______________________________
CHILDREN	☐ YES	☐ NO	______________________________
IN-LAWS	☐ YES	☐ NO	______________________________
CAREGIVERS	☐ YES	☐ NO	______________________________
PARENTS	☐ YES	☐ NO	______________________________

OTHERS ______________________________

PATIENT SIGNATURE ______________________________ DATE ______________

PARENT SIGNATURE ______________________________ DATE ______________

All patients 18 and over should contain documentation of whether a medical advance directive has been executed for Medicaid/Medicare members.

Do you have a Living Will or Power of Attorney? ☐ YES ☐ NO

We ask that if you have any change in this request, that you please inform the receptionist.

AdvancedHEALTH may leave appointment information on my voicemail:

HOME	☐ YES	☐ NO
WORK	☐ YES	☐ NO
RELATIVE	☐ YES	☐ NO

PATIENT SIGNATURE ______________________________ DATE ______________

I authorize the following to pick up prescriptions, X-rays, etc.

RELATIONSHIP			
SPOUSE	☐ YES	☐ NO	______________________________
RELATIVE	☐ YES	☐ NO	______________________________
CAREGIVER	☐ YES	☐ NO	______________________________

PATIENT SIGNATURE ______________________________ DATE ______________

We charge a $20 flat rate for 1-5 pages plus .50 per additional page and postage.

I understand that AdvancedHEALTH will ask for identification of the person picking up patient medical information or products.

Please list all other providers who provide care to you along with their specialty: ______________________________

____

____

New Patient Supplement

PROVIDER SCHEDULED WITH:

☐ **David Heusinkveld, MD** ☐ **Tamera Pace, MSN, APRN, BC** ☐ **JoAnn Ferland, APRN**

☐ **Bailey Berry, FNP-C**

Patient Name: ____ **Date of Birth:** _____ / _____ / _____

(Last) (First) ((Middle)

REASON FOR YOUR APPOINTMENT:

1. ____

2. ____

3. ____

PREFERRED PHARMACY:

Name: ____

Address: ____

Phone: ____

ADDITIONAL PHYSICIANS/SPECIALIST YOU SEE REGULARLY:

Name: __________________________ Specialty: ______________________ Location: __________________

Name: __________________________ Specialty: ______________________ Location: __________________

Name: __________________________ Specialty: ______________________ Location: __________________

Name: __________________________ Specialty: ______________________ Location: __________________

Name: __________________________ Specialty: ______________________ Location: __________________

Medication

List your current medications. Include aspirin, birth control pills, nutritional supplements, and over-the-counter medicines you use regularly.

☐ ***Check here if you brought a medication list. Please give list to your nurse***

1. ______________________________
Name of Medication | Dosage Taken | How Often Taken

2. ______________________________
Name of Medication | Dosage Taken | How Often Taken

3. ______________________________
Name of Medication | Dosage Taken | How Often Taken

4. ______________________________
Name of Medication | Dosage Taken | How Often Taken

5. ______________________________
Name of Medication | Dosage Taken | How Often Taken

6. ______________________________
Name of Medication | Dosage Taken | How Often Taken

NOTE: Please check here ☐ if you have additional medicines. Ask nurse for additional paper if needed.

PAST MEDICAL HISTORY: Please select your current medical conditions.

Condition			Condition		
Hypertension (High Blood Pressure)	☐ YES	☐ NO	Anxiety	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO	Depression	☐ YES	☐ NO
COPD (Emphysema, Chronic Bronchitis)	☐ YES	☐ NO	Seizures	☐ YES	☐ NO
High Cholesterol	☐ YES	☐ NO	Thyroid Disorder	☐ YES	☐ NO
Heart Disease	☐ YES	☐ NO			

PLEASE LIST ANY OTHER MEDICAL CONDITIONS YOU MAY HAVE:

____

____

____

ALLERGIES: Medication/Food | Type of Reaction

1. ______________________________
2. ______________________________
3. ______________________________

IF NEEDED, LIST ADDITIONAL ALLERGIES HERE:

____

____

____

History

PAST SURGICAL HISTORY: List your past surgeries.

1. ______________________________ Year ________
2. ______________________________ Year ________
3. ______________________________ Year ________
4. ______________________________ Year ________

PRIOR HOSPITALIZATIONS: List specific hospitals and reasons for hospitalization.

1. ______________________________ Month / Year ________
2. ______________________________ Month / Year ________
3. ______________________________ Month / Year ________

FAMILY HISTORY: List family members who have had the following:

High Blood Pressure: ______________________________

Diabetes: ______________________________

Coronary Artery Disease (CAD): ______________________________

Heart Attacks: ______________________________

High Cholesterol: ______________________________

Strokes: ______________________________

Asthma/COPD: ______________________________

HIV or AIDS: ______________________________

Stomach/Colon Problems: ______________________________

Psychiatric Disorders (*i.e. anxiety, depression*): ______________________________

Bleeding Disorder or Anemia: ______________________________

Cancer (*Type: i.e. breast, prostate, etc.*): ____________________ Relation: ________

____________________ Relation: ________

____________________ Relation: ________

LIST ADDITIONAL CONDITIONS YOU CONSIDER SIGNIFICANT:

____

____

____

____

History

PERSONAL HISTORY:

Occupation: ______________________________

Education: *List highest level attained* ______________________________

Marital Status: ______________________________

Spouse's Occupation: ______________________________

Children *(Include names and age)*: ______________________________

1. Alcohol use:

Do you drink alcohol? ☐ YES ☐ NO How many drinks per week? ______________________________

Do you drink alcohol daily? ☐ YES ☐ NO

What type of alcohol, and how many drinks per occasion? ______________________________

2. Smoking:

Are you a smoker? ☐ YES ☐ NO If YES, how many packs per day? ______________________________

If a former smoker, what year did you quit? ______________________________

3. Illicit drug use *(such as marijuana, cocaine, methamphetamines, ect):*

What type? ______________________________

How often? ______________________________

4. Exercise:

Do you exercise regularly? ☐ YES ☐ NO

5. Diet:

Are you satisfied with your diet? ☐ YES ☐ NO

What type of diet are you currently on? ______________________________

How much water do you drink daily? ______________________________

How many cups of coffee or tea per day? ______________________________

6. Sleep:

Hours of sleep per day: ______________________________

OB/GYN HISTORY: *Please complete if female.*

Number of pregnancies: ______________________________

Number of Miscarriages, Abortions, or Stillbirths: ______________________________

Do you currently use contraceptives/birth control? ☐ YES ☐ NO If yes, what type: ______________________________

Do you see an OB/GYN regularly? ☐ YES ☐ NO If yes, whom do you see? ______________________________

Preventative Care

IF APPLICABLE, PLEASE PROVIDE THE APPROXIMATE DATE OF YOUR LAST:

	Obtained Where?
Pap Smear (Over 21, every 3 years if normal):	______
Mammogram (45-54 every year):	______
Colonoscopy (50, every 10 years):	______
Eye Exam (yearly):	______
Bone Density (DEXA Scan 1-2 years):	______
Prostate (45, yearly):	______
PSA Screening (45, yearly):	______

IMMUNIZATIONS:

Have you received the following immunizations?			List Date, if known:
Influenza/Flu	☐ YES	☐ NO	______
Pneumonia-23	☐ YES	☐ NO	______
Prevnar-13	☐ YES	☐ NO	______
Tetanus	☐ YES	☐ NO	______
Pertussis	☐ YES	☐ NO	______
HPV/Gardasil	☐ YES	☐ NO	______
Hepatitis A	☐ YES	☐ NO	______
Hepatitis B	☐ YES	☐ NO	______
Meningitis	☐ YES	☐ NO	______
Shingles	☐ YES	☐ NO	______
COVID	☐ YES	☐ NO	______

Review Of Systems

PLEASE CHECK ANY SYMPTOMS YOU ARE CURRENTLY EXPERIENCING:

General	Weight loss ☐ Weight Gain ☐ Fever ☐ Night Sweats ☐ Fatigue ☐ None ☐
Eyes	Blurry Vision ☐ Loss of Vision ☐ Eye Pain ☐ Eye Redness ☐ Dry Eyes ☐ None ☐
ENT	Sore Throat ☐ Sinus Trouble ☐ Hoarse Voice ☐ Hearing Loss ☐ Ringing in Ears ☐ Ear Pain ☐ Tooth Problems ☐ None ☐
Cardiovascular	Chest Pain ☐ Rapid Heartbeat ☐ Murmur ☐ Leg Swelling ☐ Leg Pain While Walking ☐ None ☐
Respiratory	Shortness of Breath ☐ Cough ☐ Sputum Production ☐ Coughing up Blood ☐ None ☐
Gastrointestinal	Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Abdominal Pain ☐ Blood in Stool ☐ Frequent Heartburn ☐ Trouble Swallowing ☐ None ☐
Genitourinary	Burning with Urination ☐ Increased Frequency ☐ Urgency Incontinence ☐ Blood in Urine ☐ Erectile Dysfunction ☐ Vaginal Discharge ☐ Breast Lump or Pain ☐ None ☐
Musculoskeletal	Joint Pain ☐ Muscle Pain ☐ Muscle Weakness ☐ Back Pain ☐ None ☐ **IF YES, list where:** ______________________
Endocrine	Increased Thirst ☐ Excessive Sweating ☐ Heat Intolerance ☐ Cold Intolerance ☐ Poor Appetite ☐ Irregular Menstrual Periods ☐ None ☐
Neurologic	Headaches ☐ Tremors ☐ Tingling/Numbness ☐ Dizziness ☐ Speech Difficulty ☐ None ☐
Psychiatric	Anxiety ☐ Depression ☐ Panic Attacks ☐ Alcohol/Drug Dependence ☐ Suicidal Thoughts ☐ Work/Home Life Unpleasant ☐ None ☐ **If you suffer from any of the above, do you desire psychiatric help:** ☐ YES ☐ NO
Hematologic/Lymphatic	Easy Bruising ☐ Swollen Lymph Nodes ☐ None ☐
Skin	Changes in Moles ☐ Skin Problems ☐ Rash ☐ Itching ☐ Hair Loss ☐ None ☐

PLEASE LIST ANY ADDITIONAL SYMPTOMS YOU FEEL PERTINENT TO YOUR MEDICAL HEALTH:

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Patient Signature: ______________________________ **Date:** ______________

Healthcare Provider Signature: ______________________________ **Date:** ______________