Family Medicine of Warren, PA, PC.

Patient Contact Information

r. 11.06.19

PATIENT INFORMATION

Patient:	**DOB:** **Social Security #:**
Address:	**Sex:** Male / female
City: **State:** **Zip:**	**Race:** White/ Asian/ African American/ Native American/ Other: _____
Home phone: **Cell phone:**	**Ethnicity:** Hispanic / Latino / Other:_____
Employer: **Phone:**	**Language:** English / Other: _____
Email*	

PARENT/GUARDIAN INFORMATION

Mother/Guardian: **DOB:**	**Father/Guardian:** **DOB:**
Marital Status: Single / Married / Separated / Divorced	**Marital Status:** Single / Married / Separated / Divorced
Address: **City:** **State:** **Zip:**	**Address:** **City:** **State:** **Zip:**
Home phone: **Cell phone:**	**Home phone:** **Cell phone:**
Employer: **Phone:**	**Employer:** **Phone:**
***Email:**	***Email:**

***Only one parent can have an email for the patient portal. Please specify: Mother/Father**

PREFERRED METHOD FOR CONTACT (please circle all that apply)

Medical Issues:	Home # / Cell # / Email	Work Phone # / With Another Person / via Mail / Send via Portal
Appointment Reminders:	Home # / Cell # / Email	Work Phone # / With Another Person / via Mail / Send via Portal
General Notices:	Home # / Cell # / Email	Work Phone # / With Another Person / via Mail / Send via Portal

PRIMARY PERSON RESPONSIBLE FOR ALL BILLS

Please specify: Self/Spouse/Other: _____ Address:

EMERGENCY CONTACT

Name:	**Relationship:**	**Phone #:**
Name:	**Relationship:**	**Phone #:**

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I authorize and give permission to Family Medicine of Warren to disclose and release my private health information/or for my child to:

Name:	**Relationship:**	**Phone #:**
Name:	**Relationship:**	**Phone #:**
Name:	**Relationship:**	**Phone #:**

INSURANCE INFORMATION

Please give your insurance cards to the receptionist.

CONSENT TO TREAT/ASSIGNMENT & RELEASE

My signature authorizes treatement. It also acknowledges that the above information is true and that I have presented all eligible insurance information at the time of visit. Any unpaid balances or balance due to insurance issues will be my responsibility.

Authorized Signature:	**Date:**
Print name:	**Relationship to Patient:**

Family Medicine of Warren, PA, PC.

CONSENT TO USE AND DISCLOSURE OF INFORMATION

FOR TREATMENT, PAYMENT OR OPERATIONS

I hereby consent to the use and disclosure of information in my medical records for treatment, payment and health care operations, purposes. I understand that this consent is voluntary. I understand that information in my medical records may be used and disclosed to persons other than Family Medicine of Warren to carry out their responsibilities in connection with my medical healthcare treatment, in payment for health care services rendered to me and in activities related to health care operations.

I understand that additional information on Family Medicine of Warrens' privacy practices related to my medical records is available from the Family Medicine of Warren comprehensive Notice of Privacy Practices, a copy of which has been made available to me prior to signing this consent.

I understand that changes in Family Medicine of Warrens' privacy practices will result in modifications to the Notice of Privacy Practices and that up-to-date notices will be available at the reception desk of Family Medicine of Warren.

I understand that I may request Family Medicine of Warren to restrict how or to whom my medical records are used or disclosed, but that Family Medicine of Warren may refuse the restrictions I request. However, if Family Medicine of Warren agrees to the restrictions, it is bound to them when disclosing information in my medical records. I further understand that if there are any individuals to whom patient information may not be released, but who, under law and absent Court Order, may otherwise be entitled to receive such information (i.e. a parent whom the Court has determined is not to share legal custody of a minor), I must provide Family Medicine of Warren with a listing of the subject person's name and last known address in addition to the relevant legal documentation affording me the right to exclude them from receiving medical records of the treated individual or, otherwise, such information may not be withheld.

I understand that I can revoke this consent at any time, by notifying Family Medicine of Warren in writing, but if I do, it won't have any effect on actions Family Medicine of Warren took before they received the notification.

I understand that this consent applies to the use and disclosure of information for treatment, payment or operations purposes only and that Family Medicine of Warren may decline to provide medical health care services to me if I do not sign it.

I authorize Family Medicine of Warren to treat myself or child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Family Medicine of Warren for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. Interest fees will be applied to all unpaid balances. Any unpaid balances over 120 days will be sent to Family Medicine of Warren's Collection Agency. Collection costs and/or Attorney fees will be added to the balances. I agree to reimburse Family Medicine of Warren the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs and expenses, including reasonable attorney's fees, Family Medicine of Warren incurs in such collection efforts. A photocopy/scanned copy of this authorization shall be considered as effective and valid as the original.

I understand that if my physician, or any person employed by or under the direction and control of my physician(s), is directly exposed to my body fluids in any manner which may, according to the current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C viruses, that I am deemed by law to have consented to the release of these test results to the person who is exposed to my body fluids.

I understand that payment for services rendered will be from Insurance, self, or Federal and State funds, and that any false claims, statements, or documents, or concealment of material may be prosecuted under applicable Federal and State Laws.

_____ _____

Patient Name Date

_____ _____

Signature Relationship to Patient

PATIENT NAME:_____

MEDICATIONS

List medicines you are currently taking

NAME	DOSE	PILLS EACH TIME	TIMES /DAY
1)			
2)			
3)			
4)			
5)			

SURGERIES

List surgeries you have had such as tonsils, appendix, gallbladder, or female surgeries

1) 4)

2) 5)

3) 6)

MEDICAL HISTORY

List other practices or specialists that you see

_____

List how much tobacco, alcohol, or caffeine (coffee, cola) you use in a week

_____

List allergies to medicines and what happens when you take them

_____

List your interests and hobbies

_____

PATIENT NAME:_____

Check symptoms you currently have or have had in the past

__Abdominal pain	__Allergies	__Anemia	__Black tarry stools
__Blurred vision	__Bright red bleeding	__Broken bones	__Chest pain
__Chronic cough	__Chronic headaches	__Colitis	__Color blindness
__Diarrhea	__Gallbladder disease	__Hearing changes	__Indigestion/heartburn
__Kidney stones	__Loss of consciousness	__Muscle aches	__Nausea
__Numbness/tingling	__Pancreatitis	__Seizures	__Shortness of breath
__Trouble swallowing	__Using cane/walker	__Using glasses/lens	__Using hearing aid
__Vomiting	__Weakness or fatigue		

__Other(list):_____

Reason for current visit_____

Please put the most recent date you had the following done:

_____ Bone Density Test

_____ Colonoscopy

_____ Mammogram

_____ PSA (Prostate test)

_____ Tetanus shot

_____ Pap Smear

Patient Name (Last, First, Middle Initial) | Date of Birth | Social Security/ID Number

SIGNIFICANT MEDICAL HISTORY

Please check any problem that the patient or an immediate family member has or had:

	Patient	Mother	Father	Brother	Sister
Acne					
Attention deficit disorder					
Anemia (low blood count)					
Aneurysm-abdomen					
Aneurysm-brain					
Anxiety					
Asthma					
Abnormal pap smear					
Back pain-chronic					
Bleeding disorder					
Breast problem					
Cancer					
Irregular heart rhythm					
Chronic fatigue syndrome					
Carotid artery disease					
Coronary artery disease					
Depression					
Diabetes mellitus					
Dysfunctional uterine bleeding					
Dysmenorrhea					
Eating disorder					
Eczema					
Emphyzema					
Endometriosis					
Epilepsy/seizure					
Gallbladder disease					
Gastritis (stomach problems)					
Gastroesophageal reflux					

	Patient	Mother	Father	Brother	Sister
Headaches-chronic					
Hearing impaired					
Heart attack/heart failure					
Hepatitis/liver failure					
Hypercholesterolemia (high cholesterol)					
Hypertension (high blood pressure)					
Hyperthyroidism					
Hypothyroidism					
Irritable bowel syndrome					
Kidney stones					
Leukemia					
Lymphoma (lymph node cancer)					
Mitral valve prolapse (heart valve problems)					
Mobility impaired					
Ovarian cyst					
Peptic ulcer disease					
Pneumonia					
Premenstrual syndrome					
Pulmonary embolism (blood clots)					
Schizophrenia/mood disorder/bipolar					
Sinusitis,chronic					
Substance abuse (alcohol, drugs)					
Thyroid disease					
Thrombophlebitis					
Tobacco use					
Ulcerative colitis/colitis					
Uterine fibroids					
Vision impaired					

Other Significant Medical Problems:

FAMILY MEDICINE OF WARREN, PA, P.C.

143 Pleasant Drive, Warren, PA 16365

Phone: 814-726-3310 Fax: 814-723-1338

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Family Medicine to use, disclose, and/or receive certain protected health information (PHI) and me to/from:

___ **SEND COPIES TO** Name:_____

___ **REQUEST FROM** Address:_____

___ **TRANSFER TO** City, State, Zip_____

PLEASE SEND THE MOST RECENT LAST TWO YEARS OF MEDICAL INFORMATION. NO CD's

Name of patient: _____

This authorization permits Family Medicine to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used/disclosed, such as dates of services, types of services, level of detail etc.). Federal rules prohibit Family Medicine from re-disclosure of this information unless further disclosure is permitted by the patient with written consent.

This authorization pertains to the disclosure of the record types indicated below between the following dates of service: from_____to_____or all records retained by facility, circle one or all.

Progress notes Laboratory tests Immunization records Operative reports

Hospital records Imaging reports Other specified information:_____

The information will be used/disclosed for the following purpose (purpose may be listed as "at the request of the individual"): Circle one or all.

Continuing Care Insurance Legal Personal Use Transfer of care Other: _____

This authorization will expire on:_____or be valid until such time that you receive written notice from me revoking this release:

I have read and understand this authorization, and authorize use/disclosure of health information about the named patient as described in this authorization.

_____ _____ _____

SIGNATURE OF PATIENT/GUARDIAN **PATIENT DOB** **DATE**

_____ _____

PRINTED NAME PATIENT/GUARDIAN **RELATIONSHIP TO PATIENT**