



CENTER FOR FAMILY MEDICINE, P.A.

Authorization and Consent Agreement

Thank you for reviewing our Financial and Office Policies and Notice of Privacy Practices. Please sign in the spaces provided below to acknowledge receipt of this information, and to enter your authorized contacts.

ASSIGNMENT OF BENEFITS

I authorize direct payment to be made to the providers of Center for Family Medicine for any and all medical services rendered. I also authorize the release of any medical records for the purpose of my healthcare services.

FINANCIAL AND OFFICE POLICIES

I have read and understand the Financial and Office Policies of Center for Family Medicine and agree to abide by its guidelines.

HIPAA

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I can request a copy of this notice at any time. I have the right to review the notice prior to signing this consent.

I have had the opportunity to receive and review the Notice of Privacy Practices of Center for Family Medicine.

APPROVED HIPAA CONTACTS

Disclosure of Protected Health Information

Keeping information private is important to us and by default we will only disclose information related to the patient's billing account and medical conditions to the patient or legal guardian.

Please note, in order to share protected health information with your spouse, children, or anyone else they must be listed as an approved contact.

The following names are people I would like to be involved in or have access to my protected health information on a routine basis. I give permission to Center for Family Medicine to share my protected health information with:

Contact Name

Phone Number

Relationship to Patient

Contact Name

Phone Number

Relationship to Patient

CONSENT AND AGREEMENT

I have carefully reviewed this document and agree to fully comply with guidelines defined herein related to the Assignment of Benefits, Financial Policy, HIPAA policy, and Approved HIPAA contacts. The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any personal health information.

Patient's Name (Please Print)

Patient's Date of Birth

Signature of Patient, Parent, or Legal Guardian

Date



CENTER FOR FAMILY MEDICINE, P.A.
Consent to Obtain Prescription History

This consent form authorizes Center for Family Medicine to obtain and review my prescription history. Detailed prescription history provides your physician with information about medications being prescribed by other providers involved in your medical care. This information will improve the accuracy of our medication list in your medical chart and decrease any adverse drug reactions or inaccurate medication information such as medication names and dosages.

By signing this consent form, you agree that Center for Family Medicine can request and use your prescription medication history from other healthcare providers, pharmacies, and benefit payors (such as your insurance company) for treatment purposes.

Understanding the above, I hereby provide informed consent to Center for Family Medicine to request, view, and use my external prescription history for treatment purposes.

Patient Name (printed): _____

Patient Date of Birth: _____

Patient Signature: _____

Date of Signing Consent Form: _____

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name <i>(Last, First, M.I.):</i>	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Previous or referring doctor:	Date of last physical exam:	

PERSONAL HEALTH HISTORY

Childhood illness: Measles Mumps Rubella Chickenpox Rheumatic Fever Polio

Immunizations and dates:	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pneumonia
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chickenpox
	<input type="checkbox"/> Influenza	<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? Yes No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers-Please give us list if you have one with you.

Drug Name	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	<input type="checkbox"/> Sedentary (No exercise)			
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)			
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
Diet	Are you dieting?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat in an average day?			
	Rank salt intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low
	Rank fat intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola
	# of cups/cans per day?			
Alcohol	Do you drink alcohol?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?			
	How many drinks per week?			
Tobacco	Do/Did you use tobacco?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> e-cigarettes	<input type="checkbox"/> Pipe - #/day <input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit		
Drugs	Do you currently use recreational or street drugs?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Sex	Are you sexually active?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	I have had more than 1 sexual partner.			<input type="checkbox"/> Yes <input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:			
	Any discomfort with intercourse?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?			<input type="checkbox"/> Yes <input type="checkbox"/> No

OTHER PROBLEMS

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS
Father If unknown, check here <input type="checkbox"/>		
Mother If unknown, check here <input type="checkbox"/>		
Sibling If unknown, check here <input type="checkbox"/>	<input type="checkbox"/> M	
	<input type="checkbox"/> F	
	<input type="checkbox"/> M	
	<input type="checkbox"/> F	
	<input type="checkbox"/> M	
	<input type="checkbox"/> F	
	<input type="checkbox"/> M	
	<input type="checkbox"/> F	
Children	<input type="checkbox"/> M	
	<input type="checkbox"/> F	
	<input type="checkbox"/> M	
	<input type="checkbox"/> F	
Grandmother <i>Maternal</i>		
Grandfather <i>Maternal</i>		
Grandmother <i>Paternal</i>		
Grandfather <i>Paternal</i>		

CANCER RISK QUESTIONNAIRE

I have light colored hair, eyes, or complexion.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I have a large number of "moles" or moles that are large or irregular in shape or color.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I frequently work or play in the sun.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I was sunburned (blistered) several times before age 20.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
My skin is frequently exposed to chemicals or radioactive materials (arsenic, coal, petroleum, uranium, radioisotopes).	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I have a family history of skin cancer.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I have been to tanning salons.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I am exposed to other people's cigarette smoke.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
At work, I am exposed to arsenic, asbestor, chromates, nickel, petroleum, or uranium.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Someone in my family has had lung cancer. If yes, who? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I have had colon cancer.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Someone in my family has had colon cancer. If yes, who? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I have had polyp(s) in the colon.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I have had Crohn's disease or ulcerative colitis.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I have had a recent change from my usual bowel movements.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
There is a history of cancer in my immediate family. If yes, who _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I am 15 or more pounds overweight.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I eat a diet high in fat content.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I eat fewer than 5 servings of fruit and vegetables per day.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I have not had a complete physical in at least 5 years.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I have not been to a dentist in over three years.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

CANCER RISK QUESTIONNAIRE, CONTINUED

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every ____ days		
Heavy periods, irregularity, spotting, pain, or discharge after intercourse or between periods?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies ____ Number of live births ____		
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I have had breast cancer.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Someone in my family has had breast cancer. If yes, who? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last pap and rectal exam?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I have had an abnormal pap smear?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I gave birth to my first child after age 35 or am 35 years or older and have not been pregnant to full term.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I have had a female cancer (womb or ovary).	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I began intercourse before age 18.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

MEN ONLY

Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times ____		
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I have had testicular cancer.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I have one testicle which is smaller (atrophied) than the other.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Someone in my family had prostate cancer. If yes, who? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last prostate and rectal exam?		
I have had a vasectomy. If yes, what year? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**CENTER FOR FAMILY
MEDICINE, P.A.
PATIENT DEMOGRAPHICS**

Name _____

DOB _____ SSN _____

Address _____

City _____ State _____ Zip _____

Phone Number _____

Alternate Phone Number _____

Sex: Female Male

Marital Status: Single Married Widowed Divorced

Race: _____

Ethnicity: _____

Employer _____

Occupation _____

Emergency Contact Name: _____

Relationship to patient _____

Emergency Contact Phone # _____

Alternate Phone # _____

Preferred Pharmacy _____

Primary Care Provider:

- Cooper Schulze Hodge Woods Haney Ockwig
Kenworthy Boatner Mitchell Reinert Young
Moreno Handlang

Parent/Guardian/Guarantor Information (Required if patient is under 18 years of age)

Name _____

DOB: _____ DL # _____ Issuing State _____

Address _____

City _____ State _____ Zip _____

Primary Contact Number _____

Relationship to Patient _____

INSURANCE INFORMATION

Primary Insurance Information

Insurance Company _____

Address _____

City _____ State _____ Zip _____

Phone # _____

Member ID # _____

Group # _____

Policy Holders Name _____

DOB _____ SSN _____

Relationship to patient _____

Phone # _____

Address (if different from patient)

City _____ State _____ Zip _____

Secondary Insurance Information (if applicable)

Insurance Company _____

Address _____

City _____ State _____ Zip _____

Phone # _____

Member ID # _____

Group # _____

Policy Holders Name _____

DOB _____ SSN _____

Relationship to patient _____

Phone # _____

Address (if different from patient)

City _____ State _____ Zip _____

Signature: _____

Date: _____



CENTER FOR FAMILY MEDICINE, P.A.

Patient Portal Communication Consent

To sign up for access to your health information through our secure patient portal complete the first portion of this form. To grant access to another adult who helps manage your medical care complete all portions of this form. Patient portal sign up includes free access to the following online services: lab results, appointment management, prescription refill requests, submitting billing questions, referral requests, and a medical summary including immunization records.

Yes, I want Center for Family Medicine to communicate my information with me or those that I grant access to my record through the secure patient portal system that is designed to keep my personal information safe.

Your Information: (All sections required)

Patient's Name (Please Print)

Sex

Date of Birth

Phone Number

****Please provide the email address you would like to use to be notified of secure messages****

E-mail address

Primary Care Provider

-I understand that I must be 18 years or older in order to be signed up to access my record through the patient portal. If I am under 18 years of age and have become legally emancipated, I must provide legal documentation in order to be provided access to my record through the patient portal.

-I understand that the patient portal is intended as a secure online source of confidential medical information. If I share my user ID and password with another person, that person may be able to view me or my family member's health information.

-It is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in any way.

-I understand that the patient portal contains selected, limited medical information from me or my family member's medical record and that it does not reflect the complete contents of my medical record. I also understand that a paper copy of my records may be requested from the clinic.

-I understand that my activity within the patient portal may become part of my medical record.

-I understand that access to the patient portal is provided by Center for Family Medicine as a convenience to its patients and has the right to deactivate access to the portal at any time for any reason. I understand that use is voluntary and I am not required to use the portal.

-By signing below, I acknowledge that I have read and understand this Patient Portal Communication Consent and agree to its terms.

Patient Signature

Date

Grant Access to Another Adult

Please grant access to my record through the secure patient portal to the following adult who helps to manage my medical care. I understand that all portal communication will be sent to their email/account.

Name (Please Print) _____ **Relationship to Patient** _____

****Please provide the email address you would like to use to be notified of secure messages****

E-mail address

Patient Signature

Date