A Heartbeat Away
Your Neighborhood Clinic

Patient Data / Information de Paciente

Name/Nombre: **Date/Fetcha:**

Date of Birth/Fecha de Nacimiento: / / **Sex/Sexo: M/H F/M**

Address/Direction de Casa

City/Cidad **State/Estado** **Zip/Codigo Postal**

Phone/Telefono **Email/Correo Electronico:**

Emergency Contact Information / Informacion de Caso de Emergencia

Name/Nombre: **Phone/Telefonon:**

Relation/Relacion a paciente:

Records medical information release / Liberacion de informacion medica de registros

I hereby authorize the following individual
to disclose my protected health information (PHI) as describe below.

History/Physical - Historia, fisico

Laboratory Test Reports - laboratorio pueba informes

Pathology Reports - Pathology onformes

X-Ray - rayos x

Radiology/Diagnostic Test Reports - radiologia y diagnostico pueba onformes

Other

All Medical Records - All registros medicos

I understand and agree that: I have the right to revoke this authorization, in writing, at any time by sending such written notice to the Office Manager.

Entiendo y acepto que: tengo el derecho de revocar esta autorizacion, por escrito, en cualquier momento mediante el envio de tal notificacion por escrito a la oficina del administrador.

SIGNATURE: **Date:**

ALLERGIES TO MEDICATIONS: (circle all that apply) **No Known Drug Allergies**

Aspirin **Ceclor** **Hydrocodone (Vicodin/Lortab)** **Levaquin**

Aspirin **Ceclor** **Aspirin** **Ceclor** **Aspirin** **Ceclor**

Aspirin **Ceclor** **Aspirin** **Ceclor** **Aspirin**

Other:

SURGICAL HISTORY

Check all that apply **I DO NOT HAVE A SURGICAL HISTORY**

Adenoids (w/o tonsils)

Tonsils (w/o adenoids)

Adenoids & Tonsillectomy

Appendectomy

Artificial Joint: R L
Location(s):

Back-Reason
Cervical Thoracic Lumber

Breast Biopsy: R L

Breast Implants: R L

Breast Lift: R L

C-Section # of times:

Cancer:(Type)
Surgical Removal Chemo Radiation

Ear Tubes % of times:

Emdometrial Ablation

Eye R L
Type(s):

Gallbladder

Heart Bypass: #

Heart Stents

Hernia Repair: #

Hysterectomy

Mastectomy: R L

Orthopedic: R L
Body Parts:

Thyroiddectomy

Tubal Ligation

Vasecromy

OTHERS:

MEDICATION

I DO NOT TAKE ANY MEDICATION **I HAVE A LIST I WILL PROVIDE**

Medication	Dose (mg, mcg, mEq)	Form (tab, cap, liquid)	How Often taken (daily/weekly)	Route (oral/topical)

SIGNATURE: **Date:**

Heartbeat Away
Your Neighborhood Clinic

Patient Name: **Today's Date:**

Date of Birth: **Age:** **M** **F** **Last 4 # SS#**

Pharmacy: **Electronically Send**

Location: **Print**

Reason for Today's Visit:

FOR FEMALES: Are you pregnant or think you may be? **Yes** **No**

Date of last menstrual cycle:

Do you use tobacco products? **Yes** **No** **If yes, how much?** **Per day SMOKE OR DIP**

Do you drink alcohol? **Yes** **No** **If yes, how much?** **Per day**

Do you use illegal drugs **Yes** **No** **If yes, what kind?**

FAMILY HISTORY

The following questions pertain to your family: Brothers, Sisters, Patents, & Grandparents. ***(NOT YOU)***

	Yes	No	Unk		Yes	No	Unk
Coronary Artery Disease				Aneurysm			
High Blood Pressure				Diabetes			
Stroke				High Colesterol			
Cancer							

MEDICAL HISTORY

Check all that apply

I DO NOT HAVE A MEDICAL HISTORY

A Fib	CHF	Endometriosis	Hepatitis	Lap Band
Acid Reflux	COPD/Emphysema	Fibromyalgia	Herpes	Migraines
ADD / ADHD	Crohn's	Gallstones	High Blood Pressure	Neuropathy
Anxiety	CVA / Stroke	Gastric Bypass	High Cholesterol	Pakinson's
Arthritis / DJD	Dementia	Glaucoma	Hypothtroid	Pulmonary Embolism
Asthma	Depression	Gout	Hyperthtroid	Rheumatoid Arthritis
Breast Lump	Diabetes-Type	Heart Attack	Kidney Disease	Sciatica
Breast Reduction	Diverticulitis	Heart Disease	Kidney Stones	Sleep Apnea

OTHERS:

HIPAA Compliance Patient Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement.

The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication.

You have the right to revoke this consent in writing, signed by you. However, such s revocation will not be retroctive.

By signing this form, I understand that:

- **Protected health information may be disclosed or used for treatment, payment, or healthcare operations.**
- **The practice reserves the right to change the privacy policy as allowed by law.**
- **The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.**
- **The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.**
- **The practice may condition receipt of treatment upon execution of this consent.**

May we phone, email, or send a text to you to confirm appointments? **Yes** **No**

May we leave a message on your answering machine at home or on your cell phone? **Yes** **No**

(PRINT NAME PLEASE) **Date of Birth**

Signature: **Date:**

Witness: **Date:**