



PATIENT DEMOGRAPHICS

Patient's Name: _____

Patient's Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: (_____) _____ Cell #: (_____) _____

Date of Birth: ____/____/____ Age: _____ [] Male [] Female

Social Security #: ____-____-____ Email: _____

Marital Status: [] Single [] Married [] Widow Primary Language: _____

Occupation: _____ [] Full Time [] Part-Time [] Retired

Address: _____ Phone # (_____) _____

Who referred you to our facility?

[] Friend / Relative/ Previous Patient: _____

[] Physician _____

[] Google [] DocFind [] Realself [] Instagram [] Facebook [] Twitter [] Snapchat [] Other: _____

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What are you consulting the doctor for today? _____

Primary Care Physician: _____ Phone # (_____) _____

Pharmacy Name: _____ Pharmacy Phone# (_____) _____

By signing, I confirm that the information that I have provided is accurate to the best of my knowledge.

Date ____/____/____

(Patient or Guardian's Signature)

PATIENT HISTORY

Name: _____

DOB: _____

PAST MEDICAL HISTORY

- | | |
|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> No History <input type="checkbox"/> Anxiety <input type="checkbox"/> Asthma <input type="checkbox"/> Abnormal Chest X-ray <input type="checkbox"/> Ankle swelling <input type="checkbox"/> Arthritis <input type="checkbox"/> Back Injury <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Blood Clots in Legs <input type="checkbox"/> Breast Cancer <input type="checkbox"/> Broken Bones <input type="checkbox"/> Bruising <input type="checkbox"/> Cancer <input type="checkbox"/> Chest pain/Tightness <input type="checkbox"/> Chronic cough <input type="checkbox"/> Confusion <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Dizziness <input type="checkbox"/> Eczema <input type="checkbox"/> Emphysema <input type="checkbox"/> Facial Injury <input type="checkbox"/> Fainting <input type="checkbox"/> Head or Neck Injury <input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Disease <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Heart Surgery <input type="checkbox"/> Hepatitis <input type="checkbox"/> High Blood Pressure | <ul style="list-style-type: none"> <input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV <input type="checkbox"/> Hives <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Joint Replacement <input type="checkbox"/> Kidney Stone <input type="checkbox"/> Leg Pain <input type="checkbox"/> Lupus <input type="checkbox"/> Migraine <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Numbness of Arms or Legs <input type="checkbox"/> Pacemaker <input type="checkbox"/> Positive TB test <input type="checkbox"/> Pneumonia <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Seizures <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Skin Cancer <input type="checkbox"/> Skin Disease <input type="checkbox"/> Stroke/TIA <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Ulcers <input type="checkbox"/> Urinary Tract Infection <input type="checkbox"/> X-ray Therapy <input type="checkbox"/> Other |
|---|---|

FAMILY HISTORY

- No History
- Abnormal Bleeding
- Abnormal Clotting
- Adopted
- Anesthesia Problems
- Autoimmune Disorders
- Brain Tumor
- Breast Cancer
- Cleft Lip
- Cleft Palate
- Diabetes
- Drug Allergies
- Endocrine Disease
- Hearing Loss
- Heart Disease
- Hemophilia
- High Blood Pressure
- Kidney Disease
- Liver Disease
- Lung Cancer
- Malignant Hyperthermia
- Other Cancer
- Ovarian Cancer
- Prostate Cancer
- Skin Cancer
- Skin Disease
- Substance Abuse
- Von Willebrand

ALLERGIES	REACTION
<ul style="list-style-type: none"> <input type="checkbox"/> Adhesive Tape <input type="checkbox"/> Codeine <input type="checkbox"/> Cortisone <input type="checkbox"/> Iodine <input type="checkbox"/> Latex <input type="checkbox"/> Penicillin <input type="checkbox"/> Shellfish <input type="checkbox"/> Others 	

MEDICATIONS

Drug	Dose	Frequency	Prescribed By

SURGICAL HISTORY

Surgery/Hospitalization	Date	Notes

SOCIAL HISTORY

TOBACCO	ALCOHOL	ILLEGAL DRUGS	STD
<input type="checkbox"/> Non-User <input type="checkbox"/> Former Smoker <ul style="list-style-type: none"> • How long did you smoke? _____ • When did you quit? _____ <input type="checkbox"/> Current Smoker <input type="checkbox"/> Current Smokeless User	<input type="checkbox"/> Denies use <input type="checkbox"/> Social use <input type="checkbox"/> Daily use <input type="checkbox"/> History of alcoholism	<input type="checkbox"/> Denies use <input type="checkbox"/> Admits use <input type="checkbox"/> History of drugs abuse	<input type="checkbox"/> Denies History <input type="checkbox"/> Admits History

PATIENT ABILITY TO HEAL

- | | | |
|---|-----|----|
| <input type="checkbox"/> Does your skin appear fragile, burns easily? | Yes | No |
| <input type="checkbox"/> Do you form a thick or raised scar from a cut or burn? | Yes | No |
| <input type="checkbox"/> Do you wax or use depilatories on your face? | Yes | No |
| <input type="checkbox"/> Do you ever get cold sores? | Yes | No |

All information provided above is accurate and complete to the best of my knowledge.

Patient Signature: _____

Date: _____

Patient Disclosure Consent

HIPAA privacy rules give individuals the right to request a restriction of uses and disclosures of their protected health information. The individual is also provided the right to request confidential communications or that communications be made via alternative means such as sending information to the individuals' place of employment instead of their home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (*check all that apply*)

Home telephone # _____

OK to leave a detailed message.

Leave a message with a callback number ONLY.

Work telephone # _____

OK to leave a detailed message.

Leave a message with a callback number ONLY.

Cell Phone # _____

OK to leave a message with detailed information.

A message with a callback number ONLY.

WOULD YOU LIKE TO BE NOTIFIED OF ANY SPECIALS OR PROMOTIONS?

E-MAIL

TEXT

Emergency Contact Person : _____

Relationship _____

Phone # _____

OK to leave a message with detailed information.

Leave a message with a callback number ONLY.

Alternate telephone # _____

PRIVACY RULES REQUIRE US TO TAKE REASONABLE STEPS TO LIMIT THE USE OR DISCLOSURE OF YOUR INFORMATION TO THE MINIMUM NECESSARY TO ACCOMPLISH THE INTENDED PURPOSE USES, AND DISCLOSURES ARE PERMITTED WITHOUT PRIOR CONSENT IN AN EMERGENCY.

Signature

Print Name

Date

Summary of Notice of Privacy Practices

This summary is provided to assist you in understanding the Notice of Privacy Practices

The Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your right as a patient and our common practices in dealing with patient health information.

Uses and Disclosures of Health Information

We will use and disclose information in order to treat or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for services or to allow insurance companies to process insurance claims for services rendered to you by us or health care providers. Finally, we will disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation, and training of students.

Uses and Disclosures based on Your Authorization

Except as states in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without you written authorization.

Uses and Authorizations Not Requiring Your Authorization

In the following circumstances, we may disclose your health information without written authorization:

- ✓ To family members or close friends who are involved in your health care
- ✓ To certain limited research purposes for purposes of public health safety
- ✓ To government agencies for purposes of their audits, investigations, and other oversight activities
- ✓ To government authorities to prevent child abuse or domestic violence
- ✓ To the FDA to report product defects or incidents
- ✓ To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
- ✓ When required by court orders, search warrants, subpoenas and as otherwise required by law.

Patient Rights

As our patients, you have the following rights:

- ✓ To have access to/and or a copy of your health information
- ✓ To receive an accounting of certain disclosures we have made your health information
- ✓ To request restrictions as to how your health information is used or disclosed
- ✓ To request that we communicate with you in confidence
- ✓ To request that we amend your health information
- ✓ To request notice of our privacy practices

If you have a question, concern or complaint regarding our privacy practices, please refer to the Notice of Privacy Practices for the person or persons whom you may contact.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of the Notice of Privacy Practices and that I have read (or have had the opportunity to read if I so choose) and understand the notice.

Patient Name (Please Print)

Parent of Authorized Representative (If Applicable)

Signature

Date