NEW PATIENT HEALTH HISTORY FORM

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Contact Phone	
Address	
Email	
Previous or referring doctor:	**Date of last physical exam:**

Notice of Patient Privacy/Patient Consent Form

I understand that as part of my healthcare, the physicians of One to One Health originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for serv ices provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

One to One Health Notice of Privacy Practices provides specific information and complete description of how my personal information may be used and disclosed. I understand that a copy of the Notice of Privacy Practices is available at the front desk and understand that I have the right to review the notice prior to signing this consent. I understand that One to One Health reserves the right to change the Notice of Privacy Practices. Prior to implementation of the revised Notice of Privacy Practices, the revised Notice will be mailed to me if I provide my address below. I understand I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment, or healthcare operations and that One to One Health is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that One to One Health has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen. You can request a paper copy of this notice, or any revised notice, at any time (even if you have allowed us to communicate with you electronically). For more information about this notice or our privacy practices and policies, please contact the person listed at the end of this document.

NOTE: One to One Health must obtain your written authorization to use your Private Health Information for any purpose other than treatment or billing. If you want One to One Health to have access to disclose your Private Health Information to your spouse or any other person during your treatment, please sign below.

_____ _____

Patient Signature Date

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fev er ☐ Polio		
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital