ProHealth Partners Patient Information Sheet

PATIENT INFORMATION (*please print*)

First Name _____ Middle Initial _____ Last Name _____

Home Address _____ City _____ State _____ Zip Code _____

Billing Address (if different) _____

Work Address (if different) _____

Home Phone _____ Work Phone _____ Cell Phone _____

Preferred Contact # _____ Email Address _____

Drivers License # _____ Date of Birth _____ Social Security # _____

Sex: __M __F Marital Status: □ S □ M □ D □ W □ Other _____ How did you hear about us? _____

Primary Care Physician _____ Primary Language _____

Race _____ Ethnicity (*circle one*) Hispanic or Latino Not Hispanic or Latino

Employer _____ Employer Phone _____ Occupation _____

Emergency Contact _____ Relationship _____ Phone _____

GUARANTOR/PARENT/INSURED INFO [SEND BILL TO]:

Guardian Last Name (if applicable) _____ First _____ Initial ____

Date of Birth _____ Social Security # _____ Relationship _____

Employer _____ Address _____ Phone _____

INSURANCE INFORMATION

Primary Insurance _____

Policy Holder Name _____ DOB _____ Social Security # _____

Billing Address _____ City, State, Zip _____

Group or Policy # _____ Cert. or Member # _____ Local Union # _____

Co-pay Amount _____ Policy Effective Dates: From: _____ To: _____

Patient Relation to Policy Holder: □ Self □ Spouse □ Child □ Other: _____

Secondary Insurance _____

Policy Holder Name _____ DOB _____ Social Security # _____

Billing Address _____ City, State, Zip _____

Group or Policy # _____ Cert. or Member # _____ Local Union # _____

Co-pay Amount _____ Policy Effective Dates: From: _____ To: _____

Patient Relation to Policy Holder: □ Self □ Spouse □ Child □ Other: _____

PHARMACY INFORMATION

Pharmacy Name _____ Address _____ Phone _____

Signature (Patient or Parent of Minor): _____ Date: _____

FINANCIAL POLICY

AGREEMENT TO PAYMENT POLICY I acknowledge that I received a copy of PROHEALTH PARTNERS, INC., financial policy and agree to the terms of payment due.

AUTHORIZATION TO RELEASE INFORMATION I authorize release of my medical record information, pursuant to applicable federal and state laws, rules and regulations, to third party payers and other providers participating in my care, that agree to treat my information in a confidential manner in accordance with all applicable federal, state, and local laws. I further authorize any other individual or entity that has provided health care to me to release to PROHEALTH PARTNERS, INC., any and all of my medical records information, whether in printed or electronic form, needed to provide me with informed care. I may revoke my consent for the release of this information at any time, except to the extent that action has been taken in reliance on the consent.

ASSIGNMENT OF BENEFITS I hereby request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to PROHEALTH PARTNERS, INC., for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services.

GUARANTEE OF PAYMENT I agree to pay all applicable charges, which are not paid in full by my insurance. If amounts due to PROHEALTH PARTNERS, INC., are not paid according to this financial policy, the account shall be deemed delinquent. In the event that I default on payment of my account, I understand I am responsible for any and all cost incurred on the collection of my account, including court cost and reasonable attorney's fee. If the debt is assigned to a third party collection agency, I agree to be responsible for collection fees and interest due to amounts in default.

Patient's Signature Date

_____

Responsible Party Relationship to Patient

_____

Acknowledgement of Receipt of Notice of Privacy Practices

The Practice reserves the right to modify the privacy practices outlined in this notice.

I have received a copy of the Notice of Privacy Practices.

_____

Name of Patient (Print or Type)

_____

Signature of Patient

_____

Date

_____

Signature of Patient Representative
(Required if patient is a minor or an adult who is unable to sign this form.)

_____

Relationship of Representative

Documentation of Attempt to Obtain Acknowledgement of Receipt of Privacy Practices

Attempt to Obtain Acknowledgement

An attempt was made to obtain an acknowledgement of the Notice of Privacy Practices on _____ . The acknowledgement was not obtained because:

- ❑ The patient was undergoing emergency treatment
- ❑ The patient declined to sign the acknowledgement
- ❑ Other _____

Signature _____

Name of the Patient (Print or Type) _____

Name of Staff Member _____

Date _____

AUTHORIZATION TO COMMUNICATE PATIENT'S MEDICAL INFORMATION

COMMUNICATION WITH FAMILY & OTHERS INVOLVED IN YOUR CARE

(Signed original to be placed in the central medical record and copy to patient)

PATIENT IDENTIFICATION

Name:_____
Date of birth:_____
S.S. #:_____
Medical Record/Account#:_____

Office Name:_____
Address:_____
City/State/Zip:_____
Phone number:_____
Fax number:_____
Physician name:_____

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, indicate what kinds of information may be shared with each individual.

NAME:	RELATIONSHIP TO PATIENT	TYPE OF INFORMATION			
		ALL	Scheduling/ Appointment	Medical	Billing/ Insurance

Specific instructions or limitations:_____

_____

Validation code: _____ (Please give this to any individual who may be involved in coordinating your care or payment for care. They will be asked to give this code to our staff before we release information over the phone.)

We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. Please promptly notify your physician's office if you wish to alter the designations above.

Signature of Patient/Legal Representative:_____ Date:_____

Relationship to patient:_____

General Medical History -Please Mark All That Apply

☐ Alcoholism	☐ Depression	☐ Joint Pain
☐ Allergies/Hayfever	☐ DM Type 1	☐ Kidney Infections
☐ Anemia	☐ DM Type 2	☐ Kidney Stones
☐ Anxiety	☐ Epilepsy	☐ Migraine
☐ Asthma	☐ Fracture	☐ Multiple Sclerosis
☐ Atrial Fibrillation	☐ Gastric Ulcer	☐ Obesity
☐ Blood Transfusions	☐ Gastrointestinal Disease	☐ Old MI
☐ CAD	☐ GERD	☐ Osteoarthritis
☐ Cancer_____	☐ Gestational Diabetes	☐ Osteoporosis
☐ Cardio Vascular Disease	☐ Glaucoma	☐ Pneumonia
☐ CHF	☐ Heart Murmur	☐ Pulmonary Disease
☐ Cirrhosis	☐ Hepatitis	☐ Rheumatic Fever
☐ Colitis	☐ High Cholesterol	☐ Rheumatoid Arthritis
☐ COPD	☐ Hyperlipidemia	☐ STD
☐ CRF	☐ Hypertension	☐ Thyroid Disease
☐ Crohn's Disease	☐ Hyperthyroidism	☐ TIA
☐ CVA	☐ Hypothyroidism	☐ Tuberculosis

HOSPITALIZATIONS ☐ Yes ☐ No

☐ Appendectomy	☐ Endometrial ablation	☐ Laparoscopy
☐ Breast lumpectomy	☐ Gall bladder	☐ Mastectomy
☐ Cataract Surgery	☐ Heart Surgery	☐ Myomectomy
☐ Colectomy	☐ Hemorrhoids	☐ Oophorectomy
☐ Cone Biopsy	☐ Hernia	☐ Tonsil/Adenoidectomy
☐ D& C	☐ Hysterectomy	☐ Tubal Ligation

Other Surgical History_____

SOCIAL HISTORY

Smoker ☐ Yes ☐ No	Tobacco Use ☐ Yes ☐ No
Alcohol Use:_____	Educational Level
Caffeine Use:_____	Marital Status_____
☐ Drug Use	Exercise Habits_____
☐ Sun Protection	☐Seatbelts
☐ Tattoos	☐ Body Piercings
☐ Physical Abuse	Native Language_____
☐ Domestic Abuse	Religion_____
Other Social History:_____	Occupation:_____

PREGNANCY SUMMARY

☐ Sexually Active	☐ Abortion
☐ Birth Control Method	☐ Elective Abortion
☐ Birth Control Device insertion date	☐ Miscarriage
☐ History of Abnormal pap smears	☐ Ectopic Pregnancy
Gravida _____	☐ Term_____
Live Children:_____	☐ Preterm_____
C-Section_____	

☐ Menopause has Occurred

Other OB-GYN History:_____

GENERAL FAMILY HISTORY

Mother			Father		
Alive _____		Age _____	Alive _____		Age _____
Y	N	Good Health	Y	N	Good Health
Y	N	Unknown Maternal Hx	Y	N	Unknown Maternal Hx
Y	N	Alcoholism	Y	N	Alcoholism
Y	N	Anemia	Y	N	Anemia
Y	N	Anxiety	Y	N	Anxiety
Y	N	Asthma	Y	N	Asthma
Y	N	Birth Defects	Y	N	Birth Defects
Y	N	Coronary Arteries	Y	N	Coronary Arteries
Y	N	Cardiovascular Problems	Y	N	Cardiovascular Problems
Y	N	Congestive Heart Failure	Y	N	Congestive Heart Failure
Y	N	Cancer	Y	N	Cancer
	Type:			Type:	
Y	N	Congenital Anomaly	Y	N	Congenital Anomaly
Y	N	COPD	Y	N	COPD
Y	N	Crohn's Disease	Y	N	Crohn's Disease
Y	N	Depression	Y	N	Depression
Y	N	Diabetes	Y	N	Diabetes
Y	N	Epilepsy	Y	N	Epilepsy
Y	N	GERD	Y	N	GERD
Y	N	Heart Problems	Y	N	Heart Problems
Y	N	Hypercholesterolemia	Y	N	Hypercholesterolemia
Y	N	Hyperlipidemia	Y	N	Hyperlipidemia
Y	N	Hypertension	Y	N	Hypertension
Y	N	Hypothyroidism	Y	N	Hypothyroidism
Y	N	Kidney Disease	Y	N	Kidney Disease
Y	N	Liver Disease	Y	N	Liver Disease
Y	N	Osteoarthritis	Y	N	Osteoarthritis
Y	N	Osteoporosis	Y	N	Osteoporosis
Y	N	Mental Illness	Y	N	Mental Illness
Y	N	Pulmonary Disease	Y	N	Pulmonary Disease

Comments: