Patient Profile Information

Name: ____ Date: ________/________/___________

Reason for Todays visit:

____

How did this occur?

____

Was this related to an accident **(please circle)**? Yes | No Work or Automobile?

____

Please list any Allergies (Medication, Foods, Adhesives/Latex/Betadine):

____

Please list Current Medical Conditions- Example: High Blood Pressure; High Cholesterol; Asthma/COPD; Heart Dz.

1.______________________________ 2. ___________________________ 3. ___________________________

4. _____________________________ 5. ____________________________ 6. ___________________________

Do you have hepatitis or other communicable disease? Yes | No Type:

____

Females- Are you pregnant? Yes | No If yes, how many weeks? _______ If no, date of last menstrual cycle: ____/____/______

Have you had recent Vaccines? **Flu**: Yes | No- Year ______ **Pneumonia**: Yes | No- Year______ **COVID**: Yes | No- Year______

Please current medications you are taking (dosing and frequency):

1.______________________________ 2. ___________________________ 3. ___________________________

4. _____________________________ 5. ____________________________ 6. ___________________________

Please list surgeries you have had with date:

1.______________________________ 2. ___________________________ 3. ___________________________

4. _____________________________ 5. ____________________________ 6. ___________________________

Please list any Family History of Illness and relationship (Example: Diabetes/Heart Dz./Stroke etc.)

____

Do you currently use/consume:

- ✓ **Tobacco** Yes | No (# of packs/day ____)
- ✓ **Alcohol** Yes | No (# of drinks/day _____)
- ✓ **Illicit Drugs** Yes | No (Type:____________________________________)

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Patient Information and Profile

General Medical History

Please check ✓ YES or NO for the following: (If you do not check anything, we will assume your answer is NO)

CONSTITUTIONAL

Weight Loss ❑ Yes ❑ No
Fever ❑ Yes ❑ No

EYES

Discharge From Eye ❑ Yes ❑ No
Impaired Vision ❑ Yes ❑ No

HENT

Headaches ❑ Yes ❑ No
Neck Stiffness ❑ Yes ❑ No

CARDIOVASCULAR

Chest Pain ❑ Yes ❑ No
Lightheadedness ❑ Yes ❑ No

RESPIRATORY

Shortness of Breath ❑ Yes ❑ No
Wheezing ❑ Yes ❑ No

GASTROINTESTINAL

Nausea ❑ Yes ❑ No
Constipation ❑ Yes ❑ No

GENITOURINARY

Possible Pregnancy ❑ Yes ❑ No
Frequency ❑ Yes ❑ No
Incontinence ❑ Yes ❑ No

INTEGUMENT

Rash ❑ Yes ❑ No
New Skin Lesions ❑ Yes ❑ No

NEUROLOGIC

Muscular Weakness ❑ Yes ❑ No
Seizures ❑ Yes ❑ No

MUSCULOSKELETAL

Joint Pain ❑ Yes ❑ No
Muscle Cramps ❑ Yes ❑ No

Any other significant medical history or additional comments: ______________________________

____

____

____

____

____

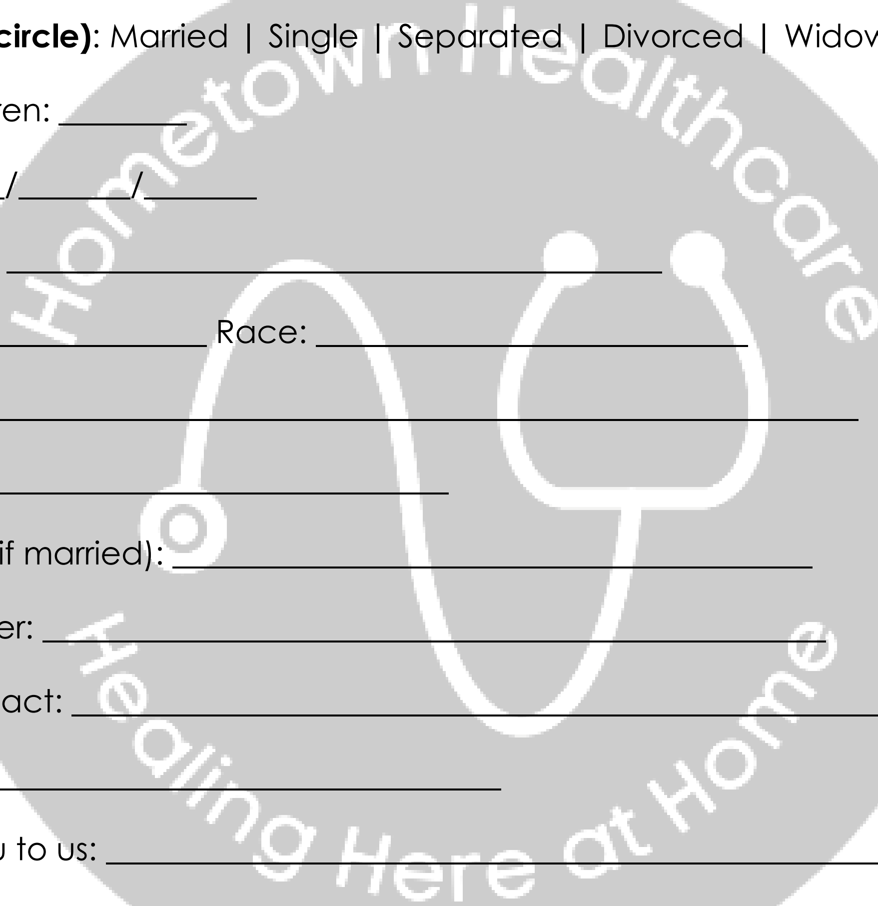
____

Name of person filling out this form (if different than patient): ______________________________

Relation to patient: ____________________

Patient Signature: ______________________________________

PATIENT INFORMATION



Name: Last________________________________ First ______________________________ Middle _________

Address: _______________________________________City___________________________State_______

Zip Code_______________

Home#: _________________________________ Work#: _________________________________

Cell#: ____________________________________ Email: ____

Are you **(please circle)**: Married | Single | Separated | Divorced | Widowed?

Number of Children: ________

Birthdate: _______/_______/_______

Social Security #: ____

Sex: ___________________________ Race: _____________________________

Employer: ____

Employer Ph#: ________________________________

Spouse's Name (if married): ____

Spouse's Employer: ____

Emergency Contact: ____

Phone#: ____

Who referred you to us: ____

Pharmacy Name: ____

Pharmacy Phone #: ____

Primary Care Provider: ____

Referring Provider: ____

Specialists Seen: ____

INSURANCE INFORMATION

Insurance Company
(Primary): ____
Policy Holder's Name: ____
Birthdate _______/_______/_______
Contract Number: ____
Group Number: ___________________________

Insurance Company
(Secondary): ____
Policy Holder's Name: ____
Birthdate _______/_______/_______
Contract Number: ____
Group Number: ___________________________

CONSENT FOR TREATMENT

I consent to necessary treatment, including drugs, medication, performance and operation of X-ray, or other studies that may be used by the attending physician, nurse, or staff.

CONSENT FOR E-PRESCRIBING

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

NON-COVERED SERVICE AGREEMENT

As your p**rovider**, I want to provide you with the best care possible. There may be certain routine services performed during your visit(s), such as DEXA scans, pap smears, biopsies, ultrasounds/X-Rays, lab work, injections, and/or other testing that I feel necessary for the maintenance of your good health that may not be covered by your insurance contract. By signing below, you agree that you will be responsible for costs not covered by your insurance.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I received a copy of the Notice of Privacy Practices.

NOTICE OF PATIENT PORTAL ACCESS

I acknowledge that Hometown Healthcare uses the patient portal to provide me with access to my medical information and as a point of contact for me with the practice/provider. I give my consent for use of the patient portal for my care and understand that it does contain protected health information.

Patient Signature: ____

Patient Email for Portal Access: ____

Date: ____________________

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Cancellation Policy/No Show Policy

We strive to promote the best quality healthcare for our patients. One of the ways we meet your healthcare needs is to provide appointments in a timely manner. In order to provide timely appointments, we have the following <u>No Show/Cancellation policy:</u>

1. *Cancellation/ No Show Policy for Medical Appointment*

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an Appointment, you may be preventing another patient from receiving much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full” appointment schedule.

If an appointment is not cancelled at least 24 hours in advance you may be subject to fees which are not covered by your insurance company. More than 3 no shows within a six-month period will result in dismissal from the practice. Violators will receive a letter after the second no show as a reminder of the policy.

2. *Scheduled Appointments*

We understand that delays can happen however we must try to keep the other patients and the p**rovider** on time.
If a patient is 15 minutes past their scheduled time, it may be necessary to reschedule your appointment.

3. Account balances

We will require that patients with self-pay balances do pay their account balances to zero (0) prior to receiving further services by our practice.
Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to the **office manager** with whom they can review their account and concerns.
Patients with balances over $100 must make payment arrangements prior to future appointments being made.

Printed Patient Name: ______________________________

Patient/Guardian Signature: ___________________________

Date: ___/___/______

AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

______**DO NOT** wish to have test results or other medical information released to any person other than myself.

______ **I DO** wish to have test results or other medical information released to the following person(s):

Name; Relationship; Phone#: ____

Name; Relationship; Phone#: ____

Name; Relationship; Phone#: ____

It is the responsibility of the patient to notify this office of any changes in the above information. If changes do occur, the patient must file another Authorization for Release of Patient Information with this clinic. Please understand that it may be necessary for us to disclose some, or all the Information contained in your medical records to other Medical Practitioners, Nurses, and/or Healthcare Providers (collectively referred to as "providers"). At times, other providers assist by assessing a patient's condition, screening for potential problems, or providing consultation under certain circumstances. All healthcare providers are required by law to maintain your patient confidentiality.

Also, due to the increased awareness of quality care and outcome measurements, it may be necessary to disclose information regarding your care to healthcare agencies (both private and governmental), your insurance company and/or your self-insured employer. Regarding the information going to your employer, other than information needed to verify your insurance coverage, the data released will consist of statistical information only.

Patient Name Printed:

____

Patient Signature:

____

Date: _____/_____/__________

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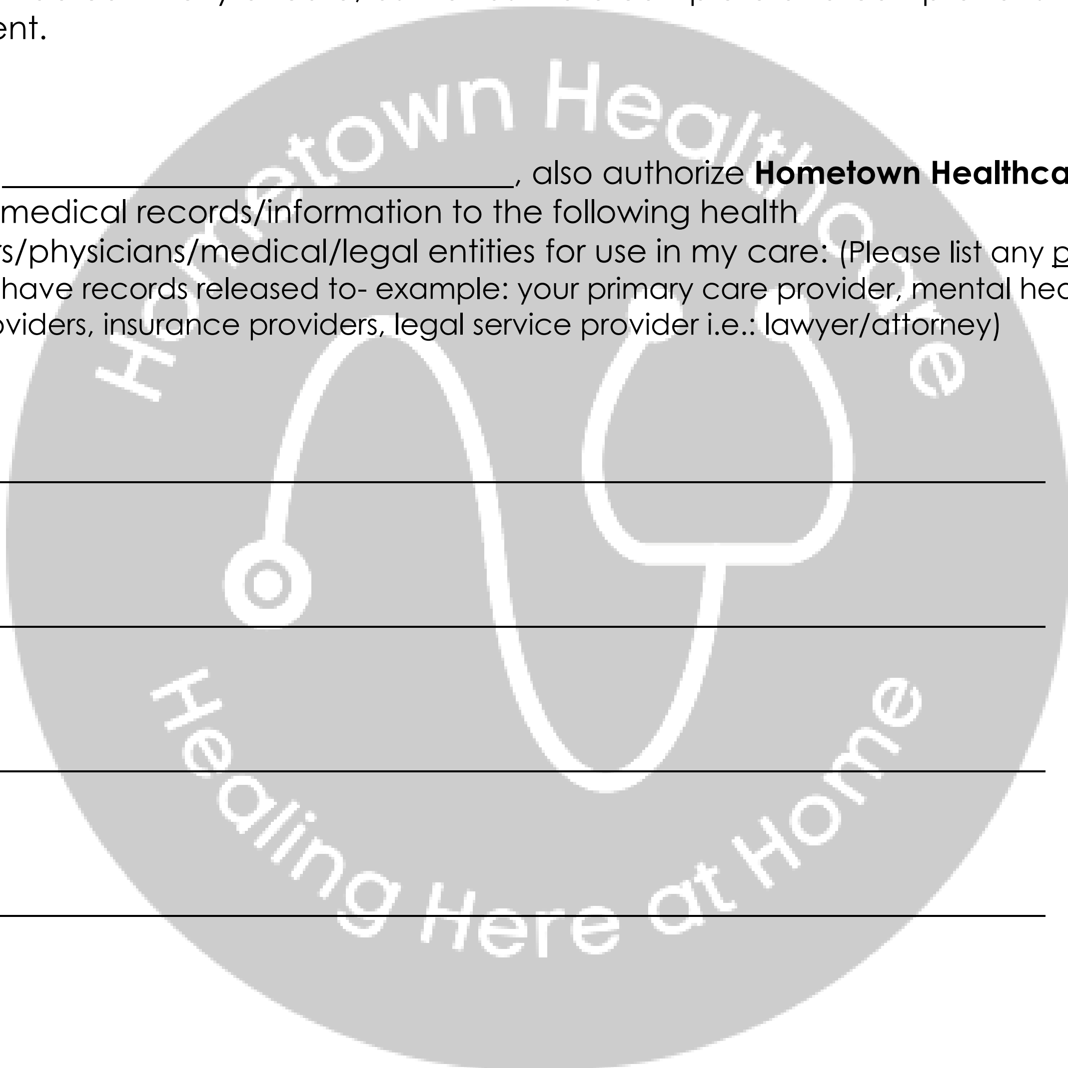
AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

I, (patient name) ________________________________, give permission to release my personal medical records, and any other protected health information to **Hometown Healthcare** for use regarding my medical care while I am a patient under their services/treatment/care. I understand that my information is protected by HIPAA and that **Hometown Healthcare** will maintain my patient privacy with any records or information obtained. I understand that this helps to provide continuity of care, as well as more complete and comprehensive care management.



I, (patient name)________________________________, also authorize **Hometown Healthcare** to release my medical records/information to the following health practitioners/physicians/medical/legal entities for use in my care: (Please list any professional you want to have records released to- example: your primary care provider, mental health provider, specialty providers, insurance providers, legal service provider i.e.: lawyer/attorney)

1.____

2.____

3.____

4.____

Patient Printed Name: ____

Patient Signature: ____

Date: ______/______/___________

Patient Health Questionnaire-9

Over the past 2 weeks have you had or experience any of the following?

Please circle your answer:

	Not at all	Some days	Over half the days	Nearly every day
1. Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
2. Feeling down, depressed, or hopeless	**0**	**1**	**2**	**3**
3. Trouble falling or staying asleep, or sleeping too much	**0**	**1**	**2**	**3**
4. Feeling tired or having little energy	**0**	**1**	**2**	**3**
5. Poor appetite or overeating	**0**	**1**	**2**	**3**
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	**0**	**1**	**2**	**3**
7. Trouble concentrating on things, such as reading the newspaper or watching television	**0**	**1**	**2**	**3**
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	**0**	**1**	**2**	**3**
9. Thoughts that you would be better off dead or of hurting yourself in some way	**0**	**1**	**2**	**3**

Total of Columns: ________

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people (circle answer)?

Not difficult at all   Somewhat difficult   Very difficult   Extremely difficult

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