

**HIPAA  
PATIENT CONSENT FORM**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice doesn't not have to agree to those restrictions
- The patient may revoke this Consent in writing at anytime and all future disclosures will cease
- The Practice may condition receipt of treatment upon the execution of this Consent

This consent is signed by: \_\_\_\_\_

Printed name—Patient or Representative (if pt a minor)

\_\_\_\_\_  
Signature

Witness: \_\_\_\_\_

\_\_\_\_\_  
Signature

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

COMPLETE THE ENTIRE FORM				DATE	
NAME		BIRTH DATE		AGE	M F
SOC SEC. # _____		SGLE	MAR	WID	DIV CHILD
HOW DID YOU HEAR ABOUT US? DOCTOR HOSPITAL FRIEND ANOTHER PATIENT - SPECIFY NAME					
		NEWSPAPER	RADIO	TV	
MAY WE CONTACT YOU AT HOME WORK CELL					
EMAIL ADDRESS					
PRESENT ADDRESS				HOME PHONE	
TOWN	STATE	ZIP	CELL PHONE		
OCCUPATION		EMPLOYER			
EMPLOYER ADDRESS				WORK PHONE	
NAME OF SPOUSE OR PARENT				PHONE	
ADDRESS					
OCCUPATION		EMPLOYER			
EMPLOYER ADDRESS				WORK PHONE	
PERSON TO CONTACT IN CASE OF EMERGENCY					
ADDRESS				PHONE	
PRIMARY MEDICAL INSURANCE - COMPANY				POLICY #	
NAME OF PRIMARY CARD HOLDER AND DATE OF BIRTH					
ADDRESS		SELF	SPOUSE	CHILD	OTHER
SECONDARY INSURANCE - COMPANY				POLICY #	
ADDRESS					
OTHER HEALTH INSURANCE					
<b>COSMETIC SURGERY AND MEDICATIONS ARE NOT COVERED BY MEDICAL INSURANCE</b>					

# Patient History Form

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

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

Date of Birth: \_\_\_\_\_

Current Age: \_\_\_\_\_

Male  Female

Occupation: \_\_\_\_\_ Company: \_\_\_\_\_

Family Physician and Address: \_\_\_\_\_

Who referred you to our office today? \_\_\_\_\_

## Your Medical History

Please indicate any of the following conditions you have now or have ever had:

<input type="checkbox"/> Allergies (asthma, hay fever)	<input type="checkbox"/> Cancer or a malignancy
<input type="checkbox"/> Bronchitis, pneumonia, pleurisy	<input type="checkbox"/> Anemia or bleeding tendency
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Exposure to X-ray therapy
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Ulcers, gallbladder trouble, colitis
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diabetes ("sugar")
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Epilepsy, migraine headaches
<input type="checkbox"/> Any other kind of heart trouble	<input type="checkbox"/> Glaucoma, iritis, or cataracts
<input type="checkbox"/> Liver disease, hepatitis, jaundice	<input type="checkbox"/> Arthritis, gout, or rheumatism
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Venereal disease (e.g. syphilis)
<input type="checkbox"/> Nephritis, kidney stones	<input type="checkbox"/> Thyroid disorder
<input type="checkbox"/> Immune deficiency or AIDS	<input type="checkbox"/> Positive HIV test
<input type="checkbox"/> Stroke	<input type="checkbox"/> Other:

## Hospitalization/Operations

Please indicate the dates and reasons for any hospitalization/operations you have had:

<u>Dates</u>	<u>Reason for Hospitalization</u>

## Allergies to Medications or Food

Please indicate any allergies you may have to any foods or medications:

<u>Food/Medication</u>	<u>Nature of Reaction</u>

## Medications

Please list all the medications you currently take. Be sure to include any "over-the-counter" medications (e.g., aspirin, tylenol, cold medications, laxatives):

<u>Date Started</u>	<u>Medication</u>	<u>Reason for Medication</u>

Please Turn To Next Page

## Family History

Please complete the following:

Is There A History Of...?	In Which Family Member?
Eczema, Hay Fever, Asthma	
Psoriasis	
Skin Cancer	
Melanoma	
Similar condition for which you are being seen today	
Other illness (please specify)	

## Systems Review

As you review the following list, please check any of those problems which apply to you:

### General:

- Loss of weight
- Weakness/Fatigue
- Fever
- Decline in general health

### Habits:

Do you smoke?  Yes  No  
Cigarettes per day? \_\_\_\_\_

What alcoholic beverages do you drink in an average week?  
Type \_\_\_\_\_

Amount \_\_\_\_\_

Do you use drugs for recreational purpose?  Yes  No

If yes, what? \_\_\_\_\_

### Kidneys and Genitals:

- Pain or burning urination
- Blood or pus in urine
- Penile or vaginal discharge
- Genital rash or ulcers

### Neck:

- Tender or swollen glands
- Thyroid problem

### Heart and Lungs:

- Pain in chest
- Irregular heart beat
- Shortness of breath
- Difficulty breathing at night
- Swollen legs or feet
- High Blood Pressure
- Heart murmurs
- Cough

### Ears:

- Loss of Hearing

### Stomach and Intestines:

- Nausea/Vomiting
- Yellow Jaundice
- Blood in stool/Black stool
- Heartburn

### Mouth:

- Sore tongue or mouth
- Bleeding gums
- Cold Sores

### Gynecological:

- Irregular menses
- Birth Control?  
 Yes  No
- If yes, what type? \_\_\_\_\_

### Eyes:

- Pain
- Redness
- Dryness
- Blurred/Double Vision

### Muscles/Joints:

- Muscle weakness
- Muscle soreness
- Joint pain
- Joint swelling

### Blood:

- Anemia
- Bleeding tendency

PLEASE GIVE US 24 HOURS NOTICE FOR CANCELLATION.

PATIENT WILL BE CHARGED \$20 FOR APPOINTMENTS NOT KEPT. THANK-YOU

## Patient Signature Waiver

I authorize any holder of medical information about me to release such information to HCFA and its agents, to any insurer, or to any other supplier of medical benefits or benefits payable for related services. I authorize the submission of claims, on my behalf for health insurance, Medicare or any other benefits, to HCFA, to any insurance company or other suppliers of medical benefits

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_