CARING FOR ALL

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Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Social Security Number: _____

Address: _____ City, State, Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone:_____

Preferred contact number: □ Home □ Cell □ Work

□ Single □ Married □ Partner □ Divorced □ Widowed □ Legally Separated

□ Male □ Female

Race: _____ Ethnicity: _____ Preferred Language: _____

Emergency Contact

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Preferred contact number: □ Home □ Cell □ Work

Responsible Party/Parent/Legal Guardian Information

Name: _____ Relationship: _____

Date of Birth: _____ Social Security Number: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Preferred contact number: □ Home □ Cell □ Work

Pharmacy Information

Name: _____ Telephone Number: _____

Street Address: _____ City, State, Zip Code: _____

Medical History

Please check off prior or current medical conditions and write approximate year of diagnosis

□ AIDS
□ alcoholism
□ anemia, type
□ anorexia
□ appendicitis
□ arthritis
□ asthma
□ bleeding disorder
□ breast lump
□ bronchitis
□ bulimia
□ cancer, type: _____
□ cataracts
□ chicken pox
□ diabetes
□ emphysema/COPD
□ epilepsy/seizure disorder
□ glaucoma
□ goiter
□ gout
□ heart attack
□ hepatitis, type: _____
□ high cholesterol
□ kidney disease
□ liver disease
□ migraine headaches
□ mononucleosis
□ multiple sclerosis
□ pneumonia
□ anxiety
□ depression
□ bipolar
□ substance abuse
□ suicide attempt
□ stroke
□ thyroid disorder
□ stomach ulcer
□ Barrett's esophagus
□ sexually transmitted disease
□ tuberculosis
□ blood clot
□ kidney stones
□ environmental allergies
□ heart disease
□ colitis

□ other: _____

_____

Women

Age of first menses: _____ Are you/could you be pregnant? □ Yes □ No

Are your periods regular? □ Yes □ No If yes, how often do they come? _____

Date of last menstrual period (first day): _____

Method of contraception: _____ Approximate number of life-time sexual partners: _____

Any history of STDS: _____

Number of total pregnancies: _____ Number of live pregnancies: _____

Any history of abnormal pap smear? □ Yes □ No If yes, Year: _____

Diagnosis: □ ASC-U □ AGC □ LGSIL □ HGSIL

Do you feel safe in your current relationship? □ Yes □ No

Have you ever felt threatened emotionally/physically? □ Yes □ No

Past Surgeries/Hospitalizations

Year	Hospital	Reason

Medications

List all of the medications you take, including over-the counter and alternative remedies.

Medication	Dose	Route	Frequency	Purpose

Allergies

Medication/Substance (e.g. shellfish, bee sting) and Reaction (e.g. rash, anaphylaxis, stomach upset):

Medication/Substance	Reaction

Family History

Relation	Alive/Dead	Age/Age of Death	Conditions
Father			
Mother			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			
Aunts/Uncles			
Sibling 1 ___ Male ___ Female			
Sibling 2 ___ Male ___ Female			
Sibling 3 ___ Male ___ Female			
Child 1 ___ Male ___ Female			
Child 2 ___ Male ___ Female			
Child 3 ___ Male ___ Female			

Social History

Have you ever smoked? □ Yes □ No If yes, # packs per day____ years total ____ If quit, when?_____

Do you drink alcohol? □ Yes □ No

If yes, number of drinks per week: _____ and type of alcohol: _____

When was the last time you had a blackout from drinking? _____

Do you use any recreational drugs? □ Yes □ No

If yes, what type of drugs? _____

Review of Systems

Check any symptoms that you have or have had in the last year.

General	□ chills	□ fever	□ weight gain	□ fatigue
	□ sweats	□ weakness	□ weight loss	□ dizziness
Skin	□ rash	□ hair loss	□ acne	□ changes in moles
	□ yellowing of skin	□ nail changes	□ non-healing sore	□ warts
Eyes	□ change in vision	□ seeing spots	□ dry eyes	□ contact lenses
	□ blurry vision	□ double vision	□ burning of eyes	□ flashes/halos
Ears/Nose/Throat	□ hoarseness	□ loss of hearing	□ post-nasal drip	□ ringing in ears
	□ sores in mouth	□ coughing blood	□ hearing aids	□ sinus problems
Musculoskeletal	□ joint pain	□ joint stiffness	□ leg pain	□ neck pain
	□ joint swelling	□ low back pain	□ arm pain	□ redness of joints
Pulmonary	□ shortness of breath	□ wheezing	□ chronic cough	□ rescue inhaler use

Review of Systems *continued*

Cardiovascular	□ chest pain	□ swelling of ankles	□ using many pillows	□ dizziness
	□ palpitations	□ irregular heartbeat	□ poor circulation	□ varicose veins
Neurological	□ weakness	□ blackouts	□ memory loss	□ restless legs
	□ paralysis	□ tremors	□ headaches	□ numbness
Endocrine	□ increase in thirst	□ cold intolerance	□ decrease in libido	□ change in appetite
	□ heat intolerance	□ fatigue	□ excess sweating	□ muscle twitching

Gastrointestinal	□ difficulty swallowing	□ constipation	□ change in stool	□ stomach pain
	□ feel full quickly	□ diarrhea	□ blood in stool	□ heartburn
	□ burping a lot	□ vomiting	□ vomiting blood	□ rectal bleeding
	□ dark/black stools	□ bloating	□ hemorrhoids	□ nausea
Genitourinary	□ urinary frequency	□ blood in urination	□ urine incontinence	□ dark urine
	□ pain with urination	□ difficulty voiding	□ weak urine stream	□ urinating at night

Hematological/Lymphatic	□ easy bruising	□ easy bleeding	□ swollen glands	□ anemia
Psychological	□ anxiety	□ mood swings	□ irritability	□ nervousness
	□ depression	□ insomnia	□ anger issues	□ nightmares
Men	□ difficulty w/erection	□ hernias	□ testicle pain	□ penile discharge
Women	□ vag. discharge/odor	□ heavy/irreg. menses	□ breast pain	□ pelvic pain

Health Maintenance

Date of last immunization: Tetanus _____ Pneumonia _____ Shingles _____

Date of last eye exam: _____ Date of last dental exam: _____

Date of last colonoscopy: _____ Result: _____ Next one due: _____

Women:

Date of last Pap smear: _____ Result: _____

Date of last mammogram: _____ Result: _____

Date of last bone density: _____ Result: _____

Telephone Consent

Patient Name: _____ Date of Birth: _____

Best number to reach you at: _____

□ **I DO NOT GIVE MY PERMISSION** for you to speak with anyone concerning your medical information.

□ **I GIVE MY PERMISSION** to discuss my medical information with the persons listed below:

Name: _____ Relationship: _____ Tel: _____

Name: _____ Relationship: _____ Tel: _____

Name: _____ Relationship: _____ Tel: _____

Note: *This DOES NOT INCLUDE any SENSITIVE information, but allows us to call regarding appointments, scheduled tests, and other pertinent information.*

□ **I GIVE MY PERMISSION** to leave messages on my answering machine/voicemail.

Note: *If your phone does not accept blocked numbers, we will not be able to reach you.*

Patient Signature: _____ Date: _____

Insurance Authorization

I hereby authorize Caring for All, PC to furnish information to my insurance carrier(s) concerning my health information regarding my illness and treatment. I hereby assign to the physician/provider all payments for medical service for myself and/or my dependents. I understand I am responsible for any amount not covered by my insurance contract.

I understand I will be responsible for any claim that has been denied by my insurance due to lack of referral of any significant insurance information deemed necessary to file a claim on my behalf.

If my insurance changes, it is my responsibility to update it with Caring for All as soon as possible. If I do not update my insurance information right away and do so at a later date, and it is not within claim filing limits, and my claim is denied, I will be responsible for full payment.

Patient Signature: _____ Date: _____

Insurance Information

Primary Insurance Company: _____ Policy Number: _____

Subscribers Name (if different than patient): _____

Date of Birth: _____ Social Security Number: _____

Address: _____ City, State, Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

If applicable, Secondary Insurance Company: _____ Policy Number: _____

Subscribers Name (if different than patient): _____

Date of Birth: _____ Social Security Number: _____

Address: _____ City, State, Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Acknowledgement of Financial Policies

I have read and understand the financial policies of Caring for All, P.C. I also agree that if it becomes necessary to forward my account to a collection agency, I will be responsible for any additional fees charged by the collection agency (due to the cost of collections), . I certify that I have provided the correct insurance information. I authorize the release of any medical information necessary to process the claim. I authorize payments to be made directly to Caring for All, P.C.

Patient Signature: _____ Date: _____

Acknowledgement of Privacy Practices

By law, we are required to provide you with our Notice of Privacy Practices (NPP). The Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information
2. The right to request corrections to your information
3. The right to request that your information be restricted
4. The right to request confidential communication
5. The right to a report of disclosures of your information, and
6. The right to a paper copy of the Notice.

We want to assure you that your medical/protected health information is secure with us. The Notice contains information about how we will ensure that your information remains private.

If you have any questions about the Notice, the name and phone number of our contact person is listed on the last page of the Notice of Privacy Practice form.

"I hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed on the last page of the Notice of Privacy Practice form. I further understand that the practice will offer me updates to the Notice of Privacy Practices should it be amended, modified, or changed in any way."

Patient/Representative Name (print): _____

Patient/Representative Signature: _____ Date: _____

□ Patient refused to sign □ Patient was unable to sign because _____