SUMMIT HEALTHCARE

Patient Name: _____ _____ _____ _____ SS#:_____
(First) (MI) (Last)

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Home Address: _____ P.O. Box: _____

City: _____ State: _____ Zip Code: _____

Home Phone :( ) _____ Cell Phone :( ) _____ E-mail address: _____

Employer: _____ Work Phone: ( ) _____ Spouse Name: _____

Spouse Employer: _____ Work Phone: ( ) _____ Spouse DOB: _____

Emergency Contact: _____ Relationship: _____ Phone: ( ) _____

Referring Physician: _____ Primary Physician: _____

Pharmacy & Location: _____ Phone: ( ) _____

Race: ❑Hispanic ❑Asian ❑Caucasian ❑Black/African American ❑American Indian or Alaska Native ❑Other: _____

Preferred Language: ❑ English ❑ Spanish ❑ Other: _____

Ethnicity (Nationality-cultural background): ❑Hispanic/Latino ❑Non-Hispanic/Latino ❑Other

-Person Responsible for Payment of Account-

Name: _____ Relationship: _____

Address: _____ Home Phone: ( ) _____

City, St., Zip: _____ Other Phone: ( ) _____

-Insurance Information-
Please Present Card(s) for Copying

Primary Insurance: _____ Policy #: _____ Group #: _____

Ins. Address: _____ Ins. Phone: _____

Policy Holder Name: _____DOB: _____ SS#: _____

Policy Holder Address: _____ City, St., Zip_____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Ins. Address: _____ Ins. Phone: _____

Policy Holder Name: _____ DOB: _____ SS#: _____

Policy Holder Address: _____ City, St., Zip_____

Other Insurance: _____ Policy #: _____ Group #: _____

Ins. Address: _____ Ins. Phone: _____

Policy Holder Name: _____ DOB: _____ SS#: _____

Policy Holder Address: _____ City, St., Zip_____

-Complete if Student or Under the age of 18-

Father Information

Name: _____

Home Phone: ( ) _____

Work Phone: ( ) _____

SS#: _____ DOB: _____

Mother Information

Name: _____

Home Phone: ( ) _____

Work Phone: ( ) _____

SS#: _____ DOB: _____

I hereby give my consent to Summit Healthcare and its business associates to use and disclose my protected health information for the purpose of treatment, payment, and health care operations as noted in the Notice of Privacy Policies provided to me by the practice. I acknowledge full responsibility for the payment of services rendered to me and agree to pay for them in full. If Summit Healthcare chooses to accept assignment of my health insurance benefits, I hereby assign all payments to which I am entitled. I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. I take full responsibility for all costs incurred by my failure to pay for services rendered.

I give permission for my doctor or designee to contact the patient's pharmacy for a list of medications.

Signature of Patient or Patient's Representative: _____ **Date:** _____

Date of Service:_____
(Office Use)

MANAGED BY the SUMMIT
Together for Exceptional Health Care

SUMMIT HEALTHCARE

Patient Name: _____ **DOB:** _____

-Acknowledgement of Receipt of Privacy Notice-

I acknowledge I have received a copy of the Summit Healthcare Notice of Privacy Practices effective September 2015.

-Authorization for Medical Care-

I hereby authorize Summit Healthcare to provide me medical treatment for any and all conditions they deem appropriate. I understand the physician or other provider will review the recommendations for testing and/or treatment they deem appropriate for my medical needs based on their professional judgment.

-Referral Waiver-

I acknowledge in the course of my treatment, Summit Healthcare may refer me to other health care facilities and/or providers for diagnostic tests, treatment, or consultation. Summit Healthcare will notify me when such a referral occurs. Summit Healthcare assumes no responsibility for knowing if the facility or provider I am referred to is contracted with my insurance plan. Should Summit Healthcare make such a referral, it is my responsibility to verify my insurance coverage, eligibility, pre-certification (if applicable), and whether or not the facility or provider I am referred to contracts with my insurance company. Summit Healthcare is not responsible should my insurance process claims at the non-contracting level for the referred service(s).

-Communication Preferences-

By signing below, ***I give permission to the person(s) listed to receive LIMITED information about my care***. I understand my healthcare provider will utilize their professional judgment to ensure that information is shared with family/friends in order to assist with my continuing care. **Any request for information not directly relevant to participation in care and any requests for copies of medical records will require a signed HIPAA compliant authorization.** This permission will be considered valid for one year unless otherwise revoked in writing.

Note: If you want to give an individual more access to your health information than offered below, you must complete a valid authorization form stating in detail the nature of the information you want released (see receptionist).

Please indicate your preferences below:

1. ☐ Do **NOT** share ANY information with anyone.
2. Please identify below individual(s) you would like us to share information with and mark the appropriate boxes regarding the type(s) of information we can share with each respective individual(s).

Name: _____ **Relationship:** _____

☐ Appointment Dates and Times ☐ Relevant Test Results & Treatment Recommendations ☐ Billing Information

Name: _____ **Relationship:** _____

☐ Appointment Dates and Times ☐ Relevant Test Results & Treatment Recommendations ☐ Billing Information

Physicians/Providers:

☐ You may also share information, including medical records, with the following physicians/providers who participate in my care:

Name: _____ **Name:** _____

College or High School Athletic Department: _____

☐ Appointment Dates and Times ☐ Relevant Test Results & Treatment Recommendations ☐ Billing Information

_____ _____ _____

Signature of Patient or Personal Representative **Printed Name** **Date**

If Personal Representative, Relationship to Patient: _____

Date of Service:_____
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Patient Name:_____ **DOB:**_____

Office Use Only

Height:_____ **Weight:**_____ **Blood Pressure**_____ **Pulse:**_____

PATIENT QUESTIONNAIRE

Reason for today's visit (please list any symptoms that you would like to discuss with your doctor

_____

_____

Is this an injury? ❑Yes ❑No

If yes Injury Date: _____ How did injury occur: _____

Where did the injury occur? _____

Type: ❑Motor Vehicle ❑Sports Injury ❑Worker's Compensation ❑Liability ❑Other: _____

Have you been treated by another healthcare provider for this problem? **❑Yes ❑No**

If yes, name of provider(s)_____

How long were you treated? _____

DESCRIPTION OF PAIN and SYMPTOMS:

Was the onset of your pain: ❑ Sudden ❑ Gradual

How long have you had this pain: _____ ❑ days ❑ weeks ❑ months ❑ years

On a scale from 0-10, rate your pain, 0-None - 10-unbearable: _____

REVIEW OF SYSTEMS

Do you currently have any of these problems? ❑ **NONE OF THESE APPLY TO ME**

Respiratory	Gastrointestinal	Neurologic	HEENT
❑Cough	❑Abdominal Pain	❑Numbness or Tingling	❑Blurred Vision
❑Difficulty Breathing	❑Heartburn	❑Seizures	❑Double Vision
❑Asthma	❑Constipation	❑Tremors	❑Eye Pain
❑Wheezing	❑Decreased Appetite	❑Vision Changes	❑Headache
❑Seasonal Allergies	❑Diarrhea		❑Ear Infection
	❑Nausea		❑Sore Throat
	❑Vomiting		
Genitourinary	**Cardiovascular**	**Metabolic**	**Skin**
❑Frequent Urination	❑Chest Pain	❑Cold Intolerant	❑Rash
❑Blood in Urine	❑Irregular Heartbeat	❑Heat Intolerant	❑Skin Infection
❑Incontinence	❑Swelling	❑Increased Thirst	❑Itching
❑Painful Urination		❑Weight Gain	❑Chronic Hives
		❑Weight Loss	
Musculoskeletal	**Psychiatric**	**Hematologic**	**Constitutional**
❑Back Pain	❑Anxiety	❑Easy Bruising	❑Chills
❑Joint Pain	❑Depression	❑Easy Bleeding	❑Fever
❑Muscle Pain		❑Blood Clots	❑Night Sweats
			❑Weakness

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(Office Use)

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Patient Name:_____ **DOB:**_____

MEDICAL HISTORY

Please select any problems you <u>currently have or have had</u> in the past.
❑NONE OF THESE APPLY TO ME

❑Aids/HIV	❑Alcoholism	❑Anemia	❑Arthritis
❑Asthma	❑Atrial fibrillation	❑Auto Immune Disorder	❑Blood Clot
❑Cancer	❑Congestive heart failure	❑COPD	❑Coronary artery disease
❑Depression	❑Diabetes Type:_____	❑Drug Abuse	❑Fibromyalgia
❑Gall bladder disease	❑GERD	❑Gout	❑Gynecological issues:_____
❑Heart Attack **year**:_____	❑ Heart murmur	❑Hepatitis **type**:_____	❑High Cholesterol
❑Hypertension	❑Inflammatory Bowel Disease	❑Kidney disease	❑Liver disease
❑Lupus	❑Osteoporosis	❑Rheumatoid arthritis	❑Seizure disorders
❑Sleep apnea	❑Stomach ulcer	❑ Stroke	❑Thyroid problems
❑Tuberculosis	❑ Urinary Tract Infection	❑Other:_____	❑Other:_____

SURGICAL HISTORY

Please list all previous surgeries and the approximate year:
❑I HAVE NOT HAD ANY SURGERIES

Surgery: Year:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Surgery: Year:

❑ Pacemaker _____
❑ Heart Stents _____
❑ Bypass Surgery _____
❑ Replacement Valves _____
❑ Defibrillator _____
❑ Colonoscopy _____

SPECIALIST

Please list all specialist you see (cardiology, nephrology, dermatology etc.)

☐ **I DO NOT HAVE A SPECIALIST**

Doctor's Name	Type of Specialty

Date of Service:_____
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Social History

Highest grade completed in school?_____ Are you still in school? ☐Yes ☐No

Occupation:_____ **Marital Status**: ☐Single ☐Married ☐Widowed ☐Divorced

Who lives at home with you (specify number of daughters/sons)? _____

Tobacco Use: ☐Current ☐Former ☐Never **Type:** ☐Chewing ☐Cigar ☐Cigarette ☐Pipe

Amount per day:_____ **Number of years used:**_____ **Year quit:**_____

Alcohol Use: ☐Current ☐Never ☐Former **Type:** ☐Beer ☐Wine ☐Hard liquor

How often do you drink? ☐Daily ☐Weekly ☐Monthly ☐Rarely **Amount:**_____

Illicit Drug Use: ☐Current ☐Never ☐Former **Age started:**_____ **Year quit:**_____

Type:_____ Frequency:_____ Last use:_____

History of child of abuse? ☐Yes ☐No **Offender(s):**_____☐Physical ☐Sexual ☐Verbal

History of domestic violence? ☐Yes ☐No **Perpetrator(s):**_____

Are you sexually active? ☐Yes ☐No **Orientation:** ☐Heterosexual ☐Homosexual ☐Bisexual

How many partners have you had sex with?_____ How old were you when you first had sex?_____

GYNECOLOGICAL HISTORY

Menopausal Type:

❑ Premenopausal ❑ Perimenopausal ❑ Post menopausal

Age when you had your first period: _____

First day of your last menstrual period: _____

Last Pap Smear: **Month**_____**Year**_____ **❑ Normal** **❑ Abnormal**

Last Mammogram: **Month**_____ **Year**_____ **❑ Normal** **❑ Abnormal**

Last Dexa Scan: **Month**_____ **Year**_____ **Results:**_____

Birth Control Method: _____

FAMILY HISTORY

Date of Service:_____
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❑ **Adopted/Unknown family history** ❑ **No relevant family history**

FAMILY HISTORY	Mother	Father	Sister	Brother	Grandmother (Maternal)	Grandfather (Maternal)	Grandmother (Paternal)	Grandfather (Paternal)
Asthma								
Blood clots								
Cancer								
Diabetes								
Heart disease								
Hypertension								
Kidney disease								
Liver disease								
Lupus								
Osteoarthritis								
Osteoporosis								
Rheumatoid arthritis								

MEDICATIONS & ALLERGIES

****A list of medications is required for treatment****

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Please list all medications which you are currently taking: (include vitamins, supplements, herbs, **over the counter**, etc.)
❑Currently taking **NO** medications (including over the counter)

Medication	Strength	Instructions (frequency)

ALLERGIES

Do you have a latex allergy? ❑ Yes ❑ No
Do you have a penicillin allergy? ❑ Yes ❑ No
Do you have any other medication allergies? ❑ Yes ❑ No
Do you have a sulfa allergy? ❑ Yes ❑ No
Do you have an iodine/dye allergy? ❑ Yes ❑ No
If yes, please list below with the **reaction** to the allergy:

Medication	Reaction	Medication	Reaction

Date of Service:_____
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