Southern Crescent Family Practice, LLC
455 Forest Parkway
Forest Park, GA 30297
678-705-0100 (P)
678-235-1800 (F)

E-PRESCRIBING CONSENT FORM

ePrescribing is defined by a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program.

These include:

- **Formulary and benefit transactions**
  Gives the prescriber information about which drugs are covered by the drug benefit plan.

- **Medication history transactions**
  Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

- **Fill status notification**
  Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Southern Crescent Family Practice can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Southern Crescent Family Practice to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____
Patient Name Date of Birth

_____ _____
Signature of Patient or Representative Date

_____ _____
Pharmacy Name Location and Phone

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Conditions of Service and Consent for Treatment

IMPORTANT: DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING ITS CONTENTS.

In consideration of services provided by Southern Crescent Family Practice (SCFP), the Patient or undersigned representative acting on behalf of the Patient agrees and consents to the following:

1. Consent to Routine Medical Treatment/Services

Patient consents to the rendering of Medical Treatment/Services as considered necessary and appropriate by the attending physician or other practitioner, a member of the SCFP medical staff who has requested care and treatment of Patient, and others with staff privileges at SCFP. Medical Treatment/Services may be performed by "Healthcare Professionals" (physicians, nurses, technologists, technicians, physician assistants or other healthcare professionals). Patient authorizes the attending or other practitioner, the medical staff of SCFP and SCFP to provide Medical Treatment/Services ordered or requested by attending or other practitioner and those acting in his or her place. **The consent to receive "Medical Treatment/Services" includes, but is not limited to: clinical care; examinations (x-ray or otherwise); laboratory procedures; medications; drugs; supplies; anesthesia; minor surgical procedures and medical treatments; recording/ filming for internal purposes (i.e., identification, diagnosis, treatment, performance improvement, education, safety, security) and other services which Patient may receive.** In the event SCFP determines that Patient should provide blood specimens for testing purposes in the interest of the safety of those with whom Patient may come in contact; Patient consents to the withdrawing and testing of Patient's blood and to the release of test information where this is deemed appropriate for the safety of others.

2. Legal Relationship between SCFP and Physician

Some of the health care professionals performing services at SCFP are independent contractors and are not SCFP employees. Independent contractors are responsible for their own actions and SCFP shall not be liable for the acts or omissions of any such independent contractors.

3. Explanation of Risk and Treatment Alternatives

Patient acknowledges that the practice of medicine is not an exact science and that **NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO THE PATIENT** concerning the outcome and/or result of any **Medical Treatment/Services**. While routinely performed without incident, there may be material risks associated with each of these **Medical Treatment/Services**. Patient understands that it is not possible to list every risk for every **Medical Treatment/Services** and that this form only attempts to identify the most common material risks and the alternatives (if any) associated with the **Medical Treatment/Services**. Patient also understands that various Healthcare Professionals may have differing opinions as to what constitutes material risks and alternative **Medical Treatment/Services. *By signing this form***:

Patient consents to Healthcare Professionals performing **Medical Treatment/Services** as they may deem reasonably necessary or desirable in the exercise of their professional judgment, **including those Medical Treatment/Services that may be unforeseen or not known to be needed at the time this consent is obtained;** and Patient acknowledges that Patient has been informed in general terms of the nature and purpose of the **Medical Treatment/Services**; the material risks of the **Medical Treatment/Services** and practical alternatives to the **Medical Treatment/Services**.

The **Medical Treatment/Services** may include, but are not limited to the following:

a). **Needle Sticks,** such as shots, injections, intravenous lines or intravenous injections (IVs). The material risks associated with these types of Procedures include, but are not limited to, nerve damage, infection, infiltration (which is fluid leakage into surrounding tissue), disfiguring scar, loss of limb function, paralysis or partial paralysis or death. Alternatives to Needle Sticks (if available) include oral, rectal, nasal or topical medications (each of which may be less effective).

b). **Physical Tests, Assessments and Treatments** such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks and other similar procedures. The material risks associated with these types of Procedures include, but are not limited to, allergic reactions, infection, severe loss of blood, muscular-skeletal or internal injuries, nerve damage, loss of limb function, paralysis or partial paralysis, disfiguring scar, worsening of the condition and death. Apart from using modified Procedures, no practical alternatives exist.

c). **Administration of Medications** via appropriate route whether orally, rectally, topically or through Patient's eyes, ears or nostrils, etc. The material risks associated with these types of Procedures include, but are not limited to, perforation, puncture, infection, allergic reaction, brain damage or death. Apart from varying the method of administration, no practical alternatives exist.

d). **Drawing Blood, Bodily Fluids or Tissue Samples** such as that done for laboratory testing and analysis. The material risks associated with this type of Procedure include, but are not limited to, paralysis or partial paralysis, nerve damage, infection, bleeding and loss of limb function. Apart from long-term observation, no practical alternatives exist.

e). **Radiological Studies** such as X-rays, CT scans or MRI scans. The material risks associated with these types of Procedures include, but are not limited to, radiation exposure.

If Patient has any questions or concerns regarding these **Medical Treatment/Services**, Patient will ask Patient's attending provider to provide Patient with additional information. Patient also understands that Patient's attending or other provider may ask Patient to sign additional informed consent documents concerning these or other **Medical Treatment/Services**.

4. Emergency and Labor Services

Patient understands Patient's right to receive an appropriate medical screening exam performed by a doctor, or other qualified medical professional, to determine whether Patient is suffering from an emergency medical condition, and if such a condition exists, stabilizing treatment within the capabilities of the PHC's staff and facilities, even if Patient cannot pay for these services, does not have medical insurance or Patient is not entitled to Medicare or Medicaid.

5. Healthcare Practitioners in Training

Patient recognizes that among those who may attend Patient at SCFP are medical, nursing and other health care personnel who are in training and who, unless specifically requested otherwise, may be present and participate in patient care activities as part of their medical education. There also may be present from time to time a medical product or medical device representative. Consent is hereby given for the presence and participation of such persons as deemed appropriate by the attending physician.

6. Remaining in Patient Care Area and Closed Circuit Monitoring/Videotaping/Photography

Patient acknowledges and understands that, Patient is advised to remain in the patient care area at all times to optimize Patient's medical care and safety. If Patient chooses to leave the area for reasons that are not treatment related, Patient assumes any and all liability for any incident, accident, misadventure or harm, including deterioration of Patient's condition, which Patient may suffer. Patient agrees to hold SCFP all Healthcare Professionals, harmless for any injury or harm resulting from Patient's decision to leave the patient care area and Patient accepts any and all responsibility for such actions. Patient also understands that closed circuit monitoring, videotaping and photography patient care may be used for educational, clinical purposes and/or safety related purposes.

7. Authorization to Release Information

SCFP is authorized to use and release information contained in the patient record as described in the SCFP Notice of Privacy Practices and as otherwise permitted or required by law. The information authorized to be used or released will include, but is not limited to, infectious or contagious disease information, including HIV/AIDS-related evaluations, diagnosis or treatment, information about drug/alcohol abuse or treatment of same and/or psychiatric or psychological information. Patient waives any privilege pertaining to such confidential information and hereby releases SCFP, its agents and employees from any and all liabilities, responsibilities, damages, claims and expenses arising from the use and release of information as authorized above. Permissible uses and disclosures include, but are not limited to, disclosures to insurance companies, their agents or other third party payors and/or government or social service agencies that may or will pay for any part of the medical expenses incurred or authorized by representatives of SCFP; alternate care providers, and services, for post-clinical care as ordered by Patient's (SCFP) physician or as requested by Patient or Patient's family or as otherwise permitted by law; or SCFP affiliates and contractors, in such case Piedmont Clinic/Hospitals, Southern Regional Medical Center, Atlanta Medical Center (Wellstar) and any of their affiliates for SCFP operations purposes, such as quality improvement, compliance and risk assessment activities. **PATIENT ACKNOWLEDGES AND AGREES THAT PATIENT'S RECORDS WILL BE AVAILABLE TO ALL SCFP AFFILIATED ENTITIES AND PROVIDERS, AND TO NON-SCFP AFFILIATED REFERRING PROVIDERS IN COMPLIANCE WITH THE PROVISIONS OF MEANINGFUL USE.** By consenting to treatment and accepting financial responsibility for any such treatment, Patient also understands and acknowledges that (a) SCFP, from time-to-time, may call and/or text the cell number Patient has provided or email treatment-related information to Patient, such as appointment and exam confirmations and reminders, wellness checkups, pre-operative instructions, prescription notifications, preventative screening and vaccine reminders; and (b) Patient's preferences to receive, change or stop these and other types of communications from Piedmont may be done by logging into the HEALOW Patient Portal at any time.

8. Personal Valuables

Patient acknowledges that SCFP shall not be liable for the loss or damage of any personal belongings, including but not limited to money, cell phones, laptops, electronic devices, jewelry, hearing aids, computers or dentures.

9. Consent Timeframe and Applicability

The above consents are applicable to all ambulatory, physician office based services, all outpatient-based services as well as non-critical services within a clinical setting. With respect to inpatient hospital based services, including infants delivered and newborn care at any SCFP Hospital affiliate, consents **ARE NOT VALID AND ARE CONSIDERED INDEPENDENT**. For services provided directly through SCFP or by an SCFP physician in an SCFP clinic, the above consents are valid for a period of one (1) year from the date of signature below.

Validity of Form

Patient acknowledges that a copy, or an electronic version of this document may be used in place of and is as valid as the original.

Patient understands that the Healthcare Professionals participating in the Patient's care will rely on Patient's documented medical history, as well as other information obtained from Patient, Patient's family or others having knowledge about Patient, in determining whether to perform or recommend the Procedures; therefore, Patient agrees to provide accurate and complete information about Patient's medical history and conditions.

Patient confirms that Patient has read and understood and accepted the terms of this document and the undersigned is the Patient, the Patient's legal representative or is duly authorized by the Patient as the Patient's general agent to execute the above and accept its terms.

Patient/Patient Representative Signature	Patient Name (**PRINT**)	Date	Time

Relationship to Patient	Reason Patient is unable to sign

SCFP Healthcare Representative Signature	SCFP Healthcare Representative Name (**PRINT**)	Date	Time

Southern Crescent Family Practice, LLC
455 Forest Parkway
Forest Park, GA 30297
678-705-0100 (P)
678-235-1800 (F)

Patient Financial Agreement and Responsibilities

Southern Crescent Family Practice is committed to providing patients with information regarding their coverage and financial responsibilities. In consideration of services provided by Southern Crescent Family Practice (SCFP), the Patient or undersigned representative acting on behalf of the Patient agrees to the following:

1. Emergency and Labor Services

Patient understands his/her right to receive an appropriate medical screening exam performed by a doctor or other qualified medical professional to determine whether Patient is suffering from an emergency medical condition, and if such a condition exists, stabilizing treatment within the capabilities of the SCFP staff and facility. Patient understands that emergency services that are beyond SCFP ability to treat in an ambulatory-physician/office based setting, if Patient does not have medical insurance or Patient is not entitled to Medicare or Medicaid.

2. Non-Medicare Patient Responsibility for Payment

In return for **Medical Treatment/Services** rendered to the Patient; Patient understands and unconditionally agrees to the following:

- Patient agrees to pay all co-payments, deductibles or co-insurances prior to or at the time of service/visit.
- Patient understands and agrees that he/she will be charged SCFP standard charge master rates for all services not covered by a Payor, in which case if in- network will be the Payors in-network allowable charges, for out-of network Payors SCFP charges based on the Payors usual and customary or reasonable fees.
- Patient specifically agrees to pay for any services, which are determined not to be covered by any health benefit plan or insurance company.
- Patient is aware that he/she is not relieved of liability by any extension of time granted for the payment of these charges, not by the acceptance of SCFP, a promissory note of the patient or any third party person, or debit/credit card automatic withdrawal system.
- If SCFP requires legal assistance to collect an account, Patient agrees to pay the cost incurred for such collections.
- SCFP may use data from third parties such as credit reporting agencies in order to verify demographic data or evaluate financial options and by this authorization expressly permit sources and employers to provide SCFP with all information requested.

3. Assignment of Insurance or Health Plan Benefits

Patient acknowledges the assignment and authorization for direct payment to SCFP for all insurance and health plan benefits and settlements whether commercial medical or medicare insurance including but not limited to, the proceeds of any settlement or judgment of any third party claim as payment for any and all services performed at SCFP. Patient agrees that the insurance company's or health plan's payment to SCFP pursuant to this authorization shall discharge the insurance company's or health plan's obligations to the extent of such payment.

4. Filing of Third Party Claims

Patient acknowledges that SCFP does not submit or accept payment of insurance benefits from third party payors ("Payors") to be credited to Patient's account. Patient agrees that the filing of insurance claims is performed as a service and in no way relieves Patient of the obligation to pay in full. Additionally the Patient acknowledges the following:

- Patient is responsible to follow up with any insurance company or employer within 30 days to see that Patient's bill is paid promptly.
- Patient understands that he/she is financially responsible for charges not paid according to this agreement. If Patient overpays the amount owed on his/her account, Patient assigns credit to be applied to any other existing unpaid accounts ("Other Accounts") for which the Patient or the insured or guarantor is also responsible. Any money remaining after the Patient's account and Other Accounts have been paid in full will be refunded to the patient or guarantor.
- Insurance companies will often deny claims when the insurance is not presented at the time of service. Please contact our Billing Department with your Insurance/Payor information by email at billing@scfp.llc. Otherwise your account may be considered self-pay/uninsured and you will be responsible for the total bill.

5. Assignment of Medicare Benefits

Patient certifies that the information given in applying for payment under Title XVIII of the Social Security Act is correct. Patient requests that the payment of authorized benefits be made on Patient's behalf to the provider of Medical Treatment/Services. Patient assigns the benefits payable for Medical Treatment/Services rendered by SCFP and all Healthcare Professionals rendering care and/or treatment to Patient and authorizes SCFP and Healthcare Professionals to submit claims to Medicare for payment. Patient authorizes any holder of medical or other information to release to Medicare and its agents any information needed to determine these benefits or benefits for related services. Patient understands he/she is responsible for any deductibles, co-payments, co-insurances, and/or non-covered services as defined by Medicare to be paid in accordance with all terms and conditions specified herein.

6. Assignment of Medicaid Benefits

Patient certifies that the information given in applying for payment under Title XIX of the Social Security Act is correct. Patient authorizes any holder of medical or other information to release to the Social Security Administration or its intermediaries or carriers any and all information needed for this or related Medicaid secondary Payor claims. Patient requests payment of authorized benefits be made on Patient's behalf to the provider of Medical Treatment/Services. Patient assigns the benefits payable for Medical Treatment/Services rendered by DCFP and all Healthcare Professionals rendering care and/or treatment to Patient and authorizes SCFP and Healthcare Professionals to submit claims to Medicaid for payment.

7. Authorization to Release Information

SCFP is authorized to use and release information contained in the patient record as described in the SCFP Notice of Privacy Practices and as otherwise permitted or required by law. The information authorized to be used or released will include, but is not limited to, infectious or contagious disease information, including HIV or AIDS-related evaluations, diagnosis or treatment, information about drug or alcohol abuse or treatment of same and/or psychiatric or psychological information. Patient waives any privilege pertaining to such confidential information and hereby releases SCFP, its agents and employees from any and all liabilities, responsibilities, damages, claims and expenses arising from the use and release of information as authorized above. Permissible uses and disclosures include, but are not limited to, disclosures to insurance companies, their agents or other third party payors and/or government or social service agencies that may or will pay for any part of the medical/hospital expenses incurred or authorized by representatives of SCFP; alternate care providers, including community agencies and services, for post-hospital care, as ordered by Patient's physician or as requested by Patient or Patient's family or as otherwise permitted by law; or SCFP affiliates and contractors for SCFP operations purposes, such as quality improvement, compliance and risk assessment activities. **PATIENT ACKNOWLEDGES AND AGREES THAT PATIENT'S RECORDS WILL BE AVAILABLE TO ALL SCFP AFFILIATED ENTITIES AND PROVIDERS, AND TO NON-SCFP AFFILIATED REFERRING PROVIDERS IN COMPLIANCE WITH THE PROVISIONS OF MEANINGFUL USE**. By consenting to treatment and accepting financial responsibility for any such treatment, Patient also understands and acknowledges that (a) SCFP, from time-to-time, may call and/or text the cell number Patient has provided or email treatment-related information to Patient, such as appointment and exam confirmations and reminders, wellness checkups, hospital pre-registration instructions, pre-operative instructions, post-discharge follow-up, prescription notifications, Medicare-required surveys, and home healthcare instructions and (b) Patient's preferences to receive, change or stop these and other types of communications from Southern Crescent Family Practice may be done by logging into the Healow Patient Portal at any time.

8. Consent Timeframe and Applicability

The above agreements are applicable to all ambulatory, outpatient, or physician office-based services and are valid for a term of one (1) year from the date of signature below.

Validity of Form

Patient acknowledges that a copy or an electronic version of this document may be used in place of and is as valid as the original. **The patient confirms that he/she has read and understood and accepted the terms of this document and he/she is the patient, the patient's legal representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.**

Patient/Patient Representative Signature	Patient Name (**PRINT**)	Date	Time

Relationship to Patient	Reason Patient is unable to sign

SCFP Healthcare Representative Signature	SCFP Healthcare Representative Name (**PRINT**)	Date	Time

SOUTHERN CRESCENT FAMILY PRACTICE, LLC
455 FOREST PARKWAY,
FOREST PARK, GA, 30297
TEL: 678-705-0100
FAX: 678-235-1800

HIPAA OMNIBUS RULE PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient/Guardian of Patient

_____ _____

Legal Representative/Guardian Relationship of Legal Representative/Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA?

☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone ☐ Home Phone Confirmation

☐ Email Confirmation ☐ Work Phone Confirmation ☐ **Any of the above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone ☐ Home Phone Confirmation

☐ Email Confirmation ☐ Work Phone Confirmation ☐ **Any of the above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

□ Phone Message ☐ **Any of the above** □ Text Message ☐ **None of the above** (opt out)

□ Email

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Patient Registration

PATIENT INFORMATION

Full legal name (First, Middle, Last, suffix) _____ **Nickname** _____ **Sex:** ❑ Male ❑ Female

Date of birth _____ **Social security number** _____ **Race** _____ **Preferred language** _____

Ethnicity: ❑ Hispanic ❑ Non-Hispanic **Marital status**: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Life partner

Complete mailing address: _____
(Street, city, state, zip code, county)

Home phone number: _____ **Cell phone number**: _____ **Work number**: _____

Email: _____

Employment status: ❑ Full-time ❑ Part-time ❑ Active duty ❑ Self-employed ❑ Not employed ❑ Retirement date: _____

Employer name: _____ **Employer phone number**: _____

Employer complete address: _____
(Street, city, state, zip code)

SPOUSE OR GUARANTOR INFORMATION (Responsible party) ❑ Same as patient

Full legal name (First, Middle, Last, suffix) _____ **Date of birth** _____ **Social security number** _____

Relation to patient: ❑ Self ❑ Spouse ❑ Mother ❑ Father ❑ Legal guardian ❑ Other: _____ **Sex**: ❑ Male ❑ Female

Home phone number: _____ **Cell phone number**: _____ **Work number**: _____

Complete mailing address – if different from patient: _____
(Street, city, state, zip code, county)

Employment status: ❑ Full-time ❑ Part-time ❑ Active duty ❑ Self-employed ❑ Not employed ❑ Retirement date: _____

Employer name: _____ **Employer phone number**: _____

Employer complete address: _____
(Street, city, state, zip code)

EMERGENCY CONTACT INFORMATION

Name (First, Last): _____

Relation to patient: ❑ Spouse ❑ Mother ❑ Father ❑ Legal guardian ❑ Other: _____

Home phone number: _____ **Cell phone number**: _____ **Work number**: _____

Complete mailing address – if different from patient: _____

INSURANCE INFORMATION ❑ Self-pay (no insurance)

Primary insurance: _____ **Patient relation to subscriber**: ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

Secondary insurance: _____ **Patient relation to subscriber**: ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

Prescription/Rx provider: _____ **(if different from insurance carrier)**

Full name of subscriber: _____ **(complete below if different from patient, spouse or guarantor)**

Subscriber date of birth: _____

Employment status: ❑ Full-time ❑ Part-time ❑ Active duty ❑ Self-employed ❑ Not employed ❑ Retirement date: _____

Employer name: _____ **Employer size**: ❑ 0 – 19 employees ❑ 20 – 99 ❑ 100+

Employer complete address: _____
(Street, city, state, zip code)

Primary care physician:	**Do you want anyone to know you are here? ❑ Yes or ❑ No**

Medical History

Full name:_____ Date of birth:_____ Date:_____

Primary doctor:_____

Doctor who requested today's visit: _____

List current/previous doctors and their specialty:_____

_____

ALLERGIES AND REACTIONS

_____

_____

_____

_____

MEDICATIONS (list dosage and how you take them, including non-prescription, herbs, birth control)

_____

_____

_____

PAST MEDICAL ILLNESSES (please check if you have had the following):

- ❑ Alcohol/Drug addiction
- ❑ Anemia
- ❑ Aneurysm
- ❑ Anxiety disorder
- ❑ Arthritis
- ❑ Asthma
- ❑ Blood disorder
- ❑ Blood clot
- ❑ Blood transfusion
- ❑ Cancer (type):
  - ❑ Breast ❑ Ovarian
  - ❑ Colon ❑ Uterine
  - ❑ _____
- ❑ Crohn's disease
- ❑ COPD/Emphysema
- ❑ Depression
- ❑ Diabetes
- ❑ Glaucoma
- ❑ Gout
- ❑ Hay fever
- ❑ Heart disease
- ❑ Heart murmur
- ❑ Hepatitis B or C
- ❑ High cholesterol
- ❑ HIV
- ❑ Hypertension
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Liver disease
- ❑ Seizure
- ❑ Sexually transmitted disease (type):
  _____
- ❑ Sickle cell disease
- ❑ Sleep apnea
- ❑ Stomach ulcer
- ❑ Stroke
- ❑ Thyroid disease
- ❑ Tuberculosis
- ❑ (Positive) TB skin test
- ❑ Ulcerative colitis
- ❑ Other:_____

OPERATIONS	DATES	HOSPITALIZATIONS	DATES

FAMILY HEALTH HISTORY ❑ Adopted

Family Members		Major Medical Problems	If Deceased, Causes	Age at Death
Maternal Grandmother				
Paternal Grandmother				
Maternal Grandfather				
Paternal Grandfather				
Mother				
Father				
Brothers and Sisters	1) ❑ M ❑ F			
	2) ❑ M ❑ F			
	3) ❑ M ❑ F			
Sons and Daughters	1) ❑ M ❑ F			
	2) ❑ M ❑ F			
	3) ❑ M ❑ F			

SOCIAL HISTORY

Occupation:		Marital Status:		Children: ❑ Yes ❑ No
Do you drink alcohol?	❑ Yes ❑ No	How often?		How many drinks?
Do you smoke?	❑ Yes ❑ No	Packs per day:	❑ ¼ pack ❑ 1½ packs	How many years?_____
Are you a former smoke?	❑ Yes ❑ No		❑ ½ pack ❑ 2 packs	Year quit?_____
Do you chew tobacco?	❑ Yes ❑ No		❑ 1 pack ❑ Other:_____	

Do you use recreational/illegal drugs? ❑ Yes ❑ No

Have you worked with asbestos or other hazardous materials? ❑ Yes ❑ No

Do you have a living will? ❑ Yes ❑ No Healthcare proxy? ❑ Yes ❑ No If so, who?
Advanced Directive for Healthcare

HEALTH MAINTENANCE

Last menstrual period:_____ Last pap smear:_____ Last mammogram:_____

Last colonoscopy:_____ Last prostate cancer screening:_____ Last bone density scan:_____

Immunizations: PPV23 / PCV13:_____ ❑ Flu:_____ ❑ TDaP:_____ ❑ COVID I & II:_____

REVIEW OF YOUR SYMPTOMS (please check if you have recently had the following symptoms):

❑ Weight gain	❑ Persistent cough	❑ Blood in stool	❑ Headaches
❑ Weight loss	❑ Chest discomfort	❑ Difficulty urinating	❑ Memory loss
❑ Night sweats	❑ Palpitations	❑ Trouble holding urine	❑ Numbness/Tingling
❑ Weakness	❑ Fainting	❑ Frequency of urination	❑ Tremor
❑ Fatigue	❑ Change in exercise tolerance	❑ Penis discharge	❑ Uncontrollable mood swings
❑ Insomnia	❑ Difficulty swallowing	❑ Vaginal discharge/bleeding	❑ Anxiety
❑ Change in hearing	❑ Indigestion or heartburn	❑ Nipple discharge	❑ Depression
❑ Change in vision	❑ Nausea	❑ Breast pain	❑ Skin Rash
❑ Runny nose	❑ Vomiting	❑ Breast lump	❑ Back pain
❑ Nose bleed	❑ Constipation	❑ Pain with intercourse	❑ Leg pain
❑ Fever	❑ Diarrhea	❑ Feeling too hot	❑ Leg swelling
❑ Blood in sputum	❑ Change in bowel habit	❑ Feeling too cold	❑ Other:_____
❑ Shortness of breath	❑ Blood in vomit	❑ Dizziness	

Please list all your reason(s) for visiting today in order of priority:

1. _____
2. _____
3. _____

Patient/Designee signature | Patient name (**PRINT**) | Date | Time

Relationship to patient | Reason patient is unable to sign