PATIENT INFORMATION

Last Name ________________________________

First Name ________________________________

Street Address ______________________________________ __________________

City/Town ___________________________________ Zip ________

Home Phone ____________________ Cell _______________________ work _______________________

Email __________________________________

Social Security #_____________________ Sex: Male/Female/other DOB___________________

Single/Married/Divorced/Separated/Widowed

Race/Ethnicity ________________________

Whom can we share medical information with? ____________________________________

Relationship _________________________ Phone # _________________

Emergency Contact info: ____

Relationship _________________________ Phone ___________________

May we retrieve your Rx history from external sources? Yes or No (please circle)

Preferred Pharmacy: ____________________ Pharmacy address/phone __________________

I understand that as part of my healthcare, Healing Hands Primary Care originates and maintains health records describing my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand that this information serves as:

A basis for planning my care and treatment; a means of communication among the healthcare professionals who contribute to my care; A source of information for applying my diagnosis treatment information to my bill; A means by which a third-party payer can verify that services billed were actually provided; A tool for routine healthcare operations such as assessing quality of care and reviewing the competence of healthcare professionals.

I understand that I have the right:

To object to the use of my health information for directory purposes; To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operation – and that the organization is not required to agree to the restrictions requested; To revoke this consent in writing, except for the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use of disclosure of my health information:

____

I, ______________________,

authorize Healing Hands Primary Care to disclose protected information (PHI) only as it relates to treatment, payment (billing), or healthcare operations as explained above.

I understand and have been provided with the Healing Hands Primary Care *Notice of Privacy Practices.*

I authorize Healing Hands Primary Care to submit claims to my insurance carrier as well as medical records needed to evaluate these claims for payment. I further authorize payment of benefits, otherwise payable to me, to be made payable to Healing Hand Primary Care. I understand that I am financially responsible for all charges not covered by my insurance.

If my insurance company is not in the Healing Hands Primary Care's network or I have no insurance coverage, I understand that I am financially responsible for all charges and must make payment today.

____ ____________________

Signature of Patient/Guardian Date

MEDICAL HISTORY

CURRENT COMPLAINTS:

____

____

ALLERGIES or DRUG INTERACTIONS:

____

____

SURGERIES:

____

____

____

BRIEF MEDICAL HISTORY:

____

____

____

Use of Alcohol Never _____ Rarely _____ Moderate ______ Daily ______

Use of tobacco Never_____ Previously, but quit ________ Current packs/day: __________

Use of drugs Never _____ Type/Frequency: ____________________________________

Do you feel Anxious _________ Depressed _________ Nervousness _____________

Do you have Memory loss ___________ Confusion __________ Insomnia ____________

FAMILY MEDICAL HISTORY:

____

____

____

MEDICATION	DOSAGE	FREQUENCY
______________________________	______________________	_______________________
______________________________	______________________	_______________________
______________________________	______________________	_______________________
______________________________	______________________	_______________________
______________________________	______________________	_______________________
______________________________	______________________	_______________________
______________________________	______________________	_______________________
______________________________	______________________	_______________________

List Doctors you have seen in the last year:

_____________________________________ ____

_____________________________________ ____

Additional Notes:

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