

MedHelp Patient Information Sheet

Please bring Driver's License and Insurance Card

Patient Name: Last: _____ First: _____ Middle: _____

Birth/Maiden Name: _____ Gender: M F SSN# _____

Marital Status: S M D W DOB: ____ / ____ / ____ Race: _____ Ethnic Group: _____ Language: _____

Patient Address: _____

Zip _____ City _____ State _____ County _____

Phone Home: _____ Phone Cell: _____

Phone Work: _____ Ext. _____ Email _____

Preferred Contact Method: [] Phone [] Mail [] Email Preferred Reminder Method: [] Cell [] Home [] Office

Primary Provider/Insurance _____

Secondary Provider/Insurance _____

CoPay Amount \$ _____

CoPay Amount \$ _____

Owner of Policy _____

Owner of Policy _____

DOB of Policy Holder _____

DOB of Policy Holder _____

Relationship to Patient _____

Relationship to Patient _____

Policy Holder Address _____

Policy Holder Address _____

Responsible Party/Guarantor Information [] same as patient Relationship to Guarantor: _____

Name: _____ DOB ____ / ____ / ____ SSN# _____

Address: _____ City: _____ State: _____ Zip _____

Phone: _____ [] Home [] Work [] Cell

Whom should we contact in case of an Emergency

Name: _____ Phone: _____

Name: _____ Phone: _____

PLEASE READ THE FOLLOWING VERY CAREFULLY

CONSENT FOR TREATMENT: I, the undersigned, consent to the care and treatment by the attending physician, his/her associates or assistants.

ASSIGNMENT OF BENEFITS AND GUARANTEE OF ACCOUNT: I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges in incurred in this office is due at the time of service. I also understand that the charges not covered by insurance remain my responsibility and assign insurance benefits to this office. In the event my account is turned over to a collection agency, I agree to pay all costs of collection fees and/or attorney's fees and all court costs if any.

Patient/Guarantor Signature: _____ Date: _____

Receipt for HIPPA Privacy Notice and Authorization to Obtain or Release Information (MR119)

Name _____ Birthdate _____

Social Security Number _____ Date _____

By providing this authorization I understand that the authorization is **voluntary** and is being done at the request of the patient. I understand that I may refuse to sign this authorization and my treatment and/or payment obligations will not be affected. I understand that the health information to be obtained and released may be subject to re-disclosure by the recipient of the health information and no longer protected by the federal Privacy Rules. I understand that I may revoke this authorization at any time by notifying MedHelp in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation. I understand that this authorization is for six (6) years until specified otherwise.

I hereby authorize MedHelp to use, disclose health information as follows:

Release to: _____ Relation to patient: _____
Name

Address: _____ Phone Number _____

Release to: _____ Relation to patient: _____

Address: _____ Phone Number _____
Name

PLEASE NOTE THAT CHECKING ANY BOX BELOW MAY RESULT IN THE STAFF OF MEDHELP LEAVING YOUR PROTECTED HEALTH INFORMATION ON AN ANSWERING MACHINE AT THE NUMBER REQUESTED BY YOU.

Yes No

[] [] The physicians/staff of MedHelp may confirm appointments to my answering machine at the number provided on my Patient Information Sheet.

[] [] The physicians/staff of MedHelp may leave lab results or results of other diagnostic studies (e.g., MRI, CT, bones scan, etc.) on my answering machine.

Special instructions: _____

My signature below is acknowledgement that I have received a copy of the MedHelp Privacy Notice (MR100) and that I agree to the conditions stated in the notice:

Patient Signature: _____ Date: _____

Medical/Family/Social History

Name: _____ Age: _____ Date: _____

Allergies

Medications: _____ [] NKDA

Food/Environment: _____

Personal History

Date of last physical: _____ Children [] Y [] N Ages: _____

Exercise: [] Daily [] Weekly [] Monthly [] Rarely [] Never

Tobacco Use: [] Yes [] No If yes, how many packs per day: _____

Alcohol Use: [] Yes [] No Frequency: _____ Type: _____

History of Substance Abuse: [] Yes [] No Type: _____

• **For Females:** Date of last pap smear: _____ First day of your last period: _____
Date of last Mammogram: _____

Medications: (Please list prescription and non-prescription medicines; include dose and how often)

Preferred Pharmacy Name and Phone: _____

Past Medical History: (Please list all surgeries & hospitalizations along with the dates)

Review of Systems: Are you having or have you had problems with:

Eyes	[] Y [] N	Hematologic (Bleeding)	[] Y [] N
Ears, Nose, Throat	[] Y [] N	Numbness/Tingling	[] Y [] N
Respiratory (Lung/Breathing)	[] Y [] N	Psychological	[] Y [] N
Gastrointestinal (Stomach)	[] Y [] N	Neurological	[] Y [] N
Cardiovascular (Heart)	[] Y [] N	Psychiatric	[] Y [] N
Urologic (Bladder)	[] Y [] N	Allergic/Immunologic	[] Y [] N
Diabetes	[] Y [] N	Musculoskeletal	[] Y [] N
High Blood Pressure	[] Y [] N	Integumentary	[] Y [] N
Endocrine (Thyroid)	[] Y [] N		

* If yes to any of the above, please explain:

Family History: Has anyone in your immediate family been diagnosed with any of the following:

(If yes, please indicate which family member)

Cancer [] Y [] N _____
Heart Disease [] Y [] N _____
High Blood Pressure [] Y [] N _____
Diabetes [] Y [] N _____
Bleeding Disorder [] Y [] N _____
Other _____

How did you hear about us? [] Billboard [] Commercial [] Drove by [] Friend/Family [] Health Fair
[] Physician Referral [] Prior Patient [] Yellow Pages/Yellowbook [] Other