Siena Hills Primary Care

Patient's Full Name: _____ SSN _____ - _____- _____

Preferred Phone: _____Cell/ Home/ Work

Secondary Phone: _____Cell/ Home/ Work

(Allow text message reminders? Yes / No)

Date of Birth: ___/___/_____ Age: ____ Gender: Male / Female

Preferred Language: English/ Spanish/ Mandarin/ Other _____

Race: White/ African-American/ Asian/ Pacific Islander or Hawaiian/ Native American/ Hispanic/ Other

Ethnicity: Hispanic or Latino/ Non-Hispanic

Home Address:_____ Apt Number_____

City:_____ State:_____ Zip:_____ E-mail: _____

Employer: _____

Work Address: _____City:_____State:____Zip:_____

Work Phone: _____ Extension:_____

Single/ Married/ Divorced/ Widowed/ Other Spouse/Partner: _____

Emergency Contact Name: _____ Relationship: _____

Telephone Number of Emergency Contact: _____

Primary Local Pharmacy: _____

Mail Order Pharmacy: Express Scripts/ OptumRx/ CareMark/ Other_____

Insurance Information

Primary Insurance Carrier:_____

Primary Cardholder's Name: _____ Relationship: _____

Date of Birth: _____ SSN: _____ Effective Date: _____

Secondary Insurance Carrier: _____

Secondary Cardholder's Name: _____ Relationship: _____

Date of Birth: _____ SSN: _____ Effective Date: _____

I hereby authorize treatment and understand that I am financially responsible for all charges incurred.

Signature: _____ Date: _____

If minor, print name of Parent/Guardian:_____

ASSIGNMENT OF BENEFITS

I hereby authorize the release of any information relating to all claims for benefits submitted on my behalf by Siena Hills Primary Care. I further agree and acknowledge that my signature on this document authorizes Siena Hills Primary Care to submit claims for benefits for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted and that I will be bound by this signature as though I had personally signed each claim form. A photocopy of this assignment shall be considered as effective and valid as the original. I hereby authorize my insurance company to pay and hereby assign directly to Siena Hills Primary Care all benefits otherwise payable for services as described on the claim forms.

PATIENT RESPONSIBILITY

Siena Hills Primary Care is contracted with many insurance carriers and is required to submit claims for medical services for patients covered under these contracts. It is the responsibility of the patient to be prepared to pay any office visit co-pays, co-insurance portions and yearly deductibles and any non-covered services. In the event of a denial of coverage from your insurance carrier, all charges will become your responsibility. For your convenience we will submit claims to insurance carriers to whom we are not network providers, but responsibility for payment of all services provided by Siena Hills Primary Care, remains with you, the patient. I hereby certify that all the information given is complete and accurate to the best of my knowledge. In the event of default on payment of charges, I agree to pay collection fees including reasonable attorney fees.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

Siena Hills Primary Care has posted the Notice of Privacy Practices on its website www.sienahillsprimarycare.com. This document is required by law and explains our duties and obligations with respect to your protected health information. A printed copy is available for your review in the waiting room and also upon request. I hereby acknowledge receipt of Siena Hills Primary Care's Notice of Privacy Practices.

PERMISSION TO DISCUSS AND COMMUNICATE MEDICAL INFORMATION

I authorize the doctors and staff of Siena Hills Primary Care to discuss my health information with the person listed as my Emergency Contact (YES/ NO). Likewise, the following person(s) are authorized:

Name: Tel: Relationship:

I give permission for the doctors and staff to leave test results and advice my voicemail: YES / NO

I authorize electronic verification of my previous prescriptions: YES / NO

I hereby acknowledge and agree to all of the items as explained above.

SIGNATURE: _____ DATE: _____

Printed Name of Patient or Guardian: _____

Siena Hills Primary Care

Medical History Sheet

Reasons for visit today: _____

Check here if auto accident ___ Check here if injury or illness is work related _____

Please be advised that your initial appointment with us cannot be billed as a "routine physical"

Please list all previous surgeries and dates performed: _____

_____

Please list all previous and current medical conditions: _____

_____

_____

Occupation: _____ Single/ Married/ Divorced/ Widow/ Other

Allergies: _____

Smoking: Never/ Date quit _____/ # packs/day _____ for _____ years.

Alcohol use: Y/N Typical number of drinks_____ per day / week

Please list all current medications, strength, and number of times a day taken. Also include over the counter medications: _____

_____

_____

Please list recent physicians seen: _____

_____

Family illnesses:

Mother – living/deceased; medical conditions: _____

Father – living/deceased; medical conditions: _____

Other relatives: _____

Please note dates and results of any recent test or treatments within the last 5 years:

Pap test_____ Mammogram_____

Colonoscopy_____ Bone Density _____Cardiac testing_____

Vaccines: Prevnar-13 _____ Pneumococcal -23 _____ Shingles _____

SYSTEM REVIEW NAME_____

Please circle if you have recently had the following:

GENERAL
fatigue overall weakness obesity weight gain / loss loss of appetite fever chills sweats insomnia headache loud snoring anemia cancer

EYES, EARS, NOSE, THROAT
vision problems eye problems hearing loss ringing in ears nose congestion runny nose allergies postnasal drip bloody nose sinus pain mouth / tongue sore tooth decay Sore throat hoarseness neck lump

HEART / VASCULAR
chest pain high blood pressure short of breath on exertion or lying down swollen ankles palpitations dizziness lightheadedness loss of consciousness heart murmur

LUNGS
pneumonia asthma chronic bronchitis shortness of breath cough phlegm/sputum wheezing coughing up blood abnormal chest X-ray previous smoker tuberculosis

DIGESTIVE
heartburn burping trouble swallowing abdominal pain ulcers nausea vomiting jaundice hepatitis gall bladder disease diarrhea constipation excess gas vomiting blood black or tarry stools rectal bleeding hemorrhoids hernia

GENITO-URINARY
trouble passing urine stones blood in urine loss of urine control urgency frequency decreased sex drive sexually transmitted disease (what kind?_____)
Male: decrease in urine flow erection difficulty penile discharge or lesion
Female: heavy or abnormal menstrual period vaginal discharge dryness breast lump hot flashes last period_____ # of pregnancies_____ live births_____ miscarriages

MUSCULO-SKELETAL
arthritis joint pain stiffness swelling muscle ache gout osteoporosis
Where: shoulder arm elbow wrist left / right hand Hip thigh
knee leg ankle left / right foot neck mid-back lower back

NEUROLOGICAL
stroke weakness of one extremity tingling or burning sensation numbness imbalance walking tremor memory loss seizures vertigo altered speech

PSYCHIATRIC
Depression moodiness poor motivation loss of enjoyment anxiety panic stress

ENDOCRINE
Diabetes diabetic complications frequent thirst and urination hot or cold intolerance thyroid problem excess hair growth abnormal hair loss

SKIN
Rash lesion mole dryness itching psoriasis discoloration nail abnormality