HEALTHY LIVING
PRIMARY CARE

PATIENT INFORMATION

Patient's Name (First, Middle, Last): _____

Address: _____

City:_____ State:_____ Zip Code: _____ Email: _____

Main Contact#: _____ Alternate#:_____ Work#: _____

Date of Birth: _____/_____/_____ Sex: ○ Male ○ Female SS# (optional): _____

Marital Status : ○ Single ○ Married ○ Divorced ○ Widowed Occupation: _____

Patient Referred By: _____ Spouse's Name: _____

Spouse's Date of Birth: _____/_____/_____ Main Contact#: _____ Alternate#: _____

Emergency Contact:_____ Relationship: _____ Phone#: _____

Primary Care Physician: _____ Phone#:_____

Referring Physician: _____ Phone#:_____

Other Patient Information

Which racial category does the patient most closely identify with?

○ African American ○ Asian ○ Caucasian ○ Hispanic

○ Native American ○ Native Hawaiian ○ Pacific Islander ○ Other: _____(Please Specify)

Ethnicity: What is the patient's ethnicity? ○ Hispanic or Latino ○ Not Hispanic or Latino

What is the patient's language of preference? ○ English ○ Spanish ○ Other: _____(Please Specify)

Insurance Information

Primary Insurance:_____ Policy/ID# _____

Name of Policy Holder:_____ DOB: _____/_____/_____ Group/Acct #:_____

Employer: _____ Employer Address: _____

City: _____ State: _____ Zip Code: _____ Work #: _____

Secondary Insurance: _____ Policy/ID#: _____

Name of Policy Holder:_____ DOB: _____/_____/_____ Group/Acct #:_____

Employer: _____ Employer Address: _____

City: _____ State: _____ Zip Code: _____ Work #: _____

Complete – Only if Patient is a Minor

Parent/Guardian Name: _____ Relationship: _____

Parent/Guardian Name: _____ Relationship: _____

Siblings:_____ DOB: _____/_____/_____ Other Siblings:_____ DOB: _____/_____/_____

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GENERAL CONSENT FORM

Patient Name: _____ **Date of Birth:** _____ /_____ /_____

Assignment of Benefits: Assignment of Benefits. I authorize Healthy Living Primary Care (HLPC) to submit claims on my behalf directly to Medicare/Medicaid/my private health insurance carrier. This means that HLPC will collect payment for supplies and services provided. I understand that I am financially responsible to the provider(s) for the charges not paid or payable. I authorize you to release any information necessary to insurance carriers regarding illnesses and treatment to process claims. This assignment will remain in effect until revoked by me in writing.

Patient Initials: _____

Consent for Treatment: I consent for HLPC to administer treatments, tests, and/or diagnostic tests to treat my/the patient's injury/ illness on an outpatient basis. I acknowledged there is no guarantee as to the outcome of any treatment I/the patient receives. In compliance with state law, if another individual is accidentally exposed to my/the patient's blood or body fluids (BBF); or if a medical or surgical procedure could expose another individual to my/the patient's BBF, HL PC may have such BBF tested for human immunodeficiency infection (HIV/AIDS) at HLPC's expense

Patient Initials: _____

Prescription Refill Policy: Refills for medications prescribed by your doctor should be requested during your office visit. Request s by phone will be addressed at our earliest convenience. We encourage the use of our patient portal for these requests. Refills will not be approved after the business hours, weekends or holidays. Therefore, please call in your refill request in a timely manner to us directly or for the pharmacy to contact our office. Refills for controlled substances require an office visit. No exceptions will be made. We reserve at least 24 hours to process all refill requests.

Patient Initials: _____

Phone Calls: By providing contact information, I authorize HLPC, its assignees, and third party collection agents to use the contact information I have provided to communicate with me and to place calls to my home/cellular/employment telephone; leave voice or text messages; and use pre-recorded/artificial/voice messages and/or auto-dialing devices in connection with any communication to me.

Patient Initials: _____

Involvement of Others in Care: I authorize HLPC to discuss my/the patient's care and medical needs with the following persons:

Name	Date of Birth (for identification)	Relationship	Phone

☐ I DO NOT wish to add an additional contact to discuss my/the patient's needs. **Patient Initials:** _____

May We Contact You By Phone and Leave a Message About Your Care?

Primary Phone #: _____ Secondary Phone #: _____

☐ Leave message with contact number only.
☐ Leave message with detailed information.
☐ Do not leave message.

☐ Leave message with contact number only.
☐ Leave message with detailed information.
☐ Do not leave message.

Patient Financial Policy

I acknowledge receipt of the "Patient Financial Policy." **Patient Initials:** _____

Notice of Privacy Practices

I acknowledge receipt of the "Notice of Privacy Practices." **Patient Initials:** _____

Minor Patient Photograph (when applicable)

I consent for USMD to photograph the minor patient for identification purposes only. **Patient Initials:** _____

_____
Print Name of Patient or Personal Representative

_____ _____
Signature of Patient or Personal Representative Date

HEALTHY LIVING
PRIMARY CARE

NEW PATIENT MEDICAL HISTORY FORM

DATE TODAY: _____

NAME: _____ _____ _____ **D.O.B.** ____/____/____
LAST FIRST M.I.

OCCUPATION: _____

REASON FOR VISIT TODAY: _____

_____

ALLERGIES (Include medications, foods, xray dyes) or ☐ **NONE KNOWN**

Name of allergen	Type of reaction	Approximate date
1		
2		
3		

CURRENT MEDICATIONS (Include prescription, over the counter, and herbal medications. Attach extra sheet if necessary) or ☐ **NONE**

Name of medication	Dose (mg)	How often taken	Reason for taking medication	Physician prescribing
1				
2				
3				

PHARMACY (list pharmacy most frequently used for prescriptions)

Name: _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ State/Zip: _____

PREVIOUS HOSPITALIZATIONS (Include all non surgical hospitalizations. Attach extra sheet if necessary) or ☐ **NONE**

Reasons for hospital stay	Date (approximate)	Hospital or city if known
1		
2		
3		

SURGERIES (Include all surgery in your lifetime. Attach extra sheet if necessary) or ☐ **NONE**

Type of surgery	Date (approximate)	Hospital or city if known
1		
2		
3		

OB/GYN HISTORY: No. of Pregnancies: _____ No. of Deliveries: _____ Last Menstrual cycle: _____

TOBACCO HISTORY

Are you an active cigarette smoker? ☐ Yes ☐ No

Have you ever been a cigarette smoker? ☐ Yes ☐ No

If yes, I smoked an average of _____ packs/day for _____ years. I quit in _____(year)

Do you use other tobacco products? ☐ Yes ☐ No

If yes, please specify _____

ALCOHOL AND DRUG HISTORY

Have you ever been diagnosed with alcoholism? ☐ Yes ☐ No

Do you currently drink alcohol regularly? ☐ Yes, currently ☐ Never/rarely

If yes, approximately how many drinks per week (beer, wine, or liquor)_____

Have you ever used intravenous drugs? ☐ Yes ☐ No

FAMILY HISTORY

Is there a history in your family of:	Yes	No	Affected relative(s)
Heart attack			
Diabetes			
Prostate cancer			
Kidney cancer			
Kidney stones			
Other significant disease			

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NEW PATIENT MEDICAL HISTORY FORM

DATE TODAY: _____

NAME: _____ _____ _____ **D.O.B.** ____/____/_____
LAST FIRST M.I.

Please check "X" the complaint(s) or ailment(s) that apply to you. If you are unsure, place a question mark (?)

General	Fatigue / Tired	☐Yes	☐No
	Fever / Chills	☐Yes	☐No
	Headache	☐Yes	☐No
	Weight Loss	☐Yes	☐No
	Weight Gain	☐Yes	☐No
	Other: _____		
Eyes	Difficulty Seeing	☐Yes	☐No
	Other: _____		
Head Ears Nose Throat	Dry Mouth	☐Yes	☐No
	Hearing Problems	☐Yes	☐No
	Hoarseness	☐Yes	☐No
	Lumps/Swelling in Neck	☐Yes	☐No
	Sore Throat	☐Yes	☐No
	Trouble Swallowing	☐Yes	☐No
	Other: _____		
Cardiac (Heart)	Chest Pain	☐Yes	☐No
	Irregular Heart Beat	☐Yes	☐No
	Pain with Walking	☐Yes	☐No
	Shortness of Breath	☐Yes	☐No
	Swelling in Feet/Ankles	☐Yes	☐No
	Other: _____		
Neuro	Dizziness	☐Yes	☐No
	Fainting	☐Yes	☐No
	Headache	☐Yes	☐No
	Memory Loss	☐Yes	☐No
	Numbness	☐Yes	☐No
	Weakness	☐Yes	☐No
	Other: _____		
Respiratory	Cough	☐Yes	☐No
	Shortness of Breath	☐Yes	☐No
	Use of Inhalers	☐Yes	☐No
	Wheezing	☐Yes	☐No
	Other: _____		
Gastro-Intestinal	Abdominal Pain	☐Yes	☐No
	Blood in Stool	☐Yes	☐No
	Change in Bowel Habits	☐Yes	☐No
	Constipation	☐Yes	☐No
	Heartburn	☐Yes	☐No
	Loss of Appetite	☐Yes	☐No
	Nausea	☐Yes	☐No
	Vomiting	☐Yes	☐No
	Other: _____		

Males Only	Blood in Urine	☐Yes	☐No
	Difficulty Achieving Erection	☐Yes	☐No
	Foul Odor in Urine	☐Yes	☐No
	Pain in Testicles	☐Yes	☐No
	Trouble Urinating	☐Yes	☐No
	Other: _____		
Females Only	Breast Discomfort	☐Yes	☐No
	Irregular Bleeding	☐Yes	☐No
	Last Menstrual Cycle *Date:* _____		
	Painful Intercourse	☐Yes	☐No
	Post Menopausal Bleeding	☐Yes	☐No
	Trouble Urinating	☐Yes	☐No
	Vaginal Discharge	☐Yes	☐No
Musculoskeletal			
	Back Pain	☐Yes	☐No
	Joint Pain	☐Yes	☐No
	Muscle Pain	☐Yes	☐No
	Swelling	☐Yes	☐No
	Other: _____		
Skin Hair Nails	Bruising	☐Yes	☐No
	Hair Loss	☐Yes	☐No
	Nail Problems	☐Yes	☐No
	Rash	☐Yes	☐No
	Skin Changes	☐Yes	☐No
	Other: _____		
Mental Health	Anxiety	☐Yes	☐No
	Depression	☐Yes	☐No
	Difficulty Sleeping/Concentrating	☐Yes	☐No
	History of Physical/Mental Abuse	☐Yes	☐No
	Mood Swings	☐Yes	☐No
	Stress	☐Yes	☐No
	Suicidal	☐Yes	☐No
	Other: _____		

Recent Tests/ Health Maintenance (Give month/year of last exam in right column. Check left column if date is estimated.)

- ☐ Bone Density: _____
- ☐ Colonoscopy: _____
- ☐ Diabetic Foot Exam: _____
- ☐ Eye Exam: _____
- ☐ Mammogram: _____
- ☐ Pap Smear: _____
- ☐ Physical: _____
- ☐ PSA: _____
- ☐ Tetanus Shot: _____