PRIME HealthCare, PC

PATIENT INFORMATION FORM

www.primehc.com

Patient Name

SEX
☐ Female
☐ Male

Answers to Questions Below ARE Required by the Federal Government American Recovery & Reinvestment Act of 2009

Social Security #

Date of Birth

Marital Status
☐ S
☐ M
☐ D
☐ W

Email Address

Race
☐ Caucasian
☐ Black
☐ Asian
☐ American Indian/Native Alaskan
☐ Native Hawaiian/Pacific Islander
☐ Other Race
☐ Unknown

Ethnicity
☐ Hispanic/Latino
☐ Not Hispanic/Latino

Ethnicity
☐ Caucasian
☐ Other
☐ Unknown

Language
☐ English
☐ Spanish
☐ French
☐ Polish
☐ Vietnamese
☐ Sign
☐ Other

Employment Status
☐ Employed ☐ Retired ☐ Part-Time Student ☐ Full-Time Student
☐ Self-Employed ☐ Disabled ☐ Unemployed

Mailing Address City State Zip Code

Home # Mobile # Work # & Extension

Employer Employer Address City State Zip Code

Referring Physician

Primary Care Physician

Referral Source
☐ Specialist ☐ PCP
☐ Physical Therapist ☐ Walk-In
☐ SFH-ER ☐ HH-ER
☐ Patient ☐ Friend
☐ Radio Ad ☐ TV Ad
☐ Yellow Pages ☐ Internet
☐ Educational Series ☐ Website
☐ Newspaper/Magazine Ad
☐ Marketing Campaign
☐ Other _____

Primary Insurance Plan Name

Group #

Effective Date

Insurance ID#

Visit Copay $ Amount

Deductible $ Amount

Subscriber: ☐ Patient ☐ Parent ☐ Spouse ☐ Other _____

Subscriber Name _____ DOB: _____

Social Security # Employer

Secondary/Supplemental Insurance Plan Name

Group #

Effective Date

Insurance ID#

Visit Copay $ Amount

Deductible $ Amount

Subscriber: ☐ Patient ☐ Parent ☐ Spouse ☐ Other _____

Subscriber Name _____ DOB: _____

Social Security # Employer

Emergency Contact

Relationship to Patient: ☐ Wife ☐ Husband ☐ Child ☐ Parent ☐ Friend ☐ Guardian ☐ Other _____

Name (F/M/L) Contact Phone # Work Phone #

I hereby authorize direct payment of medical/surgical benefits to PRIME Healthcare, PC for services rendered by our providers. I understand that I am financially responsible for any balance not covered by my insurance. I certify that the information given by me in applying for payment is correct. I hereby authorize PRIME Healthcare, PC, its agents and representatives, to access information regarding my person, whereabouts and medical history and to release all necessary information to my insurance company regarding my medical history, examinations, and treatment for the purposes of processing my insurance coverage. A photocopy of my signature is as valid as the original.

Signature _____ **Date** _____

PARENT / GUARDIAN INFORMATION

Patient's Relationship: ☐ Child ☐ Wife ☐ Husband ☐ Parent ☐ Brother/Sister ☐ Grandparent ☐ Aunt/Uncle ☐ Niece/Nephew ☐ Power of Attorney ☐ Other _____

Name (F/M/L) Social Security # DOB

Pharmacy Name/Address **Phone#**

All Patients: please complete pages 1,2 & 3 and SIGN at end of page 3 **GI History**

Last Name	First Name	Date of Birth	Today's Date

Circle the number of years of formal education you have completed

8	9	10	11	12	13	14	15	16	>16

Who suggested our office to you?

A physician referred me	Who?
A friend referred me	Who?
Other	Explain
Who is your primary care MD?	

Please state in one or two sentences the major reason for your visit.

Please list all previous operations with approximate dates. Circle None if appropriate.

1) None	6)
2)	7)
3)	8)
4)	9)
5)	10)

Please check the boxes next to all illnesses you have or have had.

- ❒ Atrial Fibrillation
- ❒ Angina Pectoris
- ❒ Artificial Heart Valve
- ❒ High Blood Pressure
- ❒ Pacemaker
- ❒ High Cholesterol
- ❒ Heart Attack
- ❒ Bleeding Disorder
- ❒ Emphysema
- ❒ Asthma
- ❒ Tuberculosis
- ❒ HIV/AIDS
- ❒ Diabetes
- ❒ Osteoporosis
- ❒ Thyroid Disorder
- ❒ Colon Polyps
- ❒ Irritable Bowel
- ❒ Ulcers
- ❒ Crohn's Disease
- ❒ Ulcerative Colitis
- ❒ Liver Cirrhosis
- ❒ Hepatitis
- ❒ Gallstones
- ❒ Lactose Intolerance
- ❒ Pancreatitis
- ❒ Diverticulosis
- ❒ Sprue
- ❒ Esophagitis
- ❒ Anemia
- ❒ Latex Allergy
- ❒ Cancer: Colon
- ❒ Cancer: Esophagus
- ❒ Cancer: Stomach
- ❒ Cancer: Pancreas
- ❒ Cancer: Prostate
- ❒ Cancer: Breast
- ❒ Sleep Apnea
- ❒ Excessive Alcohol Use
- ❒ Drug Abuse
- ❒ Depression
- ❒ Anxiety
- ❒ Suicide Attempt
- ❒ Stroke
- ❒ Migraine Headache
- ❒ Endometriosis
- ❒ Arthritis

List any other illnesses. Circle None if appropriate.

1) None	4)
2)	5)
3)	6)

I have reviewed the Prime HealthCare History

Physician Signature: _____ ***Date:*** ____ / ____ / ____

Please list any family members who have had any of the following problems.

Disease	Relation to you	Disease	Relation to you
Cancer: Colon		Colon Polyps	
Cancer: Esophagus		Crohn's Disease	
Cancer: Stomach		Ulcerative Colitis	
Cancer: Breast		Lactose Intolerance	
Sprue		Bleeding Problems	
Diabetes		Heart Disease	
Anemia		Alcohol Abuse	
Gall Bladder Stones		Hepatitis	
Liver Disease (cirrhosis)		Other	

List all your medications (including aspirin & laxatives). Circle None if appropriate

Name of Drug	Dose? (e.g. mg.)	How Often?
None		
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		

List all your medication allergies. If none are known, circle None.

None	3)	6)
1)	4)	7)
2)	5)	8)

Please circle the term that best describes your current employment status & describe.

Employed	Describe:
Retired	Previous job:
Unemployed	Previous job:
Student	Where?

Describe your use of the following: Circle None if appropriate.

Tobacco Use	None	___ Packs per day for ___ years	Stopped ___ years ago
Alcohol Use	None	Amount:	Stopped ___ years ago
Illegal Drug Use	None	Type & Amount:	Stopped ___ years ago
Coffee/tea	None	8 oz. cups per day:	

Please circle your answer:

Have you been vaccinated against hepatitis B?	Yes - No - Don't Know
Do you wish to be screened for colon cancer?	Yes - No - Don't Know

Last Name	First Name	Date of Birth	Today's Date

Please indicate whether you experience these symptoms. Circle yes or no.

Symptoms			Physician Comment
Lack of energy	Yes	No	Constitutional
Trouble sleeping	Yes	No	
Weight Loss (10 lbs in 1 yr)	Yes	No	
Weight gain (10 lbs in 1 yr)	Yes	No	
Fevers	Yes	No	
Hard or infrequent bowel movements	Yes	No	GI
Loose or frequent bowel movements	Yes	No	
Blood in bowel movements	Yes	No	
Vomit blood	Yes	No	
Heartburn/Indigestion	Yes	No	
Food sticks when swallowing	Yes	No	
Painful swallowing	Yes	No	
Yellow jaundice	Yes	No	
Chest pain	Yes	No	Cardiovascular
Irregular heartbeat	Yes	No	
Palpitations	Yes	No	
Swollen legs	Yes	No	
Fainting	Yes	No	
Shortness of breath	Yes	No	Respiratory
Wheezing	Yes	No	
Coughing up blood	Yes	No	
Asthma	Yes	No	
Frequent urination	Yes	No	GU
Blood in urine	Yes	No	
Difficulty urinating	Yes	No	
Could you be pregnant	Yes	No	
Painful menses	Yes	No	
Joint swelling	Yes	No	Musculoskeletal
Joint redness	Yes	No	
Gout	Yes	No	
Muscle aches	Yes	No	
Breast lump	Yes	No	Breast/Skin
Unusual or new rash	Yes	No	
Paralysis	Yes	No	Neuro
Stroke	Yes	No	
Seizures	Yes	No	
Loss of memory	Yes	No	
Depression	Yes	No	Psychological
Do you feel safe in current relationship	Yes	No	
Anxiety	Yes	No	
Diabetes	Yes	No	Endocrine
Excessive thirst	Yes	No	
Bleeding	Yes	No	Hemo
Easy bruising	Yes	No	
Allergy to shellfish	Yes	No	Allergy
Allergy to X-ray dye	Yes	No	

Patient's Signature _____ Date _____

PRIME HealthCare, PC

HIPAA PATIENT CALLING INFORMATION

Name: _____

Date of Birth: _____

With whom do you allow us to share your personal medical information?

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

How may we contact you?

Pleas list in the order the way you wish to be contacted. (1-4)

____**Home Phone:** _____

- DO NOT leave a message
- Leave a brief message, return number
- May leave a detailed message

____**Work Phone:** _____

- DO NOT leave a message
- Leave a brief message, return number
- May leave a detailed message

____**Cell Phone:** _____

- DO NOT leave a message
- Leave a brief message, return number
- May leave a detailed message

**I understand that it is my responsibility to notify the office of any changes in my calling or HIPPA information.

Patient Signature _____ Date _____

PRIME HealthCare, PC

Acknowledgement of Receipt of Notice of Privacy Practices

Name of Patient: _____ Date of Birth: _____

I hereby acknowledge that I reviewed a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that it may be amended at any time, and that I may request a copy of the Notice of Privacy Practices at any time.

This policy is applicable to all offices within Prime Healthcare. I understand that if I have any questions or complaints, I may contact the Privacy Officer at (860) 263-0253 EXT 231

Signature: _____ Date: _____

If not signed by the patient, please indicate your relationship to the patient: _____

For Office Use Only:

- Signed form received by: _____
- Acknowledgement refused:

  Efforts to obtain: _____ Reasons for refusal: _____