Patient Information

Patient Name__________________________________**Date of Birth**_____________________**Age**____________________

Social Security Number:___________________________ **Gender: (Circle One)** Male / Female

Street Address:____

City_____________________________________**State**______________________ **Zip Code** _________________________

Home Phone:______________________**Cell Phone:**_______________________ **Email:**___________________________

If unable to reach: Text Message [ ] May we leave a detailed message [ ] Do not leave message [ ]
Leave message to call back only [ ] Email [ ]

Race: (Circle One) Caucasian Hispanic American Indian African American Asian Pacific Islander Other

Ethnicity: (Circle One) Hispanic or Latino Not Hispanic or Latino

Employer:____**Occupation:**____________________________________

Work Phone Number:___________________________ **Marital Status: (Circle One)** Single Married Divorced Widowed

Spouse's Name__________________________________ **Social Security Number:**_________________________________

Date of Birth________________ **Cell Phone Number**_______________________ **Work Number**_____________________

Employer_______________________________________ **Occupation**____

Responsible Party/Insurance Carrier:

Name:____ **Relationship to Patient:**_________________________________

Mailing Address:____

City______________________________ **State** ___________________________________ **Zip Code**___________________

Social Security Number_____________________**Date of Birth**______________________**Phone Number**______________

Any Staff or employee of Bay Health & Wellness has my permission to discuss my account and medical conditions which may include symptoms, treatment, diagnosis, test results, medications, or any other type of protested health information with the following persons to facilitate, coordinate my care, treatment, and payment:

Emergency Contact/Release of Information

Name:____________________________**Relationship:**______________________**Phone:**___________________________

Name:____________________________**Relationship:**______________________**Phone:**___________________________

Name:____________________________**Relationship:**______________________**Phone:**___________________________

I understand that authorizing this release of my information to the above individuals is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individual(s), it may be subject to re-disclosure by the individual(s).

Patient Signature:____**Date:**______________________

Medical/Surgical History

Patient Name:____

Please take the time to carefully review your Medical/Surgical history with us.

Medical History

_______No relevant Medical History
_______Anxiety
_______Asthma
_______Atrial Fibrillation
_______Cancer (Type)_____________________________
_______Chronic Kidney Disease
_______Congestive Heart Failure
_______COPD
_______Coronary Artery Disease
_______Depression
_______Diabetes
_______Diverticulitis
_______Degenerative Disc Disease
_______Fibromyalgia
_______GERD/Reflux
_______High Cholesterol
_______High Blood Pressure
_______Kidney Stones
_______Lupus
_______Stroke
_______Vascular Disease
_______Hypothyroidism
_______Irregular Heart Beat
_______Multiple Sclerosis
_______Obstructive Sleep Apnea
_______Osteoarthritis
_______Rheumatoid Arthritis
_______ Other (List Below)

____

Surgical History

____
____
____
____
____
____

When was your last:

_____________ Colonoscopy
_____________ Flu Vaccine
_____________ Pneumonia Vaccine
_____________ Tdap Tetanus
_____________ Bone Density
_____________ Mammogram
_____________ Pap Smear
_____________ Date of Last Period
_____________ PSA
_____________Shingles Vaccine

Other Specialty Physicians you see:

____
____
____
____
____

Family/Social History

Patient Name:___________________________________

Please take the time to carefully review your Family/Social history with us.

Check all of which applies to your Family/Social history.

Father	Mother	Siblings	
			Deceased
			Alcoholism
			Dementia
			Arthritis
			Asthma
			Bleeding Disorder
			Breast Cancer
			Colon Cancer
			COPD
			Diabetes
			Emphysema
			Heart Disease
			High Cholesterol
			High Blood Pressure
			Hypothyroidism
			Kidney Disease
			Issues with Anesthesia
			Seizures
			Skin Cancer
			Stroke

______________________Other (List Below)

____

____

____

____

____

Social History

Alcohol

_______None

_______Occasional

_______Daily

_______Weekly

Tobacco

Cigarettes [ ] Smokeless [ ]

_______None

_______Less than 1 pack per day

_______1 Pack per day

_______More than 1 pack per day

_______Greater than 2 packs per day

Recreational Drugs

_______None

_______Occasional

_______Regularly (List Below)

____

____

____

Exercise

_______Never

_______Rarely

_______Regularly

Marital Status

_______Single

_______Married

_______Divorced

_______Widowed

_______Separated

Sexual Activity

_______Not Active

_______Sexually Active

Occupation

_______Full Time

_______Part Time

_______Disabled

_______Student

_______Retired

_______Unemployed

Pharmacy/Medication Information

Patient Name:____**Date of Birth**____________________

Pharmacy Name:____

Pharmacy Address:____

City____________________________**State**______________**Zip Code**__________________

Pharmacy Phone Number:____

Medication/Allergies

Please list all know Medications/Allergies.

List of Medications you are taking:

Name	Dosage

List Medication Allergies below:

Check Here if no Medication Allergies [ ]

____

____

____

____

____

____

____

____

____

Patient Consent

By signing this consent form you are agreeing that Bay Health & Wellness may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Patient Signature:____**Date:**______________________

Bay Health & Wellness

Authorized to Disclose Protected Health Information

Patient Name:_________________________Date of Birth:___________________Unit or SS#:_______________

The following person or entity is authorized to disclose my medical records:

____

____

____

____

The type and amount of information to be used or disclosed: Dates of Care From:___________To___________

- **Face Sheet**
- **History/Physical**
- **Operative Report**
- **Discharge Summary**
- **Consultation Reports**
- **Laboratory Results**
- **Pathology Reports**
- **X-Ray and Imaging Reports**
- **Entire Records**
- **Other____**

I hereby authorize the use or disclosure of information about the above named individual and I understand that:

1. This information about me is protected under Federal law.
2. I may refuse to sign the authorization.
3. I have the right to revoke this authorization in writing.
4. Any revocation will be effective only to extent that action has not been taken in reliance of my prior authorization.
5. Unless I revoke this authorization, it will expire on the following date__/__/__, event or condition:____________ _________________________ If I fail to specify an expiration date, event or condition, this authorization will respire in six months.
6. By signing below, I recognize that the protected health information used or disclosed pursuant to this authorization.
7. Treatment or payment will not be based on my signing this authorization.
8. I will receive a copy of this information.
9. **I understand that the information in my health record my include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental services, and treatment for alcohol and drug abuse.**

Patient Signature:______________________________________ Date:__________________________

Consent for Treatment

Patient Name:________________________________Date of Birth:____________________

CONSENT FOR TREATMENT: I, (or the person named on this medical record if the patient is unable to-consent) have presented to this medical office for medical treatment/services and hereby voluntarily consent to such diagnostic procedures needed to address my condition that may include, but is not limited to laboratory or x-ray treatment, drug and/or alcohol screens/tests, and to such medical care deemed appropriate by the attending provider named on this record, any assistants or designee as is necessary in his/her judgment.

I acknowledge and understand that in order to insure, to the greatest extent possible under current medical guidelines, that there is not a transmission of blood borne diseases such as Hepatitis B or Acquired Immune Deficiency Syndrome and that it may be necessary to draw and test my blood while I am a patient in this clinic. Such action would be necessary should a healthcare worker be stuck by a needle while drawing my blood or, should a healthcare worker sustain an injury in the course of my treatment or, should either I or any healthcare worker rendering care to me incur a parenteral or mucous membrane exposure to blood or other body fluids of one another. I therefore consent to have my blood drawn and tested. I further understand that my blood will not be routinely tested for diseases, that the results of any testing will be kept strictly confidential, and that I will not be charged for the tests in an exposure situation.

PERSONAL PROPERTY: The clinic will not be liable for damage to, loss, or theft of any money, jewelry, documents, or other personal belongings to a patient.

ASSIGNMENT OF INSURANCE BENEFITS: In the event the patient is entitled to health benefits of any type because of any insurance policy insuring the patient or someone else who is responsible for paying the patient's clinic or provider bills, the undersigned hereby agrees that these benefits can be paid directly to the clinic and applied to the patient's bill. The patient and or the undersigned are responsible for any portion of the bill not paid by an insurance company. The undersigned agrees to assist in processing claims for benefits.

MEDICARE AND/OR CHAMPUS AUTHORIZATION: I certify that the information given by me to the clinic in applying for payment under Title XVII of the Social Security Act or Champus program is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid or its Intermediaries or carriers any information needed for this or related Medicare/Champus claim. I request the payment of authorized benefits be made on my behalf to the clinic or provider providing interpretations in which h the clinic bills.

AUTHORIZATION TO RELEASE INFORMATION: The undersigned authorizes the clinic and any provider rendering service to release medical or other information about the patient, which may be necessary for the completion of insurance claims, review or services, or receipt of benefits. Such information may include current medical records. The information may be released to third party payers, including the third party payer's agent and or/representative or anyone responsible for payment of the hospital and/or provider charges.

FINANCIAL RESPONSIBILITY: The undersigned agrees to pay for services, accommodations, and provider services rendered to the patient, and he or she is hereby obligated to pay the account of the clinic. It is understood and agreed that charges not paid may be placed with an attorney or collection agency. It is understood and agreed that reasonable cost of collection including attorney fees, collection agency fees, and/or open account interest charges assessed are payable by the undersigned. To the extent not expressly prohibited by applicable law, the undersigned agrees to pay all clinic charges not paid in full to the clinic by third-party payer. The clinic accepts cash, checks, and Credit cards as forms of payment. The undersigned is aware that in some cases the patient's bill may not be covered in full the Insurance Company. The undersigned is aware of the fact the (patient/responsible party/guarantor) are responsible for any balance insurance does not pay. This balance due may include provisions set by your insurance company such as: co-payments, deductibles and "usual and customary" allowances. Co-payments and deductibles are due upon visit and must be paid at the time of service.

I ACKNOWLEDGE THAT I HAVE READ THIS FORM AND UNDERSTAND ITS PURPOSE AND CONTENT

______________________________	______________________________
Guarantor (Agreement to Pay)	**Patient (or authorized representative/relationship to patient)**
______________________________	______________________________
Witness (to guarantor signature)	**Witness (if anyone other than the patient signs)**
______________________________	______________________________
Date	**Date**