Primary Care & Specialty Clinics

Comprehensive Health History

PATIENT FULL LEGAL NAME____

DATE OF BIRTH____

Have you ever, or do you:

SMOKE ☐ yes ☐ no Packs per day________ Age quit ______ Any smokers in the home? ☐ yes ☐ no

SMOKELESS TOBACCO ☐ yes ☐ no ☐ quit How much?________ Year quit ____________

DRINK ALCOHOL ☐ yes ☐ no What forms?____________ Quantity______ Frequency________

ILLICIT DRUGS ☐ yes ☐ no What forms?____________ Quantity______ Frequency________

CAFFEINE USAGE ☐ yes ☐ no Coffee ______ Tea ______ Soda ______ Daily Amount________

ALLERGIES (medication & food)

☐ No known medication allergies ☐ No known food allergies

List all medication and food allergies, please identify reaction ____

____

Are you allergic to latex or latex based products? ☐ yes ☐ no Tape? ☐ yes ☐ no Iodine? ☐ yes ☐ no

MEDICATIONS

See attached list ☐

Medication	Dose	How often do you take	Medication	Dose	How often do you take

FAMILY HISTORY

Are your parents living? Mother ☐ yes ☐ no Father ☐ yes ☐ no Cause of death?________________________

Please list any health conditions/serious illnesses that your mother, father, sister(s) or brother(s) have or have been told they have had in the past (i.e. diabetes, heart condition, high blood pressure, stroke, high cholesterol, cancer, thyroid, etc.)

Father____

Mother____

Sister(s)____

Brother(s)____

TOSC-001 2

Comprehensive Health History

PATIENT FULL LEGAL NAME____

DATE OF BIRTH____

PATIENT PAST MEDICAL

- ☐ Allergies
- ☐ Anemia
- ☐ Angina *(chest pain)*
- ☐ Anxiety
- ☐ Asthma
- ☐ Arthritis
- ☐ Atrial fibrillation
- ☐ Benign Prostatic Hypertrophy
- ☐ Blood clots *location* ________________
  *P.E./DVT*________________
  When: ________________
- ☐ Blood clotting disorder
- ☐ Cancer *location* ____________________
- ☐ Cerebrovascular accident *(stroke)*
- ☐ CHF *(Congestive Heart Failure)*
- ☐ COPD *(Chronic Obstructive Pulmonary Disease)*
- ☐ Coronary artery disease
- ☐ Crohn's disease
- ☐ Depression
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Gallbladder Disease
- ☐ GERD or chronic heartburn
- ☐ Hepatitis A___B___C___
- ☐ Hyperlipidemia *(high cholesterol)*
- ☐ Hypertension *(high blood pressure)*
- ☐ Immune system disorder
- ☐ Irritable bowel disease
- ☐ Liver disease
- ☐ Malignant Hyperthermia
- ☐ Migraine headaches
- ☐ MRSA
- ☐ Myocardial infarction *(heart attack)*
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Peptic ulcer disease
- ☐ Renal *(kidney)* disease
- ☐ Seizure disorder
- ☐ Thyroid *high*___*low*___*other*________

Other ____

Have you ever had General Anesthesia? Any complications? ☐ Yes ☐ No

PATIENT PAST SURGICAL

- ☐ Angioplasty *(heart cath)* *year* _____
- ☐ Angio *(heart cath)* w/stent *year* _____
- ☐ Appendectomy *year* _____
- ☐ Arthroscopy knee *year* _____
- ☐ Back surgery *year* _____
- ☐ CABG *(heart bypass)* *year* _____
- ☐ Carpal tunnel release *year* _____
- ☐ Cataract extraction *year* _____
- ☐ Gallbladder surgery *year* _____
- ☐ Colectomy *(colon resection)* *year* _____
- ☐ Colostomy *year* _____
- ☐ Gastric bypass *year* _____
- ☐ Hernia repair *year* _____
- ☐ Hip/Knee replacement *year* _____
- ☐ Lasik *year* _____
- ☐ Liver biopsy *year* _____
- ☐ ORIF *(fracture repair)* *year* _____
- ☐ Pacemaker *year* _____
- ☐ Small bowel resection *year* _____
- ☐ Thyroidectomy *year* _____
- ☐ Tonsillectomy *year* _____

Other ____

PATIENT PAST SURGICAL **- Women only**

- ☐ Augmentation mammoplasty *(implants)* *year* _____
- ☐ Bilateral tubal ligation *year* _____
- ☐ Breast Biopsy *year* _____
- ☐ Cesarean Section *year* _____
- ☐ D & C *year* _____
- ☐ Hysterectomy *(abdominal)* *year* _____
- ☐ Hysterectomy *(vaginal)* *year* _____
- ☐ Mastectomy *year* _____
- ☐ Myomectomy *(Fibroidectomy)* *year* _____
- ☐ Reduction mammoplasty *year* _____
- ☐ Oopherectomy *(ovary removal)* *year* _____
- ☐ TAH/BSO *year* _____

Other ____

Primary Care & Specialty Clinics

Permission to Disclose Information to Those Involved in My Care

This form does not authorize releasing copies of my medical records.

I hereby allow the primary care and specialty clinics of Liberty Hospital to disclose the following information:

Check all that apply.

- ☐ Appointment times and dates
- ☐ Medical information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Tests that have been performed
- ☐ Test results
- ☐ Billing/payment information

Other health information (describe)____

To the following people who are involved with my healthcare and/or payment information:

Check all that apply and list names and phone numbers.

- ☐ Spouse____Phone_________________
- ☐ Friend____Phone_________________
- ☐ Child(ren)____Phone_________________
- ☐ Other____Phone_________________

Can confidential messages (i.e. appointment information, prescription information, test results) be left on your answering machine or voicemail?

Check all that apply.

- ☐ No, DO NOT leave messages
- ☐ Yes, at home
- ☐ Yes, at cell
- ☐ Yes, at work

Home_________________

Cell__________________

Work_________________

I understand that in certain situations the primary care and specialty clinics of Liberty Hospital could speak to other individuals who are involved in my care or payment of that care, if permitted by law, that may not be identified on this form.

I understand that I have the right to revoke (stop) my permission at any time.

X Patient Name (please print):_____________________________________**Date of birth:**______________

X Patient/Guardian Signature:____**Date:**________________

If patient is a minor, please complete the following information:

Mother's name/contact number:____

Father's name/contact number:____

Notice of Privacy Practices and Patient Rights

By signing this document, I acknowledge that I have received a copy of the the primary care and specialty clinics of Liberty Hospital Notice of Privacy Practices and Patient Rights. Copies are available in your provider's office or view a PDF at www.libertyhospital.org/privacy.

Patient Signature: ________________________________ Date__________ Time__________

Date of Birth:_______________

Patient Representative/Relationship Signature:

____ Date__________ Time__________

Witness: ____ Date__________ Time__________

For staff use only:

If the patient's signature was not obtained, please describe reason why below:

☐ Patient refused to sign acknowledgment.

☐ Patient unable to sign acknowledgment due to emergent condition.

Other: Describe below:

____

____

____

The primary care and specialty clinics of Liberty Hospital are required by law to make a good faith effort to obtain a written acknowledgment from the patient receiving treatment regarding receipt of our Notice of Privacy Practices. A patient's failure or refusal of this acknowledgment should not interfere with delivery of treatment. 45 CFR 164.520

The primary care and specialty clinics of Liberty Hospital are required to inform each patient of their patient rights in advance of providing or stopping care. 42 CFR 482.13.a (1) Interpretive Guidelines

Financial Policy for Primary Care & Specialty Clinics

Methods of Contact: I agree, in order to service my account or to collect any amounts I may owe, that Liberty Hospital or its Business Associates may contact me by phone, at any phone number associated with my account, which could result in charges. I agree to contact by text messages or e-mails (using any e-mail address provided). Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Thank you for choosing us as your healthcare provider. We are committed to providing quality medical care and your successful treatment. Please understand that payment of your bill is considered to be your responsibility as part of your treatment. The following is our financial policy, which we request that you read and sign prior to any treatment.

1. Co-pays and balances are due and payable at the time of your appointment. If we are contracted with your insurance, you will be billed any remainder after we receive a response from them. As a courtesy, we accept cash, checks, Visa, Discover and Master Card.

2. If you have an HMO or PPO insurance with a designated Primary Care Physician, please make sure you have selected a physician in our office. If you present us with the incorrect insurance card or information, you will be required to pay the entire fee including any lab services.

3. Any balance is your responsibility after insurance processes your claim. Please be aware that some, and perhaps all, of the services provided may not be covered services, and not considered reasonable and necessary under the Medicare program and/or other medical insurance. In this case, the balance is your responsibility. If you have a question about your benefits, please call your insurance company prior to your office visit and check your benefits.

4. If your visit is due to a motor vehicle accident, you may choose to file your health or auto insurance. You may also choose to be self-pay, and as such would be required to pay for the visit in full at the time of service.

5. Responsibility for payment for services rendered to the child/children of divorced or separated parents rests with the parent who seeks treatment. Any court-ordered judgment must be between the individuals involved, without including our facility or providers.

6. Accounts become past due after 30 days. We reserve the right to send an account to collections if not paid in full.

7. All returned checks must be paid with cash or money order within five working days or they will be turned over to the prosecuting attorney's office. A fee of $25 will be charged on all returned checks.

8. All deductibles and co-payments for obstetric (OB) services must be paid in full by the seventh month of pregnancy with regular payments due each month by cash, check or credit card.

Our clinics are committed to providing the best treatment for our patients. Our charges are what are usual and customary for our area. It is our hope that you will find this information helpful.

X ______________________________ ______________________________ ____________

PATIENT/GUARDIAN'S SIGNATURE | PRINT PATIENT'S NAME & BIRTH DATE | DATE

SIGNATURE ON FILE: I authorize use of this form on all of my insurance submissions. I authorize release of information to all of my insurance companies. I authorize direct payment to the clinic I attend. I permit a copy of this authorization to be used in place of the original. I understand that I am financially responsible for all charges whether or not covered by my insurance.

X ______________________________ ____________

PATIENT/GUARDIAN'S SIGNATURE | DATE