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: ______________________________________ Apt# ____________

Zip ____________ City ______________________ State ________ County ____________

Phone Home: ______________________ Phone Cell: ______________________

Phone Work: ______________________ **EMAIL:** ______________________

Preferred Contact Method: [ ] Portal [ ] Cell [ ] Home [ ] Work Preferred Reminder Method: [ ] Cell [ ] Text or Call [ ] Home [ ] Work [ ] Email

Employer ____

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

Who should we contact in case of an Emergency

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 incurred in this office are 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 not paid when due and 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, not to exceed 33.333 %.

Patient/Guarantor Signature: ______________________________ Date: ________________

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

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: ______________________
Name
Address: ______________________________ Phone Number ______________________

PLEASE NOTE THAT CHECKING 'YES' ON 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 a copy ot the MedHelp Privacy Notice (MR100) has been made available to me and that I agree to the conditions stated in the notice:

Patient Signature: ______________________________ Date: ________________

Medical/Family/Social History

Name: ____________________ DOB: __________ Date: __________

Allergies:

Medications: ____________________ [ ] No Known Drug Allergies

Food/Environment: ____________________

Personal History:

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

Tobacco Use: [ ] No [ ] Current user, Type: __________ How much per day? __________ [ ] Past user, Type: __________ How long ago? __________

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

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

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

__________ __________ __________

__________ __________ __________

__________ __________ __________

Preferred Pharmacy Name and Phone: ____________________

Occupation: ____________________

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

__________ __________

__________ __________

__________ __________

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

- **For Females:** Date of last pap smear: __________ First day of your last period: __________
  Date of last Mammogram: __________

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	Allergic/Immunologic	[ ] Y [ ] N
Urologic (Bladder)	[ ] Y [ ] N	Musculoskeletal (Bone/Joint)	[ ] Y [ ] N
Diabetes	[ ] Y [ ] N	Integumentary (Skin)	[ ] Y [ ] N
High Blood Pressure	[ ] Y [ ] N	Endocrine (Thyroid)	[ ] Y [ ] N

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? [ ] Internet [ ] Billboard [ ] Commercial [ ] Drove by [ ] Friend/Family
[ ] Health Fair [ ] Physician Referral [ ] Prior Patient [ ] Yellow Pages/Yellowbook [ ] Other __________