

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_



## Bayview Physician Services Office Policy

Thank you for choosing us as your health care provider. Our staff and physicians are committed to providing you the best service we can. The following is a statement of our office policy.

To ensure our system is set up accurately, we ask that you complete our registration form and provide us with a valid medical insurance card and a photo ID, as well as new insurance cards as they become available.

We accept assignment of insurance benefits as a courtesy to our patients. Any remaining balance will be the patient's responsibility. Deductibles applied by your insurance, not covered by another insurance, will also be the patient's responsibility. Services may require a referral or authorization prior to being seen. Please be aware that some services provided may not be covered by Medicare or other insurances and may be considered not medically necessary, experimental or investigational. Unless valid insurance is presented, patients will be responsible for payment in full at the time of visit. All copayments are to be paid at the time service is rendered.

Please be aware that some visits performed by the nursing staff, without seeing a doctor, are considered an office visit and fees will be charged accordingly.

As a service to our patients, we will send you electronic appointment reminders and possibly other important electronic messages. By providing your email address and/or cell phone number, you consent to receive electronic messages by such means. We will not provide your information to any other entity.

To ensure accurate processing of prescriptions, we ask that all refill requests are processed through your pharmacy. Your pharmacy can still request the refill even if you have no refills remaining. Routine refill requests may take up to 48 hours; however our goal is to process all requests the same day.

Referral requests may take several days to process, depending on the insurance company. Please call our receptionist with the name of the specialist, their phone number, date of your appointment and your diagnosis. Also, it may take 24-48 hours to process forms, depending on the amount of detail requested.

We are happy to provide you with a copy of your medical record. There is a fee for copied medical records. We will notify you of the records fee and it should be paid prior to the release of the records. We require at least 5 business days to receive copies of medical records.

We recognize that from time to time, you may need to have a medical form completed. To ensure we are able to meet the appropriate deadlines, please ensure that we receive this form as soon as possible. Depending on the information needed on the form, it could take several days for us to complete it.

Should you arrive late for an appointment, please be aware that you may be asked to reschedule or you may have to wait to be seen between or after the other patients who have arrived at their scheduled time.

Your appointment is very important to us. If you are unable to make your scheduled appointment, unless canceled at least 24 hours in advance, we reserve the right to charge a No Show/Late cancellation fee of up to \$50.00. Please help us serve you better by keeping your scheduled appointments.

I, \_\_\_\_\_ have read, understand and agree to the office policy of Bayview Physicians Group.

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date

# Patient Information



Patient Information	Last Name                      First                      Middle Initial			Social Security No.			
	Address			City	State	Zip Code	
	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W	Birthdate / /	Age	Occupation	Employer	
	Home Phone		Work Phone		Cell Phone		
	Email Address:			Preferred Contact Method:			
Responsible Party	Race <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American			Ethnicity <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Decline		Preferred Language <input type="checkbox"/> Decline	
	Emergency Contact Name		Relationship		Phone		
	Responsible Party - Last Name                      First                      Middle Initial			Birthdate / /		Social Security No.	
	Address			City	State	Zip Code	
Privacy	Home Phone		Work Phone		Cell Phone		
	Relationship to Patient		Occupation		Employer		
	<b>HIPAA Acknowledgements: All patients must initial all that apply:</b> I hereby acknowledge that I have been provided with a copy of the Bayview Physicians Group Notice of Privacy Policies. Is it ok to leave a message regarding your health information at your : <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> No Messages    Initials: _____ By default, no other persons may have access to my medical record except the following people:						
Insurance	Name & Relationship						
	For your convenience, we will assist you or supply you with the information necessary to file your medical insurance. Please allow us to copy your insurance cards.						
	Insurance Co. #1 Company Name ID No. Subscriber's Name Relation to Patient			Insurance Co. #2 Company Name ID No. Subscriber's Name Relation to Patient			
	Group No.			Group No.			
Consent, Agreements & Signature	Date of Birth			Date of Birth			
	SS#:			SS#:			
	<b>Deemed Consent - Consent for Treatment - Release of Medical Information - Electronic Communications - No Guarantee</b> Under Virginia Law, if any employee or agent of the practice is exposed to your blood or other body fluids in a manner which may transmit human immunodeficiency virus (HIV) or Hepatitis B or C viruses, you shall be deemed to have consented to testing for infectious with HIV or hepatitis B or C viruses. In addition, you shall be deemed to have consented to the release of such test results to the person who was exposed. I, the undersigned, as the patient or on behalf of the above named patient hereof, do hereby consent to and authorize all diagnostic and therapeutic treatment considered necessary or advisable in the judgment of the physician on duty or the referring physician, as well as an testing and/or treatment carried out by Bayview Physician Services, PC staff under the direction of the Medical Director. I agree that Bayview Physicians Group may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes. We will send you appointment reminders and other important electronic messages by text and email. By providing your email address and/or cell phone number, you consent to receive electronic messages by such means. We will not share your information. You can opt out at anytime. Chaperones will be present during certain examinations. Any request for a chaperone made by a patient and/or family member will be honored. I understand that no guarantee or assurance has been made as to the results which may be obtained from any exam, testing or treatment.						
<b>Financial Agreement - Insurance Agreement</b> I hereby authorize treatment to patient by any Bayview Physicians Group provider and/or affiliated medical staff member(s). I further authorize release of any and all medical and/or billing information as is necessary for reimbursement from any insurance carrier, Tricare or Medicare. I authorize direct payment from said insurer(s) to this practice. I accept responsibility for payment of all treatment that payor determines does not constitute as covered services, including denied Worker's Compensation claims, as well as attorney fees of 33 1/3% and other related costs of collection should such action become necessary.							
Signature of Patient/Responsible Party			Relationship to Patient		Date		



## NOTICE OF PRIVACY PRACTICES

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

Effective Date: 9 /23/2013

If you have any questions about this notice, please contact Bayview Physicians Group's Privacy Officer at :

( 757 )686-3500.

### **WHO WILL FOLLOW THIS NOTICE**

This notice describes the practices of:

Bayview Physicians Group.

Any health care professional authorized to enter information into your medical record maintained by Bayview Physicians Group.

Any persons or companies with whom Bayview Physicians Group contracts for services to help operate our practice and who have access to your medical information.

All these persons, entities, sites, and locations follow the terms of this notice. In addition, these persons, entities, sites, and locations may share medical information with each other for treatment, payment, or health care operations purposes and other purposes described in this notice.

### **OUR PLEDGE REGARDING MEDICAL INFORMATION**

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive from Bayview Physicians Group. We need this record to provide you with quality care and to comply with certain legal requirements.

This notice applies to all of the records of your care and billing for that care that are generated or maintained by Bayview Physicians Group, whether made by Bayview Physicians Group personnel or other health care providers. Other health care providers may have different policies or notices about confidentiality and disclosure that apply to your medical information that is created in their offices or at locations other than Bayview Physicians Group.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of your medical information.

We are required by law to:

Make sure that medical information that identifies you is kept private;

Give you this notice of our legal duties and privacy practices at Bayview Physicians Group, and your legal rights, with respect to medical information about you; and

Follow the terms of the notice that is currently in effect.

### **HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU**

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of these categories.

**For Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, volunteers, or other personnel who are involved in taking care of you at Bayview Physicians Group. For example, a doctor treating you for a broken hip may need to know if you have diabetes because diabetes may slow the healing process. We also may disclose medical information about you to people outside Bayview Physicians Group who may be involved in your medical care after you have been treated by Bayview Physicians Group, such as friends, family members, or employees or medical staff members of any hospital or skilled nursing facility to which you are transferred or subsequently admitted.

**For Payment.** We may use and disclose medical information about you so that the treatment and services you receive from Bayview Physicians Group may be billed by Bayview Physicians Group and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about treatment you received from Bayview Physicians Group so your health plan will pay us or reimburse you for the treatment. We also may disclose information about you to another health care provider, such as a hospital or skilled nursing facility to which you are admitted, for their payment activities concerning you.

**For Health Care Operations.** We and our business associates may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run Bayview Physicians Group and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional services Bayview Physicians Group should offer, and what services are not needed. We may also disclose information to doctors, nurses, technicians, and other personnel affiliated with Bayview Physicians Group for review and learning purposes. We may also combine the medical information we have with medical information from other health care providers to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning the identities of specific patients. We also may disclose information about you to another health care provider for its health care operations purposes if you also have received care from that provider.

**Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend different ways to treat you.

**Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition. Medical information about you that has had identifying information removed may be used for research without your consent. We also may disclose medical information about you to people preparing to conduct a research project (for example, to help them look for patients with specific medical needs), so long as the medical information they review does not leave Bayview Physicians Group. If the researcher will have information about your mental health treatment that reveals who you are, we will seek your consent before disclosing that information to the researcher. Unless we notify you in advance and you give us written permission, we will not receive any money or other thing of value in connection for using or disclosing your medical information for research purposes except for money to cover the costs of preparing and sending the medical information to the researcher.

**Individuals Involved in Your Care or Payment for Your Care.** We may release medical information about you to a friend or family member who is involved in your medical care. This would include persons named in any durable health care power of attorney or similar document provided to us. We may also give information to someone who helps pay for some or all of your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that

someone who helps pay for some or all of your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. You can object to these releases by telling us that you do not wish any or all individuals involved in your care to receive this information. If you are not present or cannot agree or object, we will use our professional judgment to decide whether it is in your best interest to release relevant information to someone who is involved in your care or to an entity assisting in a disaster relief effort.

**As Required or Permitted By Law.** We may disclose medical information about you when required or permitted to do so by federal, state, or local law.

**To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when it appears necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to someone who appears able to help prevent the threat and will be limited to the information needed.

#### **SPECIAL SITUATIONS**

**Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation, or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

**Active Duty Military Personnel and Veterans.** If you are an active duty member of the armed forces or Coast Guard, we must give certain information about you to your commanding officer or other command authority so that your fitness for duty or for a particular mission may be determined. We may also release medical information about foreign military personnel to the appropriate foreign military authority. We may use and disclose to components of the Department of Veterans Affairs medical information about you to determine whether you are eligible for certain benefits.

**Workers' Compensation.** In accordance with state law, we may release without your consent medical information about your treatment for a work-related injury or illness or for which you claim workers' compensation to your employer, insurer, or care manager paying for that treatment under a workers' compensation program that provides benefits for work-related injuries or illness.

**Public Health Risks.** We may disclose without your consent medical information about you for public health activities. These activities generally include but are not limited to the following:

To report, prevent or control disease, injury, or disability;

To report births and deaths;

To report reactions to medications or problems with products;

To notify people of recalls of products they may be using;

To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and

To report suspected abuse or neglect as required by law.

**Health Oversight Activities.** We may disclose without your consent medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. The government uses these activities to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we must disclose medical information about you in response to a court or administrative order. We also may disclose medical information about you in response to a subpoena or other lawful process from someone involved in a civil dispute.

**Law Enforcement.** We may release without your consent medical information to a law enforcement official:

In response to a court order, warrant, summons, grand jury demand, or similar process;

To comply with mandatory reporting requirements for violent injuries, such as gunshot wounds, stab wounds, and poisonings;

In response to a request from law enforcement for certain information to help locate a fugitive, material witness, suspect, or missing person;

To report a death or injury we believe may be the result of criminal conduct; and

To report suspected criminal conduct committed at Bayview Physicians Group facilities.

**Coroners and Medical Examiners.** We may release without your consent medical information to a coroner or medical examiner. This may be done, for example, to identify a deceased person or determine the cause of death. We also may release medical information about deceased patients of Bayview Physicians Group to funeral directors to carry out their duties.

**National Security and Intelligence Activities.** We may release without your consent medical information about you as required by applicable law to authorized federal or state officials for intelligence, counterintelligence, or other governmental activities prescribed by law to protect our national security.

**Protective Services for the President and Others.** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

**Psychotherapy Notes.** Regardless of the other parts of this Notice, psychotherapy notes will not be disclosed outside the Bayview Physicians Group except as authorized by you in writing or pursuant to a court order, or as required by law. Psychotherapy notes about you will not be disclosed to personnel working within Bayview Physicians Group, except for training purposes or to defend a legal action brought against Bayview Physicians Group, unless you have properly authorized such disclosure in writing.

**Inmates.** If you are an inmate of a correctional institution or in the custody of law enforcement, we may release medical information about you to the correctional institution or law enforcement official who has custody of you, if the correctional institution or law enforcement official represents to Bayview Physicians Group that such medical information is necessary: (1) to provide you with health care; (2) to protect your health and safety or the health and safety of others; (3) to protect the safety and security of officers, employees, or others at the correctional institution or involved in transporting you; (4) for law enforcement to maintain safety and good order at the correctional institution; or (5) to obtain payment for services provided to you. If you are in the custody of the North Carolina Department of Corrections ("DOC") and the DOC requests your medical records, we are required to provide the DOC with access to your records.

#### **YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU**

You have the following rights regarding medical information we maintain about you:

**Right to Inspect and Copy.** You have the right to inspect and receive a copy of your medical record unless your attending physician determines that information in that record, if disclosed to you, would be harmful to your mental or physical health. If we deny your request to inspect and receive a copy of your medical information on this basis, you may request that the denial be reviewed. Another licensed health care professional chosen by Bayview Physicians Group will review your request and the denial. The person conducting the review will not be the person who denied your request. We will do what this reviewer decides.

If we have all or any portion of your medical information in an electronic format, you may request an electronic copy of those records or request that we send an electronic copy to any person or entity you designate in writing.

Your medical information is contained in records that are the property of Bayview Physicians Group. To inspect or receive a copy of medical information that may be used to make decisions about you, you must submit your request in writing to Bayview Physicians Group's Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request, and we may collect the fee before providing the copy to you. If you agree, we may provide you with a summary of the information instead of providing you with access to it, or with an explanation of the information instead of a copy. Before providing you with such a summary or explanation, we first will obtain your agreement to pay and will collect the fees, if any, for preparing the summary or explanation.

**Right to Amend.** If you feel that medical information we have about you in your record is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Bayview Physicians Group.

To request an amendment, make your request in writing to Bayview Physicians Group's Privacy Officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

us to amend information that:

Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

Is not part of the medical information kept by or for Bayview Physicians Group;

Is not part of the information that you would be permitted to inspect and copy; or

Has been determined to be accurate and complete.

If we deny your request for an amendment, you may submit a written statement of disagreement and ask that it be included in your medical record.

**Right to an Accounting of Disclosures.** You have the right to request a list of certain disclosures we have made of medical information about you during the past six years. To request this list or accounting of disclosures, submit your request in writing to Bayview Physicians Group's Privacy Officer and state whether you want the list on paper or electronically. Your request must state a time period that may not be longer than six years. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. We may collect the fee before providing the list to you.

**Right to Request Restrictions.** Except where we are required to disclose the information by law, you have the right to request a restriction or limitation on the medical information we use or disclose about you. For example, you could revoke any and all authorizations you previously gave us relating to disclosure of your medical information.

***We are not required to agree to your request***, with the exception of restrictions on disclosures to your health plan, as described below. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

To request restrictions, make your request in writing to Bayview Physicians Group's Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

You may request that we not disclose your medical information to your health insurance plan for some or all of the services you receive during a visit to any Bayview Physicians Group location. If you pay the charges for those services you do not want disclosed ***in full at the time of such service***, we are required to agree to your request. "In full" means the amount we charge for the service, not your copay, coinsurance, or deductible responsibility when your insurer pays for your care. Please note that once information about a service has been submitted to your health plan, we cannot agree to your request. If you think you may wish to restrict the disclosure of your medical information for a certain service, please let us know as early in your visit as possible.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail, or at another mailing address other than your home address. We will accommodate all reasonable requests. We will not ask you the reason for your request. To request confidential communications, make your request in writing to the Privacy Officer and specify how or where you wish to be contacted.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice or any revised notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To obtain a paper copy of this notice, request a copy from Bayview Physicians Group's Privacy Officer in writing.

#### **CHANGES TO THIS NOTICE**

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice at Bayview Physicians Group's office. The notice will contain the effective date on the first page, in the top right-hand corner. If the notice changes, a copy will be available to you upon request.

#### **INVESTIGATIONS OF BREACHES OF PRIVACY**

We will investigate any discovered unauthorized use or disclosure of your medical information to determine if it constitutes a breach of the federal privacy or security regulations addressing such information. If we determine that such a breach has occurred, we will provide you with notice of the breach and advise you what we intend to do to mitigate the damage (if any) caused by the breach, and about the steps you should take to protect yourself from potential harm resulting from the breach.

#### **COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with Bayview Physicians Group or with the Secretary of the United States Department of Health and Human Services. To file a complaint with Bayview Physicians Group, contact our Privacy Officer by mail at 3241 Western Branch Blvd. Chesapeake, VA 23321. All complaints must be submitted in writing.

***You will not be penalized for filing a complaint.***

#### **OTHER USES OF MEDICAL INFORMATION**

Other uses and disclosures of medical information not covered by this notice may be made only with your written authorization or as required by law. If you authorize us to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. Your revocation will be effective as of the end of the day on which you provide it in writing to Bayview Physicians Group's Privacy Officer. If you revoke your permission, we will no longer use or disclose medical information about you for the purposes that you previously had authorized in writing. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

<b>Last Name:</b> _____	
<b>First Name:</b> _____	
<b>Birthdate:</b> _____	

### Acknowledgement of Receipt

I have been given a copy of Bayview Physicians Group's Notice of Privacy Practices, version effective **September 23, 2013**. I consent to the uses and disclosures of my health information as outlined in the Notice.

### Privacy Options

- I want **NO ONE** to receive my Personal Health Information except myself.
- I request the following person(s) **BE ALLOWED** to access my Personal Health Information:  
 \_\_\_\_\_  
 \_\_\_\_\_
- I request the following person(s) **NOT BE ALLOWED** to access my Personal Health Information:  
 \_\_\_\_\_  
 \_\_\_\_\_

### Communications

- I give permission to leave a verbal message at my personal residence. \_\_\_ Yes \_\_\_ No
- I give permission to leave a message regarding my appointment on my voicemail. \_\_\_ Yes \_\_\_ No
- I give NowCare permission to release any urgent care notes to my personal physician. \_\_\_ Yes \_\_\_ No
- I give permission to call me at work.      Work Phone: \_\_\_\_\_ \_\_\_ Yes \_\_\_ No

### Please Sign

<b>Patient's Name (Print)</b>	<b>Patient's Signature</b>	<b>Date</b>
Lname, Fname		

*If you are signing on behalf of the patient, please complete this section:*

<b>Representative's Name (Print)</b>	<b>Representative's Signature</b>	<b>Date</b>


**Reason Patient Cannot Sign**

### \*\*\* Office Use Only \*\*\*

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgment and the reason you could not obtain it:

\_\_\_\_\_

\_\_\_\_\_

Last Name: _____	
First Name: _____	
DOB: _____ Phone: _____	

## Release of Medical Information

I hereby authorize: \_\_\_\_\_  
(Facility) and their staff to release medical records as requested below.

**Please release to:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Information contained in the medical record of:**

Patient Name (please print)	Birthdate
<input type="checkbox"/> All Medical Records <input type="checkbox"/> Office Notes <input type="checkbox"/> Discharge Summary <input type="checkbox"/> History & Physical <input type="checkbox"/> Lab / X-ray Data <input type="checkbox"/> Psychiatric / Psychological Information <input type="checkbox"/> Operative Report(s) <input type="checkbox"/> Diagnostic Studies <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____	

Covering the period of time from: \_\_\_\_\_ to \_\_\_\_\_

For the specific purpose of: \_\_\_\_\_

I authorize release of my medical records and other information regarding my treatment including, but not limited to, psychological or psychiatric impairment, drug abuse, alcoholism, sickle-cell anemia, acquired immunodeficiency syndrome (AIDS), or test for infection with human immunodeficiency. I authorize the Facility listed above to furnish the requested information, even though the confidentiality of the information may be protected by Federal or State law.

The Facility listed above and its staff are hereby released and discharged from any liability. I will hold the Facility listed above and its staff harmless for complying with this authorization to release medical information.

Authorization will expire 60 days from date signed unless specified otherwise. Authorization can be revoked, but the withdrawal of authorization cannot be retroactive to release of information made in good faith.

Patient Name (Print)	Patient Signature	Date
Witness Name (Print)	Witness Signature	

If the above patient is under the age of 18 and / or has a legally appointed guardian, this release must be signed by his/her parent or guardian. Proof of guardianship may be required in some cases.

Patient (or Guardian) Name (Print)	Patient (or Guardian) Signature	Date
Witness Name (Print)	Witness Signature	



## NEW PATIENT MEDICAL HISTORY

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: Married Single Divorced

Referring Physician & Address \_\_\_\_\_

Other physicians you would like to receive a report or letter \_\_\_\_\_

Reason for Referral Visit \_\_\_\_\_

Is this a second opinion consultation? \_\_\_\_\_

## MEDICATIONS

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

Medication	Dosage	Frequency	How long have you been taking this medication?
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____
5	_____	_____	_____
6	_____	_____	_____
7	_____	_____	_____
8	_____	_____	_____
9	_____	_____	_____
10	_____	_____	_____



Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Chart: \_\_\_\_\_

ALLERGIES

LIST ALL DRUG ALLERGIES & YOUR REACTION TO THE MEDICATIONS

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

MEDICAL HISTORY

LIST ALL HOSPITALIZATIONS, STARTING WITH THE MOST RECENT & PROGRESSING BACKWARDS.

INCLUDE ALL HOSPITAL ADMISSIONS, SURGERIES, & PREGNANCIES.

Table with 4 columns: Illness, Date, Procedure, Where. Includes multiple blank rows for data entry.

- 1. Have you ever had a cardiac catheterization?
2. Have you ever had a blood transfusion?
3. Have you ever had ulcers?
4. Do you currently smoke cigarettes?
5. Do you drink alcohol?
6. Do you drink beverages containing caffeine?
7. Do you use any illegal drugs?
8. FOR FEMALES: If you have been pregnant, how many times?

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Chart: \_\_\_\_\_

## FAMILY HISTORY

	If Alive, Age	If Alive, State of Health	If Deceased, Cause of Death	Age at Death
MOTHER				
FATHER				
BROTHERS				
SISTERS				

## SOCIAL HISTORY

1. Are you:  Employed  Retired Your Occupation \_\_\_\_\_
2. Who lives at home with you? \_\_\_\_\_
3. Are you married?  Yes  No
4. Do you have any hobbies?  Yes  No If yes, explain \_\_\_\_\_
5. How many children do you have? \_\_\_\_\_
6. Are you under any unusual stress in your life?  Yes  No If yes, explain \_\_\_\_\_

---

---

---

---

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Chart: \_\_\_\_\_

## MEDICAL CONDITIONS

PLEASE INDICATE ANY OF THE FOLLOWING PROBLEMS THAT YOU HAVE EXPERIENCED.

### I. CARDIOVASCULAR

- 1. Chest pain or angina
- 2. Shortness of breath
- 3. Irregular heartbeat
- 4. Fast heartbeat
- 5. Dizziness
- 6. Passing out
- 7. Swelling of feet, ankles or hands
- 8. Leg pains when walking

### II. HEAD & NECK

- 1. Frequent headaches
- 2. Neck pain
- 3. Neck lumps or swelling
- 4. Need glasses
- 5. Blurry vision
- 6. See double
- 7. See halos
- 8. Eye pain or watering
- 9. Hearing difficulties
- 10. Buzzing in ears
- 11. Ear trouble
- 12. Dental or gum trouble
- 13. Soreness in mouth
- 14. ? Hoarse voice
- 15. ? Frequent nose bleeds

### III. RESPIRATORY

- 1. Shortness of breath
- 2. Wheezing or asthma
- 3. Cough up phlegm
- 4. Cough up blood
- 5. Pain in chest with breathing

### IV. DIGESTIVE

- 1. Difficulty in swallowing
- 2. Heartburn
- 3. Frequent belching
- 4. Nausea or vomiting
- 5. Vomiting blood
- 6. Stomach pain
- 7. Ulcer
- 8. Constipation
- 9. Diarrhea
- 10. Loose stools
- 11. Change in bowel habits
- 12. Black or bloody bowel movements
- 13. Rectal bleeding
- 14. Rectal pain
- 15. Liver trouble
- 16. Yellow jaundice (hepatitis)
- 17. Recent unintended weight loss
- 18. Recent unintended weight gain

### V. ENDOCRINE

- 1. Thyroid disease
- 2. Diabetes
- 3. Change in skin or hair texture
- 4. Change in tolerance to heat & cold

### VI. URINARY-GENITAL

- 1. Frequent urination (day/night)
- 2. Burning on urination
- 3. Difficulty starting urine
- 4. Blood, protein, or sugar in urine
- 5. Kidney stones
- 6. Syphilis or gonorrhea
- 7. Incontinence
- 8. Sexual dysfunction

### VII. FOR MALES

- 1. Prostate problems
- 2. Lumps or pain in testicles
- 3. Discharge

### VIII. FOR FEMALES

- 1. Menstrual difficulties
- 2. Excessive bleeding
- 3. Vaginal discharge
- 4. Vaginal bleeding
- 5. Date of last menstrual period \_\_\_\_\_

### IX. SKIN

- 1. Recurrent rash
- 2. Chronic itching
- 3. ?Other skin problems \_\_\_\_\_

### X. MUSCULOSKELETAL

- 1. Aching muscles or joints
- 2. Swollen joints
- 3. Back or shoulder pain
- 4. Arthritis
- 5. Stiffness in joints
- 6. Pain or cramping in the legs
- 7. Weakness in arm
- 8. Poor circulation

### XI. NEUROLOGICAL

- 1. Numbness or paralysis
- 2. Convulsions
- 3. Tremor or trembles
- 4. Loss of appetite
- 5. Insomnia
- 6. Difficulty sleeping
- 7. Difficulty with speech or memory
- 8. Nervousness
- 9. Depression
- 10. Mood change or disturbance
- 11. Anxiety
- 12. Mania
- 13. Hallucinations

### XII. HEMATOLOGICAL

- 1. Anemia or blood disorders
- 2. Excessive bleeding or bruising
- 3. Bleeding disorders
- 4. Clotting problems

### XIII. INFECTION

- 1. Fever with night sweats