Frisco Primary Care, P.A.

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Last Name:	First:	MI:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital Status *(circle one)* : Single / Married / Divorced / Widow / Other
Date of Birth:	Sex: ☐ M ☐ F	Email Address *(PLEASE PRINT CLEARLY)* :	Race: ☐ American Indian ☐ Asian ☐ Black / African American ☐ Hispanic ☐ White ☐ Other		
Mailing Address:		City / State:		Zip Code:	
Primary Phone:	Alternate Phone:	Please check one: ☐ OK to leave voice message with detailed information ☐ Leave message with call back information only			
Occupation:	Employer:	Work Phone:			
Chose clinic because / referred to clinic by *(please check one)* :	☐ Dr.	☐ Insurance Plan	☐ Hospital		
☐ Family	☐ Friend	☐ Location	☐ Internet Search	☐ Other	
Other family members seen here:					

INSURANCE INFORMATION

(Please give your insurance card to the front desk so we can make a copy for our records)

Primary Insurance Carrier:	ID / Policy Number:	Group Number:	Primary Policy Holder Name:
Relationship to Patient? ☐ Self ☐ Spouse ☐ Parent		Co-Pay / Deductible (if known): _____	
Secondary Insurance Carrier:	ID / Policy Number:	Group Number:	Primary Policy Holder Name:

EMERGENCY CONTACTS

Name of relative or friend:	Relationship to patient:	Phone Number:
Name of relative or friend:	Relationship to patient:	Phone Number:

PHARMACY INFORMATION

Pharmacy Name:

Address / Intersection / City: Phone Number:

SIGNED AUTHORIZATION AND CONSENT

The above information is correct to the best of my knowledge. I authorize Frisco Primary Care, P.A. to:

- File an insurance claim(s) on my behalf based on the information I provided and I will receive an Explanation of Benefits (EOB) from my insurance carrier(s) that will detail any payments, deductions, and adjustments per my individual insurance plan's guidelines.
- Request my insurance benefits be paid directly to Frisco Primary Care, P.A. for services rendered at this location.
- Release any information to my insurance company that is required to process my medical claims.
- View my prescription history from external sources.

I certify that I am an adult with appropriate decision making capacity and hereby provide consent for medical treatment by Frisco Primary Care, P.A.

PATIENT SIGNATURE: **DATE:**

FRISCO PRIMARY CARE, P.A.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE PLEASE CONTACT OUR PRIVACY OFFICER KAREN BROWN AT (972) 731-7717.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out your treatment, payment for your health care, or health care (clinic) operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you that may identify you and that relates to your past, present, or future physical or mental health or condition and related to health care services.

We are required to maintain the privacy of protected health information and to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. An updated copy will also be posted in our office.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice.

The following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a radiologist or pathologist) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare (Clinic) Operations: We may use or disclose, as-needed, your protected health information in order to support the professional and business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities.

For example, we may call you by your name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing services, transcription services, etc.) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization. Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed. We may use and disclose your protected health information in the following instances:

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in anemergency treatment situation.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request, or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include: (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: If you choose to participate in medical or scientific research, we may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Health Insurance Portability and Accountability Act, Section 164.500 et. seq.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about your health care. The request must be made in writing to **Frisco Primary Care, P.A.**. If you request a copy of your medical record, your physician's office will provide you a copy within 30 days.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information for the purpose of correcting an error or misinformation. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and that statement will become part of your medical record. Your physician may prepare a rebuttal to your statement which will also become part of your medical record. Your physician will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes to legal or regulatory agencies. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us.

3. Questions or Complaints

If you have a question or complaint about your privacy rights, please file a grievance form with the Privacy Officer of Frisco Primary Care, P.A. at 4525 Ohio Drive, Frisco, TX 75035. Should the Privacy Officer be unable to resolve your complaint to your satisfaction, you may contact the Secretary of Health and Human Services.

This notice became effective on April 14, 2003.

Frisco Primary Care, P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been provided with a Notice of Privacy Practices that provides a complete description of the uses and disclosures of certain protected health information. I understand Frisco Primary Care, P.A. reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy to me in writing.

Persons Authorized to Receive Information:

The following names are of people I authorize to have access to my protected health information. I give permission for Frisco Primary Care, P.A. to share my protected health information with:

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

I authorize the person(s) listed above to receive information about appointments, treatments, and/or other information pertinent to my healthcare and relationship with Frisco Primary Care, P.A.

☐ I do NOT authorize any information to be disclosed to any other parties other than those outlined in the Notice of Privacy Practices.

Information Release to Other Healthcare Professionals:

I authorize Frisco Primary Care, P.A. to release any pertinent medical information to other healthcare professionals directly involved in my medical care. This includes lab results, radiology reports, physician notes, prescription information, treatment plans, etc.

Expiration Date of Authorization:

This authorization does not expire unless revoked or terminated by the patient or patient's legal representative in writing.

Signatures:

_____	_____
Signature of Patient or Legal Representative	Date
_____	_____
Printed Name of Patient or Legal Representative	Witness Signature

FRISCO PRIMARY CARE, P.A.
FINANCIAL POLICY

PATIENT NAME: _____ DATE OF BIRTH: _____

Thank you for choosing Frisco Primary Care, P.A. as your health care provider. We are committed to providing excellent health care services to you, our patient. As a part of our professional relationship, it is important that you have a complete understanding of our Financial Policy.

ALL PATIENTS MUST READ AND SIGN THIS FORM PRIOR TO RECEIVING MEDICAL SERVICES.

• **It is your responsibility to provide us with your most current insurance information.** Most insurance companies only allow a limited number of days to file a claim after the date of service. If you fail to provide our office accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.

• We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company, and possibly your employer. **It is ultimately your responsibility to know and understand the types of services covered and reimbursements provided by your insurance company.**

• We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. **You are financially responsible for any services not covered by your insurance company.**

• Before receiving services, you must verify that we are participating in-network providers with your insurance company. It is also necessary that our physician is listed as your primary care provider with your insurance company, if required by your contract with your insurance company.

• **Co-payments, coinsurance, and/or deductibles are due at the time of service.** We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim – regardless of our estimation. For your convenience, we have our list of fees posted in the Lobby.

• **Patients without insurance coverage are required to pay the balance in full at the time of service.**

• We do not file claims to any Workers Compensation programs or on claims for automobile-related accidents.

• It is your responsibility to provide us with your most current billing information. Please provide your most current billing address, all available telephone numbers, and any other important contact information. If your address or contact information changes, please contact us with the updated information.

• As a courtesy and convenience for our patients, we draw labwork in our office and submit directly to the lab (LabCorp and/or Quest) for processing. **The lab will bill your insurance directly for any labwork we send to them on your behalf. If any balance on a test is unpaid by your insurance, you will receive a bill directly from the lab. It is ultimately your responsibility to understand your individual insurance policy and which lab tests / services they will and will not pay for and you have the right to decline any test(s) ordered at the time of service. We cannot recode lab visits and diagnosis codes cannot be changed once submitted to the lab for processing. If you have a dispute regarding a lab bill, please contact the lab and/or your insurance company directly.**

• We will send a statement (to the billing address you provide) notifying you of any balances you may owe to us. If you have any questions or dispute the validity of this balance, please contact our billing office within 30-days after receipt of the initial statement at (214) 842-6449.

• **We accept cash, credit cards, debit cards, and most Health Savings Account cards as forms of payment.**

• **Payment in full is due upon receipt of the statement.** Patient balances not paid in full within 30 days of the statement issue date are deemed past due. **Past due accounts may be referred to a professional collection agency for further collection activity and our physician / patient relationship with you could be terminated.**

• If your account is assigned to a professional collection agency, you will be notified by certified mail that you will no longer be able to receive services from any of the physicians at Frisco Primary Care, P.A. Failure to accept this certified letter (and/or to pick it up at the post office) serves as notice of termination of services.

• **Failure to pay your account balance will result in us cancelling or rescheduling your appointment until your balance is paid in full.**

By signing below, I acknowledge I have read and agree to the terms of the Financial Policy.

_____ _____

Patient Signature **Date**

Frisco Primary Care, P.A.
Controlled Substance Agreement

The purpose of this Agreement is to prevent confusion about certain prescription medications that are controlled substances that you may be prescribed for pain or other illness management. This Agreement is to help both you and your doctor follow the state and federal laws on controlled substances. Controlled substances include medication such as narcotic pain relievers, stimulants, anxiety medications, ADHD / ADD medications, and sleeping medications. These medications are controlled and regulated by the Department of Public Safety based upon their medicinal value, harmfulness, and potential for abuse or addiction.

Effective January 1, 2013, the Texas Department of Public Safety has implemented an online registry that requires any physician prescribing a controlled substance to check the prescription history of a patient. This online portal allows the doctor to view the prescription history of the patient to determine which (if any) controlled substances they have received in the past 12 months. This portal allows us to view the prescribing doctor's name, pharmacy name, date filled, etc. This is a mandatory state policy and does not require us to obtain written permission or signed consent from the patient.

I understand that this Agreement is important to the trust and confidence necessary in a doctor/patient relationship. I understand my doctor's goal is to provide safe and optimal medical care to the patient and he / she may be unable to do so if I intentionally withhold medical information crucial to my care. I understand that my doctor agrees to treat me based on my compliance with this Agreement. My doctor can refer me to a Pain Management specialist, psychiatric specialist, or other specialist if he/she deems it necessary.

I understand that if I violate this Agreement in any way, my doctor will stop prescribing these medications and can discontinue providing ongoing medical care to me. I agree to follow the guidelines listed below:

- I understand that my doctor will not prescribe controlled substances without a recent evaluation of my medical condition, which may include x-rays or other tests my doctor deems necessary.
- I will not use any illegal substances, including marijuana, cocaine, or other non-prescribed illegally obtained substances.
- I understand I will be subject to random drug screenings during the course of my care.
- I will not share, sell, or trade my medicine with anyone.
- I will not obtain **controlled medications**, including pain medicines, stimulants, or anti-anxiety medicines ***from any other prescriber without notifying my doctor.*** If I require emergency care or hospitalization, it is my responsibility to notify my doctor immediately of any duplicate medications prescribed. Failure to report this information is a direct violation of the Agreement.
- I will protect my medicine from getting lost or stolen. Lost or stolen medicines will not be replaced without an official police report of the theft; however, it is ultimately at my doctor's discretion. In addition, my pharmacy and/or insurance may decline this prescription even if my doctor approves a refill due to special circumstances.
- I will notify my doctor at least three (3) business days in advance of running out of my medication to allow adequate time for the doctor to approve the medication refill.
- I will not request early refills on any of the controlled substances prescribed to me.
- I will not request refills of controlled substances on weekends or holidays.
- I will take this medication only as directed by my doctor and will not take more than what he / she has recommended.
- I will only use one pharmacy to fill these medications and I will provide this pharmacy information to my doctor.
- I understand that all controlled medications will be sent directly to my pharmacy via an electronic prescription and I will not be given a paper copy of this prescription.
- I understand that in order to continue to receive my prescription, my doctor will require me to attend follow-up office visits as frequently as he / she deems necessary to monitor my condition and the medication I am on. I also understand that failure to comply with the recommended follow-up care can result in my prescription refill request to be denied and possible termination of my care.

By signing below, I agree to the terms and conditions of this Agreement. I also understand that the doctor may terminate our relationship at any time if he/she has cause to believe that I am not complying with the terms of this Agreement, or if he / she believes that I have made a misrepresentation or false statements concerning my symptoms or my compliance with the terms of this Agreement.

_____ _____

Patient Signature **Date**

Frisco Primary Care, P.A.
4525 Ohio Drive, Suite 100
Frisco, TX 75035
Phone: (972) 731-7717
Fax: (972) 731-7733

Authorization for Use or Disclosure of Protected Health Information

Printed Name of Patient _____ **Date of Birth** _____ **Date of Request** _____

Street Address _____ **City** _____ **State** _____ **Zip Code** _____ **Phone Number** _____

I hereby authorize the release of my Medical Record Information to my Primary Care Physician (PCP). The Medical Records Information will be used for continuation of medical care with my PCP.

PCP: **Frisco Primary Care, P. A.**
4525 Ohio Drive Ste. 100
Frisco, Texas 75035
FAX: (972) 731-7733

Requesting Records From: _____
Phone: _____
Fax: _____

PCP Name: ☐ **Dr. Jun Lee** ☐ **Dr. Subashini Narayanan** ☐ **Dr. Anitha Vyza** ☐ **Dr. Bo Wang**

☐ **The information to be released includes entire Medical Record**
☐ **Specific Item(s):** _____

I acknowledge and agree that the term Medical Records Information may include: notes by the provider and other personnel, results, reports, correspondence, x-rays, as well as claims, billing, and payment information. I understand that this may include information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug related conditions, alcoholism, and / or psychiatric / psychological conditions unless specifically excluded.

Please exclude the following information, if it is part of my Medical Record information (check any or all you want excluded from this authorization for use or disclosure):

☐ Chemical Dependency/Substance Abuse ☐ Psychiatric/Psychological Conditions ☐ Sexually Transmitted Diseases ☐ Drugs/Alcohol

☐ Other (describe)

By signing below, I am providing written consent for Frisco Primary Care, P.A. to obtain copies of my medical records. I also agree that photocopied signatures are valid for obtaining medical records.

Signature of Patient or Patient Representative _____ **Name of Patient *(printed)*** _____ **Date** _____

Relationship of Representative *(if not patient)* _____ **Signature of Witness** _____

HEALTH HISTORY

Patient Name _____ **Date of Birth** _____ **Today's Date** _____

MEDICAL CONDITIONS

Check conditions you currently have OR had in the past

☐ AIDS / HIV	☐ Chemical Dependency	☐ Hernia	☐ Pneumonia
☐ Alcoholism	☐ Chicken Pox	☐ High Cholesterol	☐ Polio
☐ Anemia	☐ Diabetes	☐ High Blood Pressure	☐ Prostate Problem
☐ Appendicitis	☐ Eating Disorder	☐ Kidney Disease	☐ Rheumatic / Scarlet / Typhoid Fever
☐ Arthritis	☐ Emphysema	☐ Liver Disease	☐ Shingles
☐ Asthma	☐ Epilepsy	☐ Measles / Mumps	☐ STD
☐ Bleeding Disorders	☐ Glaucoma	☐ Migraine Headaches	☐ Stroke
☐ Bronchitis (chronic)	☐ Gout	☐ Mononucleosis	☐ Thyroid Problems
☐ Cancer (specify):	☐ Heart Disease	☐ Multiple Sclerosis	☐ Tuberculosis (TB)
☐ Cataracts	☐ Hepatitis – A, B, or C *(circle one)*	☐ Pacemaker	☐ Ulcers
☐ Other medical conditions *(please describe)*:			

CURRENT MEDICATIONS

List all medications you are currently taking (attach a list if more space is needed)

MEDICATION NAME **STRENGTH** **HOW OFTEN** **CURRENT PRESCRIBING DOCTOR**

_____

_____

_____

_____

_____

_____

_____

_____

ALLERGIES

If no known allergies, leave blank

MEDICATION / SUBSTANCE **TYPE OF REACTION**

_____

_____

_____

OTHER PHYSICIANS / SPECIALISTS SEEN

List the name(s) of any other physicians or specialists seen

PHYSICIAN NAME **SPECIALTY** **CITY, STATE**

_____

_____

_____

_____

PREVIOUS PRIMARY CARE PHYSICIAN (PCP)

PHYSICIAN NAME **CITY, STATE** **PHONE NUMBER** **FAX NUMBER**

_____

HEALTH HABITS

Check if you use any of the substances below. Describe how much you use and how often.

	SUBSTANCE	HOW MUCH / HOW OFTEN?		SUBSTANCE	HOW MUCH / HOW OFTEN?
☐	Caffeine		☐	Marijuana	
☐	Alcohol		☐	Street drugs	
☐	Tobacco products		☐	Other	

FAMILY HISTORY

RELATION	CURRENT AGE *(if living)*	AGE AT DEATH *(if deceased)*	CAUSE OF DEATH *(if deceased)*
Father			
Mother			
Brother / Sister			
Brother / Sister			
Brother / Sister			
Brother / Sister			
Brother / Sister			

	CHECK IF YOUR BLOOD RELATIVES HAD / HAVE ANY OF THE FOLLOWING CONDITIONS:	RELATIONSHIP TO YOU
☐	Alzheimer's Disease / Dementia	
☐	Cancer	
☐	Chemical dependency / Addiction issues	
☐	Diabetes / Kidney disease	
☐	Heart disease / Stroke	
☐	High blood pressure	
☐	Other *(describe)*	

HOSPITALIZATIONS / SURGERIES

YEAR **HOSPITAL NAME** **REASON FOR HOSPITALIZATION / SURGERY**

_____

_____

_____

_____

_____

_____

PREVENTATIVE CARE

Check if you had the following AND indicate the year (if known)

☐	Colon cancer screening (list type)	☐	Flu vaccine
☐	Eye exam	☐	Pneumonia vaccine
☐	Mammogram	☐	Hepatitis A and/or B vaccine
☐	Bone density screening	☐	TDAP / Tetanus vaccine
☐	Prostate exam / test *(males only)*	☐	Shingrix vaccine
☐	Pap smear *(females only)*	☐	Meningitis vaccine

To the best of my knowledge, the above information is complete and correct. I understand it is my responsibility to inform my doctor if I ever have a change in health or if any of the above information changes while under his / her care.

_____ _____ _____

PATIENT NAME *(printed)* **PATIENT SIGNATURE** **DATE**