NEW PATIENT INFORMATION

TODAY'S DATE: _____

Patient's Name_____ Age_____ Birth Date_____
Home Address_____
City: _____ Zip Code: _____
Home Phone _____ Cell Phone _____ E-mail _____
Marital Status: ( )Married ( )Single ( )Divorced ( )Separated ( )Widow/er ( )Minor Sex: ( )Male ( )Female
Patient or Parent Driver's License #_____ SS #_____
Employed By_____ How Long?_____ Occupation_____
Work Address_____
City_____ Zip Code _____ Work Phone_____
Spouse/Parent Name_____

REFERRAL: Whom may we thank for referring you to our office_____
How did you learn about our office: [ ]Yellow Pages [ ]Website [ ]Register [ ]Insurance Book [ ]_____

PAYMENT METHOD: [ ]Cash [ ]Check [ ]Credit Card [ ]Medicare [ ]Insurance
PRIMARY INSURANCE COMPANY: _____
Name of Insured_____ SS #_____ Date of Birth_____
Relationship to patient_____ Employed By_____
Work Address/City/Zip_____Work Phone_____

SECONDARY INSURANCE COMPANY: _____
Name of Insured_____ SS #_____ D.O.B. _____
Relationship to patient_____ Employed By_____
Work Address/City/Zip_____Work Phone_____

REASON FOR VISIT: [ ]Injury [ ]Job Related Injury [ ]Medical Problem [ ]Second Opinion [ ]Consultation
Describe your major complaint _____
_____Date of injury or onset of problem_____ Time of Day_____
Family Physician:_____ City_____ Last Visit_____

FINANCIAL POLICY: I understand that I am financially responsible for all charges whether or not paid by my insurance. This office will bill your insurance as a courtesy but if the insurance does not pay in 90 days, you will be responsible for paying the bill. Payment of non-covered medical care, deductibles and co-pays are due at the time of service. I agree that there will be a $25.00 charge for returned checks. I agree to pay my account promptly upon receipt of a statement and accounts that become 60 days past due will be charged an eighteen percent annual interest rate until paid. Please Initial: [X] _____

MEDICAL RECORDS RELEASE / ASSIGNMENT OF BENEFITS: I hereby authorize this office to release any necessary information for the payment of insurance claims. I hereby assign insurance payments directly to this office otherwise payable to the insured. I agree to allow a copy of this authorization to be used in place of an original. I agree to notify the office 24 hours in advance to change an appointment or a $25.00 service fee can be charged to my account.
Patient, Parent, Guardian Signature_____ Date_____

HEALTH HISTORY QUESTIONNAIRE

NAME_____ **Birth Date**_____ **Today's Date**_____

Age_____ Height_____ Weight_____ Shoe Size_____ Right or Left Handedness_____

CHIEF COMPLAINT AND ITS HISTORY: Please describe what is wrong, when did the problem begin, its location, and how has it progressed. Please include what happens at night or in the morning?_____

_____

_____

_____

_____

_____

Quality of Pain: [ ]Burning [ ]Throbbing [ ]Sharp [ ]Dull or [ ]Aching. Severity:1 to 10 scale -- 10 being unbearable?_____

Duration and Timing of the pain? _____

What causes the pain to decrease or increase? _____

Do you have any associated medical problems? _____

Previous treatments -- if by a doctor, include the date and doctor's name _____

_____

OTHER CURRENT MEDICAL CARE: Please list your Regular Doctor and all other current health care providers:

Illness or Medical Problem Health Care Provider City of office Location Phone Dates of Treatment

_____

_____

Is your general health good? [ ]No [ ]Yes - When was your last blood test? _____

Have you had a physical in the last year? [ ]No [ ]Yes - When and who was your doctor? _____

If a Diabetic patient, how often do you test and what was your last reading? _____

PAST MEDICAL HISTORY: Check off any condition that has been treated in the past? [ ]Diabetes, [ ]Diabetic Foot Ulcers, [ ]AIDS / HIV Positivity, [ ]Hepatitis, [ ]Heart Attack, [ ]Heart Murmurs, [ ]Irregular Heart Beat, [ ]Mitral Valve Prolapse, [ ]Rheumatic Fever, [ ]Congestive Heart Failure,[ ]Hypertension, [ ]Stroke,[ ]Convulsions, [ ]Seizures, [ ]Cancer, [ ]Asthma, [ ]Emphysema, [ ]Rheumatoid Arthritis, [ ]Bleeding problems, [ ]Sickle-cell Disease, or [ ]Blood Transfusions.

PAST ILLNESS, INJURY OR SURGICAL HISTORY: Please list all major illnesses, injuries, hospitalizations and operations.

Year	Operation, Injury, Illness, Hospitalization	Doctor/Hospital/City	Residual Problems
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CURRENT ALLERGIES: Please list any reactions to any medications, tapes, soaps, latex rubber or other substances.

[ ]I am PENICILLIN ALLERGIC, it causes [ ]Hives [ ]Shortness of breath [ ]Anaphylaxis reactions.

[ ]Other Allergies _____

CURRENT MEDICATIONS: List the type and dosage of all medications including aspirin, birth control, herbs and vitamins.

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

SOCIAL HISTORY: Pregnancy: Are you pregnant? [ ]No [ ]Yes _____ Describe birth control method? _____

Tobacco History: [ ]No [ ]Yes - Packs per day ___ How many years?___ When did you quit? ____ Year's Smoked?____

Alcohol History: [ ]No [ ]Yes - How often and how much each week _____

Recreation Drugs: [ ]No [ ]Yes _____

Living Situation: Where and who do you live with? _____

Emotional issues: Describe any emotional problems _____

Job Description: Describe work activities _____

Exercise: Describe type and frequency _____

HEALTH HISTORY QUESTIONNAIRE - Continued

NAME_____ **Today's Date**_____

FAMILY HISTORY:

	If Living	at Death	Cause of Death
Mother	_____	_____	_____
Father	_____	_____	_____
Brothers	_____	_____	_____
	_____	_____	_____
Sisters	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____

DID ANY BLOOD RELATIVES HAVE THE FOLLOWING ILLNESSES:

Diabetes_____ Migraine Headaches_____
Bunions _____ Cystic Fibrosis _____
Flat Feet_____ Birth Defects _____
Breast Problems _____ Epilepsy _____
High Blood Pressure _____ Glaucoma _____
Heart Disease _____ Rheumatoid Arthritis_____
Stroke _____ Gout _____
Cancer _____ Multiple Sclerosis _____
Asthma/Emphysema _____ Colitis _____
Tuberculosis _____ Alcoholism _____

RECENT INTERNATIONAL TRAVEL / TESTS: Where & when did you travel out of the county? _____

Boosters Received: Measles__ Tetanus__ Pneumococcus__ Typhoid__ Yellow Fever__ Polio__ Cholera__ Hepatitis A__B__

Last Tetanus _____ Last TB test_____ [ ]Pos. [ ]Neg. [ ]BCG Last Chest X-ray _____ Last Blood Test _____

REVIEW OF BODY SYSTEMS: Please list the date of onset and if the condition occurs rarely or frequently.

	Onset	Rare or Frequent
CONSTITUTIONAL		
Weight Loss / Gain	_____	_____
Weakness	_____	_____
Fatigue	_____	_____
Fever	_____	_____
HEAD & NECK		
Headaches	_____	_____
Neck Pain	_____	_____
Fainting Spills	_____	_____
EYES		
Glasses or Contacts	_____	_____
Blurred Vision	_____	_____
Cataracts	_____	_____
Glaucoma	_____	_____
EAR, NOSE, THROAT & MOUTH		
Hearing Problems	_____	_____
Loss of Balance	_____	_____
Ringing in Ears	_____	_____
Nose Bleeds	_____	_____
Sleep Apnea	_____	_____
Neck Artery Issues	_____	_____
Dentures	_____	_____
Gum Problems	_____	_____
CARDIOVASCULAR		
Chest Pain	_____	_____
Out of Breath Quickly	_____	_____
Sleep Sitting Up	_____	_____
Leg Cramps at Night	_____	_____
Dizziness / Fainting	_____	_____
Leg Blood Clots	_____	_____
Varicose Veins	_____	_____
High Cholesterol	_____	_____
RESPIRATORY		
Chronic Cough	_____	_____
Cough Up Blood	_____	_____
Shortness of Breath	_____	_____

	Onset	Rare or Frequent
GASTROINTESTINAL		
Stomach Nausea	_____	_____
Abdominal Pains	_____	_____
Vomiting	_____	_____
Stomach Ulcer	_____	_____
Constipation	_____	_____
Diarrhea	_____	_____
Abdominal Pain	_____	_____
Appendicitis	_____	_____
Appetite loss	_____	_____
Excessive Thirst	_____	_____
Black/Bloody Stool	_____	_____
Gallbladder Trouble	_____	_____
Colitis	_____	_____
GENITOURINARY		
Bladder Problems	_____	_____
Painful Urination	_____	_____
Dark/Bloody Urine	_____	_____
Frequent Urination	_____	_____
Prostate Trouble	_____	_____
GYNECOLOGICAL		
Post-menopausal	_____	_____
Breast Problems	_____	_____
Menstrual Problems	_____	_____
MUSCULOSKELETAL		
Muscle Weakness	_____	_____
Back Pain	_____	_____
Scoliosis	_____	_____
Unequal Leg Length	_____	_____
Knee Pain	_____	_____
Walking Leg Cramps	_____	_____
Weak Ankles	_____	_____
Foot Joint Pain	_____	_____
Swollen Ankles/Feet	_____	_____
Gout in the Foot	_____	_____
Flat Feet	_____	_____

	Onset	Rare or Frequent
SKIN/INTEGUMENT		
Rash / Condition	_____	_____
Keloid Problems	_____	_____
Bruise Easily	_____	_____
Sores Hard to Heal	_____	_____
Foot Fungus	_____	_____
Toe Nail Problems	_____	_____
Toe Nail Fungus	_____	_____
NEUROLOGICAL		
Loss of Memory	_____	_____
Neuropathy	_____	_____
Foot Numbness	_____	_____
Coordination issues	_____	_____
Weakness/Paralysis	_____	_____
Muscle Weakness	_____	_____
Muscle Spasms	_____	_____
PSYCHIATRIC		
Nervousness	_____	_____
Mood Swings	_____	_____
Depression	_____	_____
ENDOCRINE		
Hot/Cold Intolerance	_____	_____
Severe Thirst/Hunger	_____	_____
Heavy Sweating	_____	_____
Thyroid Trouble	_____	_____
HEMATOLOGIC / LYMPHATIC		
Anemia	_____	_____
Anticoagulants	_____	_____
Jaundice Episodes	_____	_____
ALLERGIC / IMMUNOLOGIC		
Measles / Rubella	_____	_____
Polio	_____	_____
Mumps	_____	_____
Scarlet Fever	_____	_____
Mononucleosis	_____	_____
Allergic Anaphylaxis	_____	_____

NOTICE OF PRIVACY PRACTICES

I. OUR LEGAL DUTY: This notice describes how medical information about you may be used and disclosed and how you can get access to your information. Please review it carefully. The privacy of your medical information is important to this office and this protection became effective on April 14, 2003 through applicable federal and state laws. This notice will remain in effect until replaced by this office and will cover our privacy practices, our legal duties, and your rights concerning your protected health information. We reserve the right to change our privacy practices and the terms of this notice at any time as permitted by applicable law for all protected health information that we maintain, including medical information we created or received before we made the changes.

II. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION: We will use and disclose your protected health information about you for treatment, payment, and health care operations including the following examples of the types of uses and disclosures. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

1. Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.
2. Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may under take before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.
3. Health Care Operations: We may use or disclose, as needed, your protected health information in order to conduct certain business information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment. We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, and transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.
4. Uses and Disclosures Based On Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below. You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.
5. Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that is in your best interest based on our professional judgment to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care regarding your location, general condition or death.
6. Marketing: Your information will not be sold to a mailing list company by this office. We may use your protected health information to contact you with information about our office and treatment information or treatment alternatives that may be of interest to you and we may use a business associate to assist us in these activities. Unless the information that is provided to you is by a general newsletter or in person, you may opt out of receiving further such information by using the contact information listed below.
7. Research: We may use or disclose your protected health information for research purposes in limited circumstances.
8. Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety or others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

9. Health Oversight: We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit program, other government regulatory programs and civil rights laws.
10. Abuse or Neglect: We may disclose your protected health information, applicable federal and state laws, to a public health or a governmental entity or agency that is authorized by law to receive reports of child abuse or neglect if we believe that you have been a victim of abuse, neglect or domestic violence.
11. Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse effects, product defects or problems deviations or to conduct post marketing surveillance, as required.
12. Required by Law: We may use or disclose your protected health information when we are required to do so by law such as from the U.S. Department of Health and Human Services or when authorized by worker's compensation or applicable state laws.
13. Process and Proceedings: We may disclose your protected health information to law enforcement officials or a court under certain circumstances in response to a court order, warrant or grand jury subpoena, administrative order, subpoena, discovery request or other lawful process.

III. PATIENT RIGHTS

1. Access: You have the right to get copies of your protected health information by making a request in writing to the contact person or the office address listed below. If you request copies, we will charge you twenty-five (25) cents per page and $25 per hour for staff time to locate and copy your protected health information, and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee of $35. If you want X-ray copies, we will charge you $10 for each X-ray in your file or for those X-rays that you request to be copied in writing.
2. Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations for the past six (6) years. This list of instances will document the date, the name of the person or entity, a description of what was disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, a $35 charge will occur for each request.
3. Restriction Requests: You have the right to request in writing that we place additional restrictions on our use of the disclosure of your protected health information. We are not required to agree to these additional restriction, but if we do, we will abide by our agreement (except in an emergency). The agreement must be signed by the contact person for the office to be valid.
4. Confidential Communication: You have the right to request that we communicate with you about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.
5. Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amended and to include the changes in any future disclosures of that information.
6. Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form by contacting us using the information listed below.

IV. QUESTIONS AND COMPLAINTS: If you want a copy of our notice (or any subsequent revised notice) or .more information about our privacy practice or have questions or concerns, please contact us using the information below. If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S. Department of Health and Human Services and we will provide you with the address to file you complaint upon request. We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

V. ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____	_____	_____	_____
Patient Name (please Print)	Parent or Authorized Representative (if applicable)	Date	Signature