New Patient

PATIENT INFORMATION SHEET

NAME: ____________ GENDER: ____________ DOB: ____________ DATE: ____________
ALLERGIES: ______________________________

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

____________ ____________ ____________
____________ ____________ ____________
____________ ____________ ____________

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

ADHD
Alcoholism
Allergies, Seasonal
Anemia
Anxiety
Arrhythmia (irregular heart beat)
Arthritis
Asthma
Bipolar
Bladder Problems / Incontinence
Bleeding Problems
Cancer: ____________
Headaches
Crohn's Disease

COPD/ Emphysema
Dementia
Depression
Diabetes: 1 or 2
Diverticulitis
DVT (Blood Clot)
GERD (Acid Reflux)
Glaucoma
Heart Disease
Heart Attack (MI)
Hiatal Hernia
High Blood Pressure
Kidney Stones
Kidney Disease

High Cholesterol
HIV
Hepatitis
Irritable Bowel Syndrome
Lupus
Liver Disease
Macular Degeneration
Neuropathy
Osteopenia/Osteoporosis
Parkinson's Disease
Peripheral Vascular Disease
Peptic Ulcer
Psoriasis
Pulmonary Embolism (PE)

Rheumatoid Arthritis
Seizure Disorder
Sleep Apnea
Stroke
Thyroid Disorder
Ulcerative Colitis

Last Menstrual Period	Date: ____	Normal Abnormal
Colonoscopy	Yes/No Date:____	Normal Abnormal
Mammogram	Yes/No Date:____	Normal Abnormal
Dexa (Bone Density)	Yes/No Date:____	Normal Abnormal
Pap	Yes/No Date:____	Normal Abnormal

Other medical problems not listed above:

____

Surgical History: Please list all prior surgeries and approximate dates performed.

____________ ____________
____________ ____________

SOCIAL / CULTURAL HISTORY:

Education Level: ☐ Elementary ☐ High School ☐ Vocational ☐ College ☐ Graduate / Professional

Are there any vision problems that affect your communication? ☐Yes ☐ No

Are there any hearing problems that affect your communication? ☐Yes ☐ No

Are there any limitations to understanding or following instructions (either written or verbal)? ☐Yes ☐ No

Current Living Situation (Check all that apply):

☐ Single Family Household ☐ Multi-generational Household ☐ Homeless ☐ Shelter ☐ Skilled Nursing Facility ☐ Other: ____________

Continued on other side.

Smoking/ Tobacco Use: ☐ Current ☐ Past ☐ Never Type: ______________ Amount/day: _________ Number of Years: ______

Alcohol: ☐ Current ☐ Past ☐ Never Drinks/week: _________

Recreational Drug Use: ☐ Current ☐ Past ☐ Never Type: ____

Are you sexually active? ☐Yes ☐ No

Are there any personal problems or concerns at home, work, or school you would like to discuss? ☐Yes ☐ No

Are there any cultural or religious concerns you have related to our delivery of care? ☐Yes ☐ No

Are there any financial issues that directly impact your ability to manage your health? ☐Yes ☐ No

How often do you get the social and emotional support you need?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Comments (Please feel free to comment on any answers marked "yes" above):

____

____

FAMILY HISTORY:

FATHER: Living: Age ___________ Deceased: Age ___________

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: ___________	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: ____

MOTHER: Living: Age ___________ Deceased: Age ___________

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: ___________	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: ____

SIBLINGS:

____

____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

____

____

Patient Signature: ___________________________________ Date: ____________________

New Patient Information and Consent

What is the reason for your visit today?

Patient Information

Name (First, Middle, Last)		Date of Birth	Age	Social Security #	Birth Gender ☐ M ☐ F
Mailing Address	Apt #	City, State ZIP			
Email Address		Primary Phone ☐ Home ☐ Cell		Okay to leave message? ☐ Yes ☐ No	
Primary Care Provider (where you go for your routine medical care)		☐ None ☐ Doctors Care is my primary care provider			
Preferred Language		Race ☐ Black or African American ☐ Asian ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ American Indian/Alaska Native ☐ Prefer not to answer			
Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino					

Emergency Contact

Contact Name	Phone Number	Relationship to Patient

Guarantor/Responsible Party (person responsible for payment)

Legal Name of Responsible Party (First, Middle, Last)	Social Security #
Email Address (if different from the patient email above)	Date of Birth

Preferred Pharmacy

Pharmacy Name	Pharmacy Location

Medical Insurance (please present your ID and insurance card to the receptionist)

PRIMARY Insurance Company Name	Policy Number/Member ID	Group Number
Insured Name	Insured Date of Birth	Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent
Insurance Company Address (usually on back of insurance card)		Phone

SECONDARY Insurance Company Name	Policy Number/Member ID	Group Number
Insured Name	Insured Date of Birth	Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent
Insurance Company Address (usually on back of insurance card)		Phone

Please continue to the next page.

New Patient Information and Consent

CONSENT FOR TREATMENT: I hereby voluntarily consent to care, treatment, testing and all other services performed by healthcare providers at Pioneer Family Medicine & Urgent Care. At the same time, I do understand that I have the right to refuse consent to any proposed care, treatment, testing, surgery, or procedure. Moreover, I have the right to ask questions and discuss my concerns with my healthcare provider. I am aware that the practice of medicine and surgery is not an exact science. I understand that diagnosis and treatment may cause injury or even death. I acknowledge that no guarantees have been made to me as to the outcome of my care, examination and; or treatment at Pioneer Family Medicine & Urgent Care. While I understand that I am required to sign this consent annually or as necessary, I may revoke this consent at any time my writing to the Pioneer Family Medicine & Urgent Care Release of Information Dept., PO BOX 994, Nortonville, KY 42442..

RELEASE OF MEDICAL INFORMATION: I understand that Pioneer Family Medicine & Urgent Care shall maintain both electronic and paper based documentation of the medical care received. This medical record will typically include individually identifiable information about my symptoms and health condition; results of physical examination and diagnostic tests; a plan regarding future care and treatment; as well as demographic and photographic identifiers. Such information about me is protected health information (PHI) and, as such, will be used, shared or disclosed only for the purpose of treatment, payment, and healthcare operations. Otherwise, it will not be inspected or released without my specific authorization except in certain circumstances outlined in the **Notice of Privacy Practices**.

Additionally, I am aware that data and information concerning essential medical treatment and healthcare services rendered on my behalf may be released, when necessary, to healthcare providers in emergent situations and/or to public and private health insurance plans in order to receive payment as outlined in the Pioneer Family Medicine & Urgent Care Financial Policy. However, I may request that PHI associated with that portion of my healthcare at Pioneer Family Medicine & Urgent Care, for which I paid out-of-pocket, not be disclosed to my health plan or insurance company. I understand that this request must be in writing.

A copy of the Notice of Privacy Practices is posted openly in both English and Spanish within the facility, and a paper copy is available at each registration desk.

PATIENT RIGHTS & RESPONSIBILITIES: I acknowledge that my healthcare is a partnership between Pioneer Family Medicine & Urgent Care and me; hence, I agree to actively participate and accept both my role and responsibility in reference to my healthcare and the rights available to me. A list of patient rights and responsibilities is posted in both Spanish and English within the facility. A copy of this is available upon request.

ADVANCE DIRECTIVES: Adults 1 8 and older have the right either (a) to give directions about their future medical care or (b) to designate patient representatives to make medical decisions for them if they lose individual decision-making capacity. I understand that information about advance directives is available to me upon request.

ATTESTATION: I have read and now fully understand the content of this consent form and its entirety, and all of my questions have been answered to my satisfaction.

ASSIGMENT & RELEASE: I hereby authorize my insurance benefits to be paid directly to the physicians and I am financially responsible for non-covered services. I also authorize the physician to release information required in the processing of this claim and all future claims. If any account is sent to a collection agency, I agree to pay all collection and attorney fees.

PATIENT SIGNATURE ______________________ **DATE:** __________

PATIENT PRINTED SIGNATURE ______________________

Patient HIPPA Acknowledgement and Consent Form

We at Pioneer Family Medicine & Urgent Care (the "Practice") are providing this Acknowledgement and Consent Form ("Consent") to You in compliance with the Health Insurance Portability and

this Consent, and by signing you acknowledge that you had the chance to review it. The terms of our Notice may change. If we change our Notice, we may notify you that a change has been made and you can obtain a revised copy by contacting our office.

Restrictions and Revocation

You have the right to request that we restrict how PHI about you is used or disclosed. We are not required to agree to any restrictions, but if we do, we will honor that agreement. You may revoke this Consent in a signed writing, at any time, and all disclosures from that point on will cease. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

Protecting and Sharing Your Information Accountability Act of 1996 (HIPAA), which provides guidelines to healthcare providers and other parties on safely sharing and protecting patient health information. By signing this Consent, you acknowledge that you understand its contents and you consent to our collection of your personal information, including individually identifiable health information (protected health information or ' 'PHI") such as your name, address, social security number, and insurance information.

Use & Disclosure

Signing this Consent also represents your consent to our use and disclosure of your private personal information, including PHI, to carry out your diagnosis, treatment, payment and health care operations. You are entitled to a copy of this Consent.

Notice of Privacy Practices

Our Notice of Privacy Practices ('Notice") provides information about how we may use and disclose your protected health information. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review the Notice before signing

We will do our best to protect all private and personal information that we receive, yet the sharing of such information with us is at your own risk. Information used or disclosed pursuant to this Consent may be redisclosed by the Practice and may no longer be protected by federal or state law.

Conditions and Application

The Practice may condition providing treatment to you upon your execution of this Consent. This Consent applies to any service the Practice provides or any interactions you have with us.

In compliance with HIPAA regulations, Pioneer Family Medicine & Urgent Care is committed to protecting your private health information. We need to know the names of the people that you will allow us to discuss your medical information, if

any.

Please List Names Below:

____

Name | Relationship | Phone Number

____

Name | Relationship | Phone Number

Patient/Representative Signature:_______________________________________Date:______________

Patient/Rep Printed Name:____Date:_____________