PATIENT INFORMATION

Last Name:_____ First Name:_____ M.I._____

Nick Name:_____ DOB:_____ Gender:_____ Marital Status:_____

Primary Phone:_____-_____-_____Secondary Phone:_____-_____-_____SSN: _____-_____-_____

Mailing Address:_____ City:_____ State:_____ Zipcode: _____

Physical Address:_____ City:_____ State:_____ Zipcode:_____

Emergency Contact:_____ Primary Phone:_____-_____-_____ Relation:_____

Emergency Contact:_____ Primary Phone:_____-_____-_____ Relation:_____

Imaging Facility:_____ City:_____ Phone: _____-_____-_____

Laboratory Name:_____ City:_____ Phone: _____-_____-_____

Pharmacy Name:_____ City:_____ Phone: _____-_____-_____

Insurance:_____ ID#:_____ Group: _____

Policy Holder Name:_____ DOB: _____ Relation:_____

Email Address: _____Preferred Method of Contact: _____

LEGAL GUARDIAN/ GUARANTOR INFORMATION

Last Name:_____ First Name:_____ M.I._____

Nick Name:_____ DOB:_____ Gender:_____ Marital Status:_____

Primary Phone:_____-_____-_____Secondary Phone:_____-_____-_____Relation:_____

Mailing Address:_____ City:_____ State:_____ Zipcode: _____

Physical Address:_____ City:_____ State:_____ Zipcode:_____

Next of Kin:_____ Primary Phone:_____-_____-_____ Relation:_____

Patient Health Information

MEDICATIONS:

(list all prescribed or over the counter medications, supplements, or vitamins taken regularly or semi-regaularly)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

ALLERGIES:

(list all drug, food, and environmental)

_____

_____

MEDICAL HISTORY:

(circle all current and past medical problems)

Anemia	Cancer	Heart disease	Liver disease
Anxiety Disorder	Coronary Artery Disease	Hepatitis	Pulmonary Embolism
Arthritis	Deep Vein Thrombosis	High Cholesterol	Reflux/GERD
Asthma	Depression	Hypertension	Seizures/Epilepsy
Autoimmune disease	Diabetes	Hyperthyroidism	Stroke
Bleeding disorder	Diverticulitis	Hypothyroidism	Tuberculosis
Bronchitis	Gout	Kidney disease	Breast cancer
COPD	Headaches	Kidney stones	Rectal Bleeding

Other: _____

SURGICAL HISTORY

(Please list all surgeries and the date of service)

_____

_____

_____

_____

FAMILY HISTORY

(List history of the following conditions. Include relationship i.e. maternal grandmother, paternal grandmother)

Cancer: _____

Diabetes: _____

Heart Disease/Problems: _____

Bleeding Problems: _____

Respiratory Problems: _____

Problems with Anesthesia:_____

SOCIAL HISTORY

Smoking Status: _____Smoking how much? _____ Tobacco years of use: _____

Able to care for self?: _____ Live alone or with others? _____ Do you have an Advance Directive?: _____

Are you currently employed?:_____ Occupation: _____

Education: _____ General stress level: _____

Number of children: _____ Guns present in home?: _____ Alcohol intake: _____

Caffeine intake: _____ Illicit drugs: _____

Diet: _____ Exercise level: _____ Hard of hearing or deaf?: _____

Legally blind in one or both eyes?: _____ Sexually Active?:_____ Do you use protection?: _____

Sexual orientation: _____ Smoke alarm in home: _____ Has smoked since age: _____

Passive smoke exposure: _____ Chewing tobacco: _____ Seat belts used?: _____ Sunscreen?: _____

Swimming/diving: _____ Can child swim?:_____ Is the patient ambulatory?: _____

Last Physical Exam: _____ Last PAP: _____ Last Tetanus: _____ Last Colonoscopy: _____

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Folsom Internal Medicine, Inc.

Bre Howard, Privacy Officer

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

I hereby authorize this medical practice to use and disclose health information concerning patient:

Patient Last Name: _____

Patient First Name: _____

This health information may be disclosed to:

(include last name, first name, and relationship to patient)

_____

_____

_____

_____

_____

Please mark the type of records that may be disclosed:

_____ Any and all health information other than psychotherapy notes may be released, including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below

_____All psychotherapy notes may be released, except as specifically provided below:

_____Claims/Billing Records

_____Other:_____

The information may be used only for the following purposes (if you do not want to explain the purpose, write "At the request of the individual"):_____

I understand that I may revoke this authorization at any time notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt.

I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.

Effect of Refusal to Sign Authorization

I understand that my health care treatment or benefits will not be affected whether I sign or do not sign this form.
I understand that if I do not sign this form:
A health plan may not enroll me or make me eligible for benefits.
My physician will not perform the expert, employment, life insurance or other physical or medical evaluation which would otherwise be performed solely for the purpose of disclosure to a third party.

The authorization is in effect and will remain in effect until: _____

I understand that I have a right to received a copy of this authorization upon request.

Signature: _____ ***Date:*** _____

Legal Guardian/Guarantor Full Name: _____

*If not signed by the patient please indicate the relationship :*_____