**Patient Demographics**

|  |  |  |
| --- | --- | --- |
| Last Name | First Name | Middle Name |

|  |  |
| --- | --- |
| Birthdate: | SSN: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Gender: | Female |  | Male |  |

|  |  |
| --- | --- |
| Address: |  |
| Email Address: |  |
| Phone Number: | Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |
| --- | --- | --- |
| Primary Language: | Race: | Ethnic Origin: |

|  |  |
| --- | --- |
| Insurance Company |  |
| Member/Subscriber ID: |  |
| Policy Holder Name |  |
| Copay | $ |
| Social Security Number |  |
| Relationship to Patient |  |
| Birthdate |  |
| Phone Number |  |

|  |  |
| --- | --- |
| Insurance Company |  |
| Member/Subscriber ID: |  |
| Policy Holder Name |  |
| Copay | $ |
| Social Security Number |  |
| Relationship to Patient |  |
| Birthdate |  |
| Phone Number |  |

Primary Insurance Secondary Insurance

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Were you referred to our office? | No |  | Yes |  | If yes, how or by whom? |

|  |  |  |  |
| --- | --- | --- | --- |
| Next of Kin / Contact |  | \_\_ Cell \_\_\_ Home Phone |  |
| Relationship to Patient |  | Address |  |

*I release to The Center for Integrated Health Care, PC the above confidential information and authorization to use this information for billings insurance claims as well as notifications to other providers, when indicated.*

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

Patient’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health History**

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

 Last, First Middle Initial

**1. Previous Medical and Surgical History**

1. **Past surgeries** (including broken bones, accidents, etc.; list by age):

|  |
| --- |
|  |

1. **Illnesses** (including hospitalizations):

|  |
| --- |
|  |

1. **Allergies** (drug, environmental, food...etc):

|  |  |  |
| --- | --- | --- |
| **Name** | **Reaction** | **Mild, Moderate, Severe** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

1. **Immunizations** (list last date/year administered):

|  |  |
| --- | --- |
| **Type** | **Date, Year Administered** |
| Tetanus |  |
| Flu  |  |
| Pneumonia  |  |
| Hepatitis B |  |
| Other (list): |  |
|  |  |
|  |  |

1. **Current Medications** (please list name, dosage/strength, and frequency):

|  |
| --- |
|  |
| Preferred Pharmacy (name, location): My pharmacy informs me when prescriptions are ready for pick up. \_\_Yes \_\_ No |

1. **Do you have any of the following medical conditions?**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Diabetes |  | Heart Disease |  | Asthma |  |
| High Blood Pressure |  | Thyroid Problems |  |  |  |

 **2. Social History:**

1. **Marital Status:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Single |  | Married |  | Widowed |  | Divorced |  | Separated |  |

1. **Children:**

|  |  |
| --- | --- |
| How Many? | Years of Birth? |

1. **Education:**

|  |  |
| --- | --- |
| # of Years Completed | Degree |

1. **Current Employer:**

|  |  |  |
| --- | --- | --- |
| Company | Position | Time with Company |

1. **Cigarette Use:** (please check one)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Never Smoker |  | Former Smoker |  |  |  |
| Current Light Smoker 1-9 Day |  | Moderate Smoker10-19 Day |  | Current Heavy Smoker 20-39 Day |  |

 F. **Alcohol Use**:

|  |  |
| --- | --- |
| Number of Drinks per day | Times Per Week |

**3. Family History:**

Please answer the following about your medical history. Please note hypertension, diabetes, heart disease, alcoholism, mental illness, or thyroid)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Relation** | **Living**  | **Deceased**  | **Age/ Age at death** | **Diseases** |
| Mother |  |  |  |  |
| Father |  |  |  |  |
| Child |  |  |  |  |
| Child |  |  |  |  |
| Child |  |  |  |  |
| Maternal Grandmother |  |  |  |  |
| Maternal Grandfather |  |  |  |  |
| Paternal Grandmother |  |  |  |  |
| Paternal Grandfather |  |  |  |  |
| Sibling |  |  |  |  |
| Sibling |  |  |  |  |
| Sibling |  |  |  |  |

**4. Review of Symptoms (check all that apply):**

1. **General:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Fatigue |  | Weakness |  | Daytime Sleepiness |  |
| Fever |  | Night Sweats |  | Difficulty Sleeping |  |
| Weight Loss |  | Weight Gain |  |  |  |

 B. Skin

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Rash |  | Easy Bruising |  | Moles |  |
| Itching |  | Dry Skin |  | Acne |  |

 C. **Eyes:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Contacts/Glasses |  | Dry Eyes |  | Blindness |  |
| Itchy Eyes |  | Glaucoma |  | Cataract Surgery |  |
| Double Vision |  |  |  |  |  |

 D. **Ears, Nose, Throat, and Sinus:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Nasal Congestion |  | Post Nasal Drip |  | Snoring |  |
| Trouble Swallowing |  | Painful Swallowing |  | Hoarse Voice |  |
| Hearing Loss |  | Hearing Aids |  | Dentures |  |
| Allergies |  | If yes to allergies: Seasonal |  | Environmental |  |

 E. **Lungs:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Asthma |  | Mourning Cough |  | Wheezing |  |
| Chest Tightness |  | Pauses in Breath |  | Sputum Production |  |
| Shortness of Breath |  |  |  |  |  |

 F. **Heart:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Chest Pain |  | Heart Murmur |  | Heart Palpitations |  |
| Chest Pressure/Fullness |  | Racing Heart Rate |  |  |  |

 H. **Joints:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Arthritis? |  | Gout? |  | Neck Pain? |  |
| Back Pain? |  | Use a walker? |  | Use a cane? |  |
| Use a wheelchair? |  | Tried physical therapy? |  | Tried a chiropractor? |  |
| Tried massage therapy? |  |  |  |  |  |

 I. **Breast:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Nipple Discharge |  | Fibrocystic Changes |  | Cyclic Pain |  |
| Lumps non painful |  | Lumps painful |  |  |  |

 J. **Neurological:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Headaches |  | Migraines |  | Cluster Headaches |  |
| Seizure |  | Tremor |  | Head Injury |  |
| Blackouts |  | Fainting |  | Memory Loss |  |
| Lightheadedness |  | Paralysis |  |  |  |

 K. **Rectal:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Rash |  | Hemorrhoids |  | Rectal Pain |  |
| Rectal Bleeding |  | Black Stools |  | Problems Holding Stool |  |

 L. **Urinary:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Burning |  | Blood in Urine |  | Problems Holding Urine |  |
| Problems Starting Urine |  | Prostate Infection |  | Urinary Tract Infection |  |
| Bladder Infection |  |  |  |  |  |

 M. **Gynecological (female):**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Vaginal Discharge |  | Vaginal Burning |  | Vaginal Itching |  |
| Sexual Problems |  | Hysterectomy |  | Severe Menstrual Cramps |  |
| Heavy Menstrual Bleeding |  | Irregular Periods |  | Pain During Intercourse |  |

 N. **Male Information:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Testicular Lumps |  | Testicular Swelling |  | Testicular Pain |  |
| Erectile Dysfunction |  | Penile Discharge |  |  |  |

 O. **Mental Health:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Nervousness/ Anxiety |  | Jumpy |  | Sweating |  |
| Restless |  | Fatigue |  | Irritability/Agitation |  |
| Hopeless Feeling |  | Constant Worry |  | Frequent Crying/Weeping |  |
| Sleeping Problems |  | Decrease in Sex Drive |  | Fearful Feelings |  |
| Fear of Dying |  | Thoughts of Death/Suicide |  | Lack of or Losing Focus |  |
| Forgetful |  | Feelings of Worthlessness |  | Sad/Down/Depressed |  |
| Increased Appetite |  | Decreased Appetite |  | Feelings of Invincibility |  |

**Authorizations and Policies**

**Insurance Company Assignment and Release**

I, the undersigned, do hereby assign directly to The Center for Integrated Health Care, PC all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance or myself for any of my dependents. I hereby authorize the release of all information necessary to secure payment of benefits. I authorize the use of my signature on all insurance claim submissions for myself or my insured dependents.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization for Treatment and Financial Responsibility**

I, the undersigned to hereby give authorization to the medical staff of The Center for Integrated Health Care, PC to evaluate, treat, order lab and/or other tests and to perform office procedures. I accept full financial responsibility (regardless of insurance payment or non-payment) for all charges incurred by myself or any person(s) I am responsible for (i.e. minor child, foster child, grandparent, and spouse, other…). Account balances must be cleared (no balance due) prior to scheduling another appointment unless prior arrangements have been made.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Appointment Policy**

Patients are requested to give notice as soon as possible when cancelling or rescheduling an appointment in order for the appointment slot to be available for someone else. Appointments cancelled with less than 24 hours’ notice or missed appointments will be charged a fee between $25-$75 depending on the appointment type and number of previously missed appointments. If a patient has an excess number of missed appointments or late cancellations he/she may be dismissed as a patient from the practice. An afterhours voicemail is provided for cancellations. By signing below I agree to the appointment policy and agree to pay any fees from missing my or my dependent’s appointment.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Notice of Electronic Health Communications Privacy Policies & Release Authorization**

This notice serves to inform you of how your protected health information (PHI) is used and disclosed upon your authorization to receive electronic health information through The Practice Fusion Patient Health record Portal (PHR).

**Use and Disclosure of Protected Health Information (PHI)** - Protected Health Information (“PHI”) may not be used or disclosed in violation of the Health Insurance Portability and Accountability Act (“HIPAA”) Privacy Rule (45 C.F.R. parts 160 and 164) (Herein after, the “Privacy Rule”) or in violation of state law.

Upon signing this authorization for either your consent or refusal of release of your PHI through our PHR, your rights are as follows:

 Your PHI will ONLY be disclosed to YOU via Practice Fusion’s secure Patient Health Record portal through the email addressed provided and verified by you during the set-up process. You may view Practice Fusion’s security statement by visiting [www.PracticeFusion.com](http://www.PracticeFusion.com). At any point, if you would like to un-enroll in the PHR, you may notify our staff in writing, and we will remove the authorization from your account.

 Your PHI transmitted through the PHR will never be sold, used or disclosed for any other purpose than for your personal use. We will never utilize the PHR for third-party marketing purposes.

**Benefits of the PHR portal: 24/7 electronic access to lab results, a secure messaging system which allows communication with Dr. Gerry and the front office staff (Kay, Danyell, & Patrice), an appointment scheduling tool, a list of past and upcoming appointments, reminders for upcoming appointments, and the ability to update your contact and insurance information**. To name just a few messaging options: You may use the system to request medication refills (direct refill requests to Kay); schedule, confirm, and cancel office visits; inquire about the status of lab orders and referral requests; report health updates, and more.

\_\_\_\_\_\_\_ **YES**, I give my permission for CIHC’s staff to enroll me in the Patient Health Record Portal. I understand that the transmission of my personal health information and communications with Dr. Gerry and office staff are securely sent through an email address that I provide and will verify during the set-up process.

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

\_\_\_\_\_\_\_\_ **NO**, I do not give my authorization to participate in the Patient Health Record. I understand that I will not have access to my personal health information via the Patient Portal. I also understand that should I decide at a later date to enroll, I may do so.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TEXT MESSAGES AUTHORIZATION**

We are now able to text appointment reminders, to obtain feedback, and to provide general health reminders/information to your cell phone.

 **If you would like to participate in this service, please complete the following consent.**

\_\_ I decline to participate.

\_\_ I consent to receiving appointment reminders and other healthcare communications & information via text from the Center for Integrated Health Care sent to my cell phone number and any number forwarded or transferred to from that number. \_\_\_\_\_\_**(patient’s initials)**

The cell number that I authorize to receive text messages is ( \_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that this authorization to receive text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing.

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_

Staff Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_

NOTE: For appointment reminders: **Please reply to reminder text messages to confirm or cancel your appointment.**

**Approved Contacts**

|  |  |
| --- | --- |
| **Patient Name:** |  |
| **DOB:** |  |
| **Phone #:** |  |
|  |  |

In accordance with HIPAA privacy regulations, only people listed as approved contacts on a patient’s chart can be communicated with regarding your private health information, appointment status, or account status.

Please complete the following fields to include the names of whomever we may communicate with regarding your account. Pleases select which information you give permission to share with the corresponding contact.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** | **Relationship:** | **Phone Number:** | **Permission to share:** |
|  |  |  |  Medication History/Status Appointment Status   Health Information/Updates   Account Balance/Status |
|  |  |  |  Medication History/Status Appointment Status   Health Information/Updates   Account Balance/Status |
|  |  |  |  Medication History/Status Appointment Status   Health Information/Updates   Account Balance/Status |
|  |  |  |  Medication History/Status Appointment Status   Health Information/Updates   Account Balance/Status |

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AUTHORIZATION TO RELEASE RECORDS

When completed and signed by you, this form authorizes CIHC to request your medical and/or clinical records from your prior health care provider.

Your Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

I hereby authorize the release of my medical and pharmaceutical records from (enter prior physician’s name and/or facility)

Name/Facility \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

to the Center for Integrated Health Care, PC

\_\_ Medical Records for period beginning \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization shall remain in effect until the information is either received or disclosed or I revoke said authorization.

I have the right to revoke this authorization in writing at any time by sending such written notification to CIHC offices. However, my revocation will not be effective to the extent that CIHC has acted in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my medical doctor generally may not condition medical services upon my signing this authorization unless the medical services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of this information and is no longer protected by the HIPAA Privacy Rule (45 C F R parts 160 and 164).

I have carefully read and understand the above statements, and I do herein expressly and voluntarily consent to disclosure of the above information.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_