PLATEAU CLINIC

NEW PATIENT INFORMATION SHEET

Dr. Paul Conley

PATIENT INFORMATION

PATIENT NAME (LAST) _____ (FIRST) _____ (MI) ___

ADDRESS _____

DATE OF BIRTH _____ AGE_____ SOCIAL SECURITY #_____

MALE_____ FEMALE_____ MARITAL STATUS_____ EMAIL ADDRESS_____

EMPLOYED: Y N NAME OF EMPLOYER_____

RETIRED: Y N EMPLOYER ADDRESS_____

SPOUSE NAME _____ SPOUSE'S DATE OF BIRTH_____

IF CHILD PARENTS NAME_____

NEXT OF KIN (SOMEONE NOT LIVING IN YOUR HOUSEHOLD)_____

RELATIONSHIP_____ PHONE_____

GUARANTOR INFORMATION (IF DIFFGERENT FROM PATIENT)

NAME (LAST)_____ (FIRST)_____(MI)___

ADDRESS_____

Phone #_____ WORK #_____CELL#_____

RELATIONSHIP TO PATIENT_____

DATE OF BIRTH_____ SOCIAL SECURITY NUMBER _____

EMPLOYED Y N NAME OF EMPLOYER_____

EMPLOYER ADDRESS_____

DO YOU HAVE A LIVING WILL OR MEDICAL POWER OF ATTORNEY? YES NO

I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION INCUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENTS OR EXAMINATIONS RENDERED TO MY INSURANCE AND ANY OF MY TREATING PHYSICIAN'S. THE RELEASE IS SOLELY FOR THE PURPOSE OF FACILITATING THE BILLING AND REIMBURSEMENT, DIRECTLY TO THE PHYSICIAN OF BENEFITS UNDER WHICH I AM ENTITLED. I ALSO AUTHORIXE THE FAXED TRANSMISSION OF MEDICAL RECORDS ON MY BEHALF TO MY INSURANCE COMPNAY OR ANY OTHER PHYSICIAN'S.

SIGNATURE_____DATE_____

PLATEAU CLINIC AUTHORIZATION FORM

I, _____ hereby authorize Plateau Clinic to (list all that apply) use and/or disclose certain protected health information about myself to the following individuals as set forth in this Authorization Form as well as leave a message on an answering machine for said patient on home and/or cell numbers provided on patient information sheet.

Name **Relationship to Patient**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature of Patient, Legal Guardian, or Personal Representative Date

_____

Printed Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority (if applicable)

Patient/Guardian/Personal Representative to be provided with a signed copy of this authorization upon request.

HEALTH HISTORY PLATEAU CLINIC

Name_____ Date of Birth_____

Referring Physician_____

Reason for visit today_____

Surgical History

Please list all procedures and operations you have had

_____

_____

_____

_____

_____

_____

_____

_____

Medication History

Please list all medications that you are currently taking including over the counter medications such as Tylenol, Ibuprofen, Aspirin, Laxatives, Vitamins, etc.

_____

_____

_____

_____

_____

_____

_____

_____

What pharmacy do you use?_____

Allergies

Please list all known drug, food, and environmental allergies

_____

_____

_____

_____

_____

_____

_____

_____

Social History

Please answer the following questions:

1. Do you smoke?_____ If yes, how much?_____
2. Do you use chewing tobacco?_____
3. Are you exposed to second hand smoke?_____
4. Do you drink caffeine?_____ If yes, how much?_____
5. Do you drink alcoholic beverages?_____ If yes, how much?_____
6. Do you now or have you ever taken illegal drugs?_____
7. What is your occupation?_____

Family History

Circle yes or no and please indicate relationship to you:

Breast Cancer	Yes	No	Relationship _____
Colon Cancer	Yes	No	Relationship _____
Diabetes	Yes	No	Relationship_____
Heart Disease	Yes	No	Relationship_____
Arthritis	Yes	No	Relationship_____
Kidney Disease	Yes	No	Relationship_____
Asthma	Yes	No	Relationship_____
High Blook Pressure	Yes	No	Relationship_____
Other (please specify) _____			Relationship_____

Date of your last period_____

Date of last mammogram_____

Are you now or could you be pregnant?_____

I certify that the above information is correct to the best of my knowledge. I will not hold the doctor of staff members responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature Date

PAST MEDICAL HISTORY **PLATEAU CLINIC**

	Yes/No		Yes/No
ADHD		Heart Murmur/Valvular Disease	
Abnormal Weight Loss		Hepatitis (Acute or Chronic)	
Alcoholism		Hernia(s)	
Allergies		High Cholesterol	
Anemia		Hypertension	
Anxiety Disorder		Hyperthyroidism	
Arthritis		Kidney Disease	
Asthma or Breathing Problems		Liver Disease	
Bladder or Kidney Problems		Lumbar Disc Disease	
Bleeding Disorder		Measles	
Blood Diseases		Migraine Headaches	
Breast Lump		Miscarriage	
Broken Bones		Mononucleosis	
Bronchitis		Multiple Sclerosis	
Cancer		Mumps	
Carotid Disease		Pacemaker	
Chemical/Drug Dependency		Pneumonia	
Chronic Obstructive Pulmonary Disease		Polio	
Constipation		Prostate Problems	
Deep Vein Thrombophlebitis		Psychiatric Care	
Depression		Rheumatic Fever	
Diabetes		Scarlet Fever	
Ear or Hearing Problems		Sexually Transmitted Disease	
Epilepsy		Stroke	
Glaucoma		Suicide Attempt	
Goiter		Thyroid Problems	
Gout		Tonsillitis	
HIV Positive		Tuberculosis	
Headaches or Dizziness		Typhoid Fever	
Heart Attach(MI)Angina		Ulcers	
Heart Disease		Vaginal Infections	

Notes:

1. **ASSIGNMENT OF INSURANCE BENEFITS/PROMISE TO PAY:**
I hereby assign and authorize payment directly to the Physician Clinic all insurance benefits, sick benefits, injury benefits due because of liability of a third-party, or proceeds of all claims resulting from the liability of a third party, payable by any party, organization, et cetera, to or for the patient unless the account for this Physician Clinic, outpatient visit or series of outpatient visits is paid in full upon discharge or upon completion of the outpatient series. If eligible for Medicare, I request Medicare services and benefits. I further agree that this assignment will not be withdrawn or voided at any time until the account is paid in full. I understand that I am responsible for any charges not covered by my insurance company.
I understand that I am obligated to pay the account of the Physician Clinic in accordance with the regular rates and terms of the Physician Clinic. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above Physician Clinic visit may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment. I consent for the Physician Clinic to work with my insurance company/companies on my behalf on authorization, appeal on my behalf any denial for reimbursement, coverage, or payment for services or care provided to me.

2. **PATIENT CONSENT FOR E-PRESCRIBING (ELECTRONIC 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.
I have been provided the Electronic Prescribing Notice.

3. **NOTICE OF PRIVACY PRACTICES:**
Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received a copy of the Physician Clinic's Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at the Physician Clinic, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.

4. **GENERAL CONSENT FOR TESTS, TREATMENT, AND SERVICES:**
I have been informed of the treatment procedures considered necessary for me and that the treatments/procedures will be directed by a physician or independent Advanced Practitioner, in accordance with state laws, scope of practice, and licensure of medical staff.
I hereby consent to engaging in virtual health/telemedicine services, where available, as part of my treatment. I understand that "virtual health" or telemedicine services includes the practice of health care delivery, diagnosis, consultation, treatment, transfers of medical data, and education using interactive audio, video, or data communications.

5. **ADVANCE DIRECTIVE ACKNOWLEDGEMENT:**
Federal law requires that patients be provided information about their rights to make advance health care decisions, including Living Will, Durable Medical Power of Attorney or designation of surrogate decision made for healthcare decisions. If you have already completed any of these documents, please inform your physician and the Physician Clinic.
Please check one:
- ☐ I have executed an advance directive and have supplied a copy to the Physician Clinic.
- ☐ I have executed an advance directive and have been requested to supply a copy to the Physician Clinic.
- ☐ I have reviewed the directive(s) on file with this Physician Clinic and it is/they are my current directive(s).

Patient Label

☐ I have not executed an advance directive. I have received information about advance directives from this Physician Clinic.

☐ I have not executed any advance directives, and I do not wish to receive information about advance directives from this Physician Clinic

6. **RESEARCH STUDIES:**

Are you currently a participant in any research study or project: *(If yes, please briefly describe what is being studied (drug, medical device or other)* _____

Who can the Physician Clinic contact with questions about the Study? _____ .

7. **CONSENT TO PHOTO/VIDEO:**

I consent to the photographing, videotaping and/or video monitoring, including appropriate portions of my body, for medical and medical record documentation purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations.

8. **CONSENT TO PHOTOGRAPH AT THE TIME OF REGISTRATION:**

I, or my authorized legal representative, hereby give consent to the medical practice to take my photograph at the time of registration. I understand this photograph will be stored in the medical practice's ambulatory medical record electronically as my photo identification.

9. **E-MAIL:**

I hereby consent to provide my e-mail address, so that representatives from the Physician Clinic can e-mail information to me about health education or disease prevention and up-to-date information about the Physician Clinic, its affiliated physicians, and our services. I understand I will be able to change my preference at any time.

Email Address:

10. **CELL PHONES:**

I hereby consent to provide my telephone number(s), including my wireless telephone number(s), so that representatives from the Physician Clinic, its successors or assigns can contact me in any manner including but not limited to by manually placing a call, by using an automatic telephone dialing system or an artificial or prerecorded voice, by texting, or by e-mailing, regarding any matter, including but not limited to my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. This consent includes any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time.

11. **VIDEOTAPING/RECORDING:**

I understand and agree not to photograph, videotape, audiotape, record or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure those accompanying me comply with this requirement.

The undersigned certifies that s/he has read (or have had read to me) the foregoing, understands it, accepts its terms, and has received a copy of. I hereby agree to all terms and conditions set forth above and understand that any sections of this consent that I do not consent to, I have struck through and initiated the section that does not have my consent or permission.

Patient's Signature or Legal Representative				Date	Time
Relationship to Patient			Interpreter If Utilized	Date	Time
Witness Signature	Date	Time	If Telephone Consent, Second Witness Signature	Date	Time

Patient Label