**Patient Information: (Please fill out every field completely. Circle Items in blue**)

|  |  |  |  |
| --- | --- | --- | --- |
| First Name and M.I. |  | I II III IV V | Other: |
| Last Name |  | Jr Sr |
| Mailing Address |  | Date of Birth: |
| Address line 2 |  |  |
| City, State |  | Phone Number: |
| Zipcode |  |  |
| Sex: M F |  | Relationship to patient: |
| Email Address |  | Self Parent Spouse Guardian |

Insurance information

(Disregard fields if they are completed above)

|  |  |
| --- | --- |
| Insurance Name: | Insurance Phone: |
| Subscriber name: | Subscriber DOB: |
| Member ID: |
| Group Name/Employer: | Group ID Number: |
| Relationship to Subscriber: Self Spouse Child Other: |
| Concerns/Questions: |
|  |
|  |

I authorize release of my information in the event of an emergency to the following person: (If none, leave blank)

|  |  |
| --- | --- |
| Emergency Contact Name: |  |
| Emergency Contact Phone: |  |
| Any Restrictions: |  |
| Relationship: |  |

Signature\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature of patient/responsible party)

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Patient \_\_\_\_\_\_\_\_

*\*If the patient is unable to sign this agreement or is a minor, I am entering into the agreement on behalf of and as the legally authorized representative of the patient. The appropriate paperwork has been given by the patient to the Clinic.*

**HIPPA PROTECTED HEALTH INFORMATION – ACCESS FORM**

I understand that stated and federal laws permit HALLSVILLE MEDICAL CLINIC to share Protected Health Information), with the persons involved in my care or the payment of my health care services. I further understand that I have (i) the right to grant certain persons access to my PHI and (ii) the opportunity to restrict access to my PHI from certain persons who might otherwise have access. I understand that granting access DOES NOT give the person access to copies of my medical records.

Access: I grant permission for the following persons to have access to my Protected Health Information.

NAMES (please print) DOB Phone Number

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

I understand that I may change or revoke this form at any time by contacting the Health Information Management Department (directly forwarded to the Business Office Administrator) at the Hallsville Medical Clinic office location. I understand that such changes or revocation will not be effective for disclosures that have already been made or access which has already occurred based on this form.

YES or NO You may leave confidential clinical information on my answering machine/voicemail.

Signature\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature of patient/responsible party)

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Patient \_\_\_\_\_\_\_\_

*\*If the patient is unable to sign this agreement or is a minor, I am entering into the agreement on behalf of and as the legally authorized representative of the patient. The appropriate paperwork has been given by the patient to the Clinic.*

***CONSENTS AND AGREEMENTS SIGNATURE***

 *I understand that the following packets of paperwork were made available to me to review before and at my initial new patient visit. My signature below indicates my authorization of these policies IN REGARDs TO my medical treatment. I can request a copy of any/all of these documents at any time, and I am aware they are also available for review on* [*www.hallsvillemedicalclinic.com*](http://www.hallsvillemedicalclinic.com)

* Patient Consent – (GIVING CONSENT TO RECEIVE TREATMENT AT THE CLINIC LOCATION, RELEASE/ACQUISITION OF INFORMATION, HEALTH INFORMATION EXCHANGE, HIPPA NOTICE OF PRIVACY PRACTICES)
* Patient Authorization – (assignment OF BENEFITS, FINANCIAL responsibility, AUTOMATED COMMUNICATIONS, OUTPATIENT DEPARTMENT)
* Financial Policy – (AGREEMENT OF FINANCIAL responsibility, THE CLINIC’S RIGHT TO COLLECT PAYMENT FOR SERVICES, AND TO BILL INSURANCE IF ALLOWABLE)
* CLINIC CARE CONSENT – (GENERAL CONSENT, PERSONAL PROPERTY, RIGHTS AND ADVANCE DIRECTIVES, FINANCIAL ASSISTANCE, RELEASE OF INFORMATION, MEDICARE/MEDICAID BENEFITS, COMMUNICATIONS, ACCIDENTAL EXPOSURE AND STATE REPORTING, OWNERSHIP, PHOTOGRAPHY, ETHICS, TEACHING AND OBSERVATION, NOTICE OF PRIVACY PRACTICES, DIRECTORY, ASSIGNMENT OF BENEFITS, INSURANCE NETWORK, BALANCE BILLING DISCLOSURES)

(Requests for these documents can be made by email to hmc@hallsvillemedicalclinic.com or in person)

**ACKNOWLEDGEMENT:** By signing below, I certify that I have read this document, understand its contents and agree to the terms. I acknowledge that I am the patient, or I am the patient’s legally authorized representative and/or Guarantor. A photocopy or a faxed copy of this consent shall be deemed as valid as the original.

Signature\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature of patient/responsible party)

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Patient \_\_\_\_\_\_\_\_

*\*If the patient is unable to sign this agreement or is a minor, I am entering into the agreement on behalf of and as the legally authorized representative of the patient. The appropriate paperwork has been given by the patient to the Clinic.*

**MEDICAL HISTORY**

***(please fill out in entirety- if you have questions, you can ask the MA, or PA-C)***

|  |  |  |  |
| --- | --- | --- | --- |
| Last Name: | First Name: | DOB: | M or FOther: |
| Marital Status: *(Circle)* Single Partnered Married Separated . Divorced Widowed | Occupation: |
| Previous/Referring Doctor: | Date of last Physical: / / |
| Medications: Please bring all prescription medications you are currently taking |
| Name | Dose/Directions | Reason |
|  |  |  |
|  |  |  |
|  |  |  |

*(Additional room on back of next page if needed. A physical list is also a acceptable substitute)*

|  |  |
| --- | --- |
| Allergies  | Reactions |
|  |  |
|  |  |
|  |  |

Do you currently have, or have ever had, any of the following illnesses or conditions:

* **Anemia**
* **Abnormal Pap**
* **Alcohol/Drug use**
* **Anxiety/Depression**
* **Arthritis**
* **Asthma**
* **Atrial Fibrillation**
* **Blood Clots**
* **Cancer**
	+ **Type: \_\_\_\_\_\_\_\_\_\_**
* **Chronic Lung Disease**
* **Colon/Bowel Disease**
* **Diverticulites**
* **Dementia**
* **Diabetes**
	+ **(type I or II)**
	+ **\_\_\_\_\_\_\_\_\_\_**
* **Gallbladder Disease**
* **Emphysema**
* **Heart Attack**
* **Glaucoma**
* **Head injury**
* **Gout**
* **Hay Fever**
* **Heart Disease**
	+ **Type \_\_\_\_\_**
* **Hepatitis/Liver Disease**
* **Hernia**
* **High Blood Pressure**
* **High Cholesterol**
* **Heart Murmur**
* **Infection of the uterus**
* **Kidney Disease**
* **Migraines**
* **Neuropathy**
* **Osteoporosis**
* **Other injuries**
* **Peripheral Artery Disease**
* **Pneumonia**
* **Positive TB test**
* **Prostate problem**
* **Psychiatric – Depression**
* **Psychiatric – Other**
* **Rheumatic Fever**
* **Seizures**
* **Sexually Transmitted Disease**
* **Sleep Apnea**
* **Stroke**
* **Thyroid Disease**
* **Tuberculosis**
* **Ulcer**

|  |  |
| --- | --- |
| **Surgical and Hospitalization History**  | **Dates** |
|  |  |
|  |  |
|  |  |
| **Immunizations** | Date | Immunization | Date |  | Date |
| Flu Vaccine |  | Zostavax (Shingles)Shinglex (Shingles) |  | Pneumococcal PPV23 |  |
| TDAP (Whooping cough/tetanus) |  | HPV |  | Hepatitis A |  |
| Pneumococcal PCV13 |  | Meningococcal ACWY |  | Hepatitis B |  |
| Covid-19 (*type):* |  | Menigococcal B |  | TD (tetanus shot) |  |

**Please list the names of physicians and specialists you have seen:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Specialty  | Name  | Specialty  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Item** | **Date last performed** | **Result (if applicable)** | **Comments** |
| Aortic Aneurysm Screen |  |  |  |
| Cholesterol Test |  |  |  |
| Colonoscopy |  |  |  |
| Dental Exam |  |  |  |
| Eye Exam |  |  |  |
| Hepatitis C Test |  |  |  |
| HIV Test |  |  |  |
| HPV Test |  |  |  |
| Mammogram |  |  |  |
| Pap Smear |  |  |  |
| Prostate Exam |  |  |  |
| Stool Test for Blood |  |  |  |
| **Family History****(use back of page if needed)****Please circle items in blue** | **Age** | **Medical Conditions****Indicate Healthy or diabetes, high blood pressure, cholesterol, heart disease, stroke, cancer (type)** |
| Mother | Living or Deceased  |  |  |
| Father | Living or Deceased  |  |  |
| Sibling | M or F  | Living or Deceased  |  |  |
| Sibling | M or F | Living or Deceased  |  |  |
| Sibling | M or F | Living or Deceased  |  |  |
| Sibling | M or F | Living or Deceased  |  |  |
| Grandmother (Mother’s side) | Living or Deceased  |  |  |
| Grandfather (Mother’s side) | Living or Deceased |  |  |
| Grandmother (Father’s side) | Living or Deceased |  |  |
| Grandfather (Father’s side) | Living or Deceased |  |  |
| Children | M or F | Living or Deceased |  |  |
| Children | M or F | Living or Deceased |  |  |
| Children | M or F | Living or Deceased |  |  |
| Other Family | Cancer Heart Attacks Stroke Diabetes |

**Patient History**

|  |  |  |
| --- | --- | --- |
| Smoking | Cigarette Use: Never Former Smoker Current Smoker | Date or Age quit:Other tobacco use (*please circle*): Pipe, Cigars, Chewing Tabaco Other: E-Cigarettes Marijuana |
| Alcohol | Do you drink Alcohol? YES or NOFrequency per month:Frequency per Week: | Each week, how many: \_\_\_\_\_Servings of beer? \_\_\_\_\_\_\_\_\_\_Glasses of wine? \_\_\_\_\_\_\_\_\_\_\_ |
| Drugs |  Have you used recreational or street drugs within the last two years? Yes or NoHave you ever used recreational drugs with a needle? Yes or No |
| Sexual Health | Sexually Active: Yes or No | Sexual Partners: Male Female |
| # of children\_\_\_\_\_# of pregnancies\_\_\_\_# of miscarriages\_\_\_\_# of abortions\_\_\_\_Date of last menstrual period (start date): \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |
| Women: |  |

**TO THE BEST OF MY KNOWLEDGE, THE INFORMATION I HAVE GIVEN ABOVE IS ACCURATE, COMPLETE, AND TRUE.**

Signature\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature of patient/responsible party)

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Patient \_\_\_\_\_\_\_\_

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