Patient Information and History

Name: Last:_____ First: _____ MI:_____ DOB:_____

Address: _____ City: _____ Zip: _____

Phone: (home) _____ (cell) _____ Driver's License # _____

Can we contact you about your health by E-mail? Y ☐ N ☐ E-mail: _____

Drug Allergies: _____ Type of Reaction: _____

Current Medications:_____

Has any member of your family had any of the following: **M = mother** **F = father** **S = sibling**

High Blood Pressure	M	F	S	Diabetes	M	F	S
Heart Attack/Surgery	M	F	S	Stroke	M	F	S
Anemia/Blood Disorder	M	F	S	Cancer (type)	M	F	S _____
Mental Illness/Depression	M	F	S	Other Serious Illness Not Listed _____			

List Any Past Hospitalizations or Surgeries:

_____

Conditions you are now or have ever been treated for:

Allergies/Hayfever	Y	N	Arthritis	Y	N	Ulcer/Colitis	Y	N
Cancer	Y	N	Anemia	Y	N	Hypertension	Y	N
Thyroid Problem	Y	N	Asthma	Y	N	Dizziness/Fainting	Y	N
Gall Bladder Disease	Y	N	Bronchitis	Y	N	High Cholesterol	Y	N
Ear Problem	Y	N	Pneumonia	Y	N	Stroke	Y	N
Heart Attack/Disease	Y	N	Diabetes	Y	N	Rheumatic Fever	Y	N
Eye Disorder/Glaucoma	Y	N	Gout	Y	N	Psychiatric Care	Y	N
Epilepsy/Convulsions	Y	N	Hepatitis	Y	N	Depression/Anxiety	Y	N
Lung Problems/Cough	Y	N	Kidney Disease	Y	N	Neurological Disorder	Y	N
Sinus Problems	Y	N	Heartburn/Reflux	Y	N			

Other Condition Not Listed: _____

<u>Habits</u>

Tobacco	Y	N	Packs Daily? _____	How Long? _____
Alcohol Use	Y	N	Beer/Wine/Other _____	Per week? _____
Exercise	Y	N	How Often? _____	What Type? _____

Any Drug Use, Oral or Intravenous? Y ☐ N ☐ (type) _____

Emergency Contact

Name _____ Relationship _____

Phone number _____

I hearby grant permission to the Prescott Health Clinic, PLLC to render any necessary health care or emergency treatment to me.

I understand that full payment is due and payable at time of service

Signature:_____ Date: _____

(Parent or Guardian if applicable)

Acknowledgment of Receipt of Privacy Notice and Patient Consent Form
Prescott Health Clinic

Original to be Maintained in Patient's permanent medical record

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used by the Prescott Health Clinic to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
Conduct normal healthcare operations such as quality assessments and practitioner certifications.

In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. Examples of this type of usage would be if a patient threatened to harm someone, or if medical records are ordered by a court of law.

I have been informed, by you of your **Notice of Privacy Practices** prior to signing this consent. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to Time and that I may contact this organization to obtain a current copy of the **Notice of Privacy Practices.** I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have already taken action relying on this consent.

By signing this form:

- I consent to your use and disclosure of protected health information about me for treatment, payment and health care operation.
- I acknowledge that I have received a copy of your condensed **Notice of Privacy Practices.**
- I state that I understand the information presented above, and that I know I have the opportunity to receive a complete, detailed **Notice of Privacy Practices** (5 pages) upon my request.
- I also state that I understand that the Prescott Health Clinic may condition receipt of treatment upon my execution of this consent.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed Name if signed on behalf of the patient Relationship