Document # DMG1020 Acct #:_____

Patient Information **Date:_____**

Patient name:_____ DOB:_____

Address:_____ SSN:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email:_____

Sex: ☐ Male ☐ Female

Gender Identity: ☐ Male ☐ Female ☐ Female-to-Male ☐ Male-to-Female ☐ Genderqueer

Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Other:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered ☐ Other:_____

Race: ☐ White ☐ White European ☐ African American ☐ American Indian, Alaska Native

☐ Asian ☐ Native Hawaiian, Pacific Islander ☐ Other:_____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline

Smoking Status: ☐ Never ☐ Current every day ☐ Current some days ☐ Former

☐ Heavy tobacco smoker ☐ Light tobacco smoker ☐ Decline

Preferred Pharmacy: _____Location: _____ Phone Number: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Primary Insurance Information

Carrier: _____ ID#: _____ Group#: _____

Claims Address: _____

Policyholder Information if other than self

Name:_____ DOB:_____

Address (If different):_____

I certify that all the above information is correct and up to date.

Printed Name:_____ **Signature**:_____

Financial Responsibility

As a courtesy, Rocky Run Family Medicine sends claims to primary and in many cases, secondary insurances. We do not send claims to automobile insurances for motor vehicle accidents. For a workers' compensation visit, you must provide us with your company information so the office visit does not get billed to your insurance. It is fraud to misrepresent or misinform us of your insurance policy or card.

It is the responsibility of the patient to pay any copays, coinsurances, deductibles, and insurance denied charges associated with your visit.

Copays are contractually due at the time of service. If your copay is not paid at the time of your visit, you will be responsible for your copay amount plus an additional $15 fee.

It has been our policy since 2006 that missed appointments, and appointments cancelled or changed within 1 business day, are subject to additional fees. A copy of our full policy is available upon request.

I understand that copays, coinsurance, deductibles, and denied charges are my responsibility. _____

I understand the policy for missing, cancelling, changing, and being late to appointments. _____

Patient Name:_____ DOB:_____

Signature:_____ Date:_____

HIPAA Consent Form

Must be completed at the first visit of each calendar year for each patient

I understand that as part of my healthcare, Rocky Run Family Medicine maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care and treatment. I also understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that the services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have access to a HIPAA Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand I have the right to review the notice prior to signing this consent. I understand the practice reserves the right to change their notice and practice. I also understand that I have the right to restrict how my Protected Health Information (PHI) may be used or disclosed to carry out treatment, payment, or healthcare operations and that the practice is required to agree to the restrictions requested. I understand that I may revoke this consent in writing. Any patient, guardian, or personal representative has the right to request confidential communication of PHI. Such requests must be in writing and the practice will accommodate reasonable requests.

With this consent, Rocky Run Family Medicine may mail to my home or other designated location any appointment reminders and other correspondence marked personal and confidential that assist the practice in carrying out treatment, payment, and healthcare operations.

By signing this form, I am giving my consent to Rocky Run Family Medicine to use and disclose my PHI to carry out treatment, payment, and healthcare operations.

I may revoke my consent in writing.

Patient Name:_____ DOB:_____

Signature:_____ Date:_____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

This authorization grants permission for the party (parties) named below to: have access to medical information, laboratory results, test findings, and telephone communication; pick up medications, referrals, and notes; be made aware of my diagnosis, prognosis, and treatment plans; and have access to my financial information. Also included is an authorization to leave similar medical information on a private phone or voice messaging system

I understand this authorization is voluntary.

Patient's Name: _____ Date of Birth: _____

I request and authorize Rocky Run Family Medicine
to release healthcare information of the patient named above as follows:

Name:_____ Relationship to Patient:_____
Name:_____ Relationship to Patient:_____
Private number / voicemail on which messages may be left: _____

☐ Check here if you do not authorize anyone else to have access to your information or have any number on record for leaving detailed messages

I understand that this authorization will (check 1):
- ☐ Expire 1 year from the date signed by the patient
- ☐ Be effective for the lifetime of the patient unless revoked in writing
- ☐ Be effective until _____

This request and authorization applies to:
☐ Healthcare information relating to the following treatment, condition, or dates:_____

☐ All healthcare information (except as noted below)

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) or number listed above.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) or number listed above.

Patient Signature: _____ Date: _____

Acct #:_____

DOB:_____

Patient Medical History

Please indicate if you currently have or have had any of the following:

	Yes	No	Details		Yes	No	Details
Headaches, Migraines				Bowel Irregularity			
Epilepsy, Seizures				Rectal Bleeding			
Depression				Hemorrhoids			
Anxiety				Hernia			
Mental Health Issues (list specifics)				Gallbladder Disease			
				Bladder Infections			
Insomnia				Incontinence			
Sleep Apnea				Prostate Problems			
Hearing Loss				Kidney Disease			
Ringing in Ears				STD			
Glaucoma/ Cataracts				HIV/AIDS			
Fatigue				Hepatitis			
True Food Allergies				Sexual Dysfunction			
Stroke				Menstrual Dysfunction			
Eating Disorders							
Thyroid Disease				Infertility			
Dizziness/Fainting				Arthritis			
Weakness				Osteoporosis			
Chest Pain				Neck Pain			
Heart Murmur				Back Pain			
Heart Palpitations				Bursitis/Tendonitis			
Heart Disease				Hives			
Elevated Cholesterol				Chronic Rash			
High/Low Blood Pressure (list which)				Diabetes			
Circulation Problems				Cancer			
				Weight Loss			
Bleeding Tendency				Weight Gain			
Anemia				Measles			
Blood Transfusion				Mumps			
Leg Pain/Swelling				Chickenpox			
Shortness of Breath				Whooping Cough			
Wheezing				Polio			
Asthma				Tetanus			
Pneumonia				Erectile Difficulties			
Tuberculosis (TB)				Any Other Illnesses/Diseases Not Listed			
Indigestion/Heartburn							
Ulcer							
Abdominal Pain							

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Social History

	Yes	No	Details		Yes	No	Details
Smoke (list # per day and for how many years)				Caffeine Use (how much)			
Alcohol (list frequency and amount)				Exercise Outside of Daily Activities (what/how often/how long)			
Use Drugs				Employed (list occupation)			
Live Alone				Under Stress			
Have Children (how many/sex/birth year)							

Surgical History

	Yes	No	Details		Yes	No	Details
Tympanostomy (ear tubes)				Hysterectomy			
Appendectomy				Hip Replacement			
Gallbladder Surgery				Knee Surgery			
Heart Surgery (indicate what type)				Cataract Repair			
Tonsillectomy				Sinus Surgery			
Bunionectomy				Any Surgeries Not Listed (include only date and year or surgery)			
Back Surgery							

Family History

If yes to any below, please include which family member

	Yes	No	Details		Yes	No	Details
Asthma				Epilepsy			
Heart Disease (note age of first event)				Bleeding Disorder			
High Blood Pressure				Kidney Disease			
High Cholesterol				Thyroid Disease			
Stroke				Mental Illness			
Cancer (type, age)				Osteoporosis			
Glaucoma				Arthritis			
Diabetes				Any Other Illness/Disease Not Listed			

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Females Only

	Yes	No	Details		Yes	No	Details
Age Periods Began				Premature			
Cycle Length (average # days from first day of period to first day of next period)				Stillbirths			
Period Length				Miscarriages			
Flow				Abortions			
Discomfort				Tubal Pregnancy			
PMS (pre-menstrual syndrome)				Pregnancy Complications			
Number of Pregnancies				Vaginal Deliveries (what year/s)			
Full term				Cesarean Sections (what year/s)			

Medications

Please list any medications you are currently taking:_____
_____
_____

Please list any known drug allergies you have and your reaction to them:
_____
_____
_____
_____