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Patient Intake Form

Patient Name:_____ Date:_____
(Last, First MI)

Medical History:

Current Medications:

_____

_____

Allergies:_____

Please check any of the following that apply:

☐ Abdominal Pain	☐ Anxiety	☐ Arthritis
☐ Atrial Fibrillation	☐ Bleeding Disorders	☐ Breast Cancer
☐ Cancer(other):	☐ Cervical Cancer	☐ Colitis
☐ Depression	☐ Diabetes	☐ Diarrhea
☐ Eczema	☐ Heart Disease	☐ Heart stents
☐ Hemorrhoids	☐ Herpes/cold sores	☐ High blood pressure
☐ HIV/AIDS	☐ Hypertension	☐ Melanoma
☐ Migraine/headaches	☐ Nausea/vomiting	☐ Ovarian Cancer
☐ Palpitations	☐ Stroke	☐ Supraventricular Tachycardia
☐ Thyroid disease	☐ Tire easily	☐ Trouble sleeping
☐ Tuberculosis	☐ Uterine/Endometrial Cancer	☐ Varicose Veins
☐ Other:		

Surgical History:

_____

_____

_____

Social History:

Alcohol use: _____drinks per day/week

Recreational drug use:_____

Do/did you smoke?_____ For how long?_____ When did you quit?_____

How often do you exercise?_____ Type:_____

Family History:

Please check any of the following that apply to an immediate family member:

☐Anemia	☐Asthma	☐Bleeding disorders
☐Blood clots	☐Breast cancer	☐Cervical cancer
☐Colon cancer	☐Diabetes	☐Heart disease
☐High blood pressure	☐Melanoma	☐Migraine/headaches
☐Obesity	☐Ovarian cancer	☐Prostate cancer
☐Seizures	☐Thyroid disorders	☐Uterine cancer
☐Other:		

Financial Policy

Thank you for selecting Dr Grace for your healthcare needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered.

I understand that results may vary from patient to patient and that results are not guaranteed.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and agree to these statements.

_____ _____

Patient signature Date

All statements on this patient intake form are accurate and true to the best of my knowledge. I understand that treatments will be based on the information provided. If I willingly withhold knowledge from my treating physician, I accept full liability from any consequences arising there from.

_____ _____

Patient signature Date

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Patient Contact Information/ Consent to Communicate

Patient Name: _____ Date:_____
(Last, First MI)

Address: _____Date of Birth:_____

_____
(City, State Zip)

How did you hear about our practice?_____

Method		Okay to leave a message?	Preferred Contact:
Home phone:		YES/NO	
Cell phone:		YES/NO	
Work phone:		YES/NO	
Email address: Is it okay to email medical information to this address? YES/NO Is it okay to email appointment reminders/promotions to this address? YES/NO			

Emergency Contact:

Name**:**_____Relationship:_____ Phone:_____

The following individual's have authorized access to my medical records:

Name: _____ Relationship:_____
Name: _____ Relationship:_____

Patient Signature:_____ Date:_____

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HIPPA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

Patient Signature:_____ Date:_____