

Patient Information Form

Last Name		First Name		Middle/Maiden Name		Date of Birth		Sex (circle): M - F	
Mailing Address			Apt./Lot		City		State/Zip		How did you hear about us?
Marital Status (circle): Married - Single - Divorced - Widowed - Separated				Mother's Name if Minor Patient			Father's Name if Minor Patient		
Home Phone () ()		Work Phone () ()		Mobile Phone () ()		Email Address			
Race (circle): Black - White - Asian - Hispanic - Other: _____				Ethnicity (circle): Hispanic - Non-Hispanic - Unknown			Preferred Language		
Spouse/Parent Name		Do you have a Living Will or Medical Advance Directive?					Yes - No		
Emergency Contact if different than parent or spouse list above		Emergency Contact Address			City		State/Zip		
Emergency Contact Phone Numbers:		Home Phone () ()		Work Phone () ()		Mobile Phone () ()			

Insurance Information

Primary Carrier Insurance Company		Effective Date		Primary Carrier Insurance Company		Effective Date				
Insurance Carrier Mailing Address		City		State/Zip		Insurance Carrier Mailing Address		City		State/Zip
Policy Holder's Name				Policy Holder's Name						
Policy #		Group #		Policy #		Group #				

Responsible Party Information

If other than parent/spouse listed above

Head of Household or Parent with Custody of Minor				Relationship to Parent					
Mailing Address		Apt./Lot		City		State/Zip		Phone #	
								Home () ()	
								Work () ()	
								Mobile () ()	

Authorization for Treatment

I authorize Physician Associates, LLC to perform procedures and treatment including the administration of medicine and local anesthetics along with other surgical and medical procedures that may be necessary. I authorize the release of any medical information necessary (including the release of HIV/AIDS, Mental Health, Substance Abuse - to include alcohol & drugs and any reportable communicable diseases), to process a claim and hereby assign benefits payable to Physician Associates, LLC in the event of another health insurance becoming primary over my health insurance. To further provide continuity of care, I authorize the release of medical information to specialty physicians under contract with Physician Associates, LLC. Furthermore, any services not covered by my insurance will become my responsibility for full payment of services rendered by Physician Associates, LLC.

Patient/Legal Guardian Signature

Date

Patient/Legal Guardian Print



HEALTH QUESTIONNAIRE

Patient's Name
MRN
DOB

Patient Name: _____

DOB: _____

Please indicate each of your chronic medical problems by marking the appropriate box below:

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Asthma	Please list any other medical problems:
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Emphysema/Lung Disease	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Problems	
<input type="checkbox"/> Stroke	<input type="checkbox"/> Anemia	
<input type="checkbox"/> Cancer	<input type="checkbox"/> High Cholesterol	
<input type="checkbox"/> Thyroid	<input type="checkbox"/> Glaucoma	

Please list all medications that you are now taking, strength (in milligrams) and how often. Include non-prescription medications, vitamins and herbal supplements.

Are you allergic to any medications? Yes No If yes, please list them and the reaction they cause.

Social History

Tobacco _____ a day	Number of years _____ Year Quit _____
Alcohol _____ drinks per week	Caffeine _____ cups a day
Street Drugs _____	Low fat diet <input type="checkbox"/> Yes <input type="checkbox"/> No
Exercise _____ type	Times a week _____ minutes/session
Water _____ cups a day	Marital Status _____
# of Children _____	Occupation _____
Do you have a living will? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, have you given us a copy? <input type="checkbox"/> Yes <input type="checkbox"/> No

Family History

If any blood relative has suffered from the following conditions, check the box and indicate which relative.

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> Asthma	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Emphysema/Lung Disease	
<input type="checkbox"/> Thyroid	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Cancer	

Patient Name: _____

Please list any surgeries/hospitalizations (including the year):

Are you under the care of any other doctor for any medical problems? _____

If so, whom and for what medical problem? _____

Year of last: Tetanus Shot _____ Flu Shot _____ Pneumonia Vaccine _____

Women only: Date of first day of last menstrual period: ___/___/___ Contraception Type _____

Number of: Pregnancies _____ Live Births _____

Miscarriages _____ Abortions _____

Date of last: PAP _____ (Abnormal? _____) Mammogram _____ (Abnormal? _____)

Date of last: Osteoporosis Scan _____ Flushing/Menopausal Symptoms Yes No

Have you been a victim of abuse? Yes No

Men only: Date of last: Prostate Exam _____ Last PSA (Prostate Blood Test) _____

Procedures (list year):

Sigmoidoscopy	Colonoscopy	Stress Test
EKG	Cholesterol (normal Y/N)	Sugar (normal Y/N)

Please place a checkmark next to any symptoms that you are currently having and indicate the year if the symptoms occurred in the past.

GENERAL	<input type="checkbox"/> Fever	<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Unexplained Weight Loss or Gain	<input type="checkbox"/> Fatigue
SKIN	<input type="checkbox"/> Rashes	<input type="checkbox"/> Cancers	<input type="checkbox"/> Change in Hair, Skin or Nails	
EYES	<input type="checkbox"/> Glasses	<input type="checkbox"/> Contact Lenses	<input type="checkbox"/> Pain	<input type="checkbox"/> Changing Vision <input type="checkbox"/> Discharge
EAR NOSE	<input type="checkbox"/> Ear Pain	<input type="checkbox"/> Change in Hearing	<input type="checkbox"/> Persistent Runny Nose	
THROAT	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Change in Voice	<input type="checkbox"/> Sinus Trouble	
HEART	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Swelling in Ankles	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Heart Murmur
LUNGS	<input type="checkbox"/> Cough	<input type="checkbox"/> Short of Breath	<input type="checkbox"/> Wheeze	
GASTRO- INTESTINAL	<input type="checkbox"/> Nausea	<input type="checkbox"/> Blood in Stool	<input type="checkbox"/> Change in Bowel Movements	
	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Heartburn		
GENITO- URINARY	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Painful or Frequent Urination	<input type="checkbox"/> Incontinence	
		<input type="checkbox"/> Sexually Transmitted Disease		
	Women:	<input type="checkbox"/> Vaginal Discharge	<input type="checkbox"/> Change in Menstrual Cycle or Sexual Function	
	Men:	<input type="checkbox"/> Testicular Pain	<input type="checkbox"/> Decreased Urinary Stream	
		<input type="checkbox"/> Penile Discharge	<input type="checkbox"/> Change in Sexual Function	
ORTHOPEDIC	<input type="checkbox"/> Painful Joints	<input type="checkbox"/> Muscle Weakness		
NEURO/PSYCH	<input type="checkbox"/> Seizures	<input type="checkbox"/> Tremor	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Frequent Headaches
	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety		
ALLERGY	<input type="checkbox"/> Hives	<input type="checkbox"/> Hay Fever		
CIRCULATION	<input type="checkbox"/> Leg Swelling	<input type="checkbox"/> Blood Clots		

PHYSICIAN ASSOCIATES
Notice of Privacy Practices Acknowledgment Form

Physician Associates' Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting your physician's office or by visiting our Web site at www.paof.com.

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 are bound by our 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 as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I have read the Physician Associates Notice of Privacy Practices

Signature of Patient or Authorized Representative

Date Signed

Print Name

Print Name of Patient

Patient Date of Birth

PHYSICIAN ASSOCIATES USE ONLY

Patient declined signing this acknowledgement form

Reason given: _____

Staff Member Name: _____

Office Location: _____ Date: _____



FINANCIAL AGREEMENT

In consideration of the patient receiving services from Physician Associates, LLC, I agree:

- I am responsible for all expenses for treating the patient.
- Payment of charges is due at the time of the appointment.
- If Physician Associates files my insurance for me, I agree to pay for non-covered insurance benefits, co-insurance, co-pays and deductibles.

Patient Signature

Responsible Party's Signature (Parent/Guardian of Minor)

Printed Name

Printed Name

Date

Date

AUTHORIZATION TO RELEASE INFORMATION & TO PAY BENEFITS

I authorize Physician Associates, LLC to release any of my medical information, including drug and alcohol and HIV positive test results, to my insurance company(s), as needed to process my insurance claim.

I authorize my insurance company to make payments directly to Physician Associates, LLC for covered medical and/or surgical services.

Patient Signature

Responsible Party's Signature (Parent/Guardian of Minor)

Printed Name

Printed Name

Date

Date

PHYSICIAN ASSOCIATES, LLC

Authorization for the Use and Disclosure of Protected Health Information (Medical Record)

_____ hereby authorizes the use or disclosure of the individually
Print Patient/Legal Representative or Parent/Legal Guardian Name

identifiable health information of _____ **as described herein.**
Print Patient Name Date of Birth

Person/organization authorized to use/disclose the information:	Person/organization authorized to receive the information:
Name/organization _____	Name/organization _____
Address _____	Address _____
City, State, Zip _____	City, State, Zip _____
Phone _____ Fax _____	Phone _____ Fax _____

For the purpose of: Legal Request Moving out of Area New Local Physician Other (please specify)

Date(s) of Service: From: _____ **To:** _____

This authorization will expire on the following date, event or condition: _____
If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. Mental health, alcohol, drug, HIV and/or AIDS information is confidentially protected by Federal and state law which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. I further request that no genetic counseling/testing information in my record be released without my written authorization, except as otherwise required by law. I understand that I may select the information from the list below to be released by placing my initials in the space provided. Furthermore, I understand that any disclosure of information from my records carries with it the potential for an unauthorized re-disclosure of my health information. I further understand that Physician Associates, LLC may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization.

Place your initials by each item to be released or reviewed:

- | | | |
|-------------------------|------------------------------------|------------------------------------|
| ____ Complete Record | ____ All diagnostic test results | ____ Pathology/Operative Report(s) |
| Or | ____ Consultation/Progress Note(s) | ____ Lab only |
| ____ Abstract of Record | ____ Radiology only | ____ Other (please Specify) _____ |

In addition, place your initials by each specific item: (if applicable)

- | | | |
|--------------------------|-----------------------|---|
| ____ Mental Health | ____ HIV Testing | ____ Genetic Counseling/Testing Information |
| ____ Drug and/or Alcohol | ____ AIDS Information | |

Patient/Legal Representative or Parent/Legal Guardian **Signature Required** Date of Authorization

Patient Date of Birth Social Security Number (optional) Identification Shown

Translator or Interpreter's Name Telephone Number

Address City State Zip Code

Official Use Only: _____
Name of Person Releasing Information Date