

**New Patient Paperwork**

First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex\_ \_\_\_\_\_\_\_\_\_\_ Martial Status\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can we talk to your spouse, children, or family members about your care? Y N

Name and relationship of people we can speak to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I do hereby agree and give my consent to the Nurse Practitioner to furnish medical care and treatment considered necessary and proper in diagnosing or treating my physical and mental condition I understand my Nurse Practitioner may utilize a nurse or medical assistant to assist with my plan of care. I consent to the use of the health data sharing portal; my connected care providers can receive and share information. I consent to you to bill my medical insurance on my behalf.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Medical History**

**Circle all that apply**   **Relation to you**

Breast Cancer

Colon Cancer

Ovarian Cancer

Elevated Cholesterol

Dementia

Thyroid Disease

Autoimmune disease

Kidney Disease

Diabetes Type 1

Diabetes Type 2

Hypertension

Other

**Patient Health History**

Do you have any known drug allergies? Y N Name of Drug\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reaction \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List Medication and supplements currently taking:

**Medication** **Dose**

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Have you ever smoked tobacco or nicotine? Y N Age and onset of use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of nicotine vape, cigarettes, or chewing \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your level of alcohol consumption? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use any illicit or recreational drugs? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last wellness date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Colon cancer screening date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breast cancer screening date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List any Surgeries or recent hospitalization** **Date**

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**Obstetric History**

|  |  |
| --- | --- |
| Full Term |  |
| Premature |  |
| Ectopic |  |
| Multiple births |  |
| Living |  |
|  |  |

**Medical History**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ADD/ADHD | Yes | No | Headaches | Yes | No |
| AIDS/HIV | Yes | No | Heart Disease | Yes | No |
| Allergies/  Hay fever | Yes | No | Heart Problems | Yes | No |
| Anesthesia Complications | Yes | No | Hepatitis | Yes | No |
| Anxiety | Yes | No | High Cholesterol | Yes | No |
| Arthritis | Yes | No | Hypertension | Yes | No |
| Asthma | Yes | No | Hyperthyroidism | Yes | No |
| Birth defects/inherited disease | Yes | No | Hypothyroidism | Yes | No |
| Bladder/Kidney issues | Yes | No | Infertility | Yes | No |
| Blood Diseases | Yes | No | Kidney Disease | Yes | No |
| Blood transfusion | Yes | No | Kidney Stones | Yes | No |
| Breast Cancer | Yes | No | Liver Disease | Yes | No |
| Breast Problem | Yes | No | Lung Disease | Yes | No |
| COPD | Yes | No | MRSA exposure | Yes | No |
| Cancer | Yes | No | Meniere’s Disease | Yes | No |
| Chronic ear infections | Yes | No | Mental Illness | Yes | No |
| Constipation | Yes | No | Muscle, joint, bone problems | Yes | No |
| Coronary Artery Disease | Yes | No | Obesity | Yes | No |
| Depression | Yes | No | Osteoporosis | Yes | No |
| Developmental/behavioral disorders | Yes | No | Ovarian Cancer | Yes | No |
| Diabetes | Yes | No | Polyps | Yes | No |
| Difficulty Swallowing | Yes | No | Pulmonary Embolism | Yes | No |
| Diverticulitis | Yes | No | Reflux/Gerd | Yes | No |
| Ear/hearing problems | Yes | No | Seizures/Epilepsy | Yes | No |
| Eating Disorders | Yes | No | Skin Problems | Yes | No |
| Eczema | Yes | No | Stroke | Yes | No |
| Endometriosis | Yes | No | Thrombophilia | Yes | No |
| Fibromyalgia | Yes | No | Thyroid Problems | Yes | No |
| GI problems | Yes | No | Tuberculosis | Yes | No |
| Gout | Yes | No | Varicosities | Yes | No |
| Other | Yes | No | Vision/eye Problems | Yes | No |
|  | | | | | |

**HIPPA Acknowledgement and Consent Form**

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

* Conduct, plan, and direct my treatment and follow-up care among the multiple health care providers who may be involved in that treatment directly or indirectly.
* Obtain payment from designated third-party payers.
* Conduct normal healthcare operations such as quality assessment or evaluations and health care provider certifications

I have been informed by you or your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information (available in the office in print form.) I have reviewed such Notice of Privacy Practices prior to signing this consent and acknowledge that I have studied the Privacy Practices from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Notices of Privacy Practices.

I understand that I may revoke this consent in writing at any time except to the extent that the organization has acted relying on this consent.

Print Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Clinic Patient Polices**

**Health Insurance:** We bill your insurance company as a courtesy to you. Each insurance company has its own rules for determining how much they will pay for each claim. Your policy is a contract between you and your insurance company. It is your responsibility to know your insurance policy and be familiar with your coverage. If your insurance company denies your claim, you are responsible for your payment in full.

**Payments:** Unless we approve other arrangements, the balance on your statement is due upon receipt, if payments are not received, we reserve the right to refuse future appointments on delinquent accounts. If your account becomes past due, we will take the necessary steps to collect the debt. Once sent to collections the patient will not be allowed to make further appointments with Hazel Healthcare.

**No Show and Late arrivals:** Please provide 24-hour notice when you cannot make an appointment, many times the clinic can fill these vacancies with appointments the same day. Without communicating your inability to make your appointment, the missed appointment will result in a “no-show " A no show visit will result in a $95.00 charge that has to be paid before another appt will be scheduled. and two no shows in a 12-month period will result in forfeiting your ability to receive care at Hazel Healthcare. If you are more than 10 minutes late to your scheduled appointment, you will be asked to reschedule your appointment. If you are late more than 3 times in a 12-month period, you will forfeit your ability to receive care at Hazel Healthcare.

**Prescription Refills**: Please contact your pharmacy to request medication refills. They will contact us for approval. Please allow 72 hours (about 3 business days) for all prescription refills. We do not refill prescriptions after hours, on weekends or holidays. If you are on a controlled substance and you do not have refills at your pharmacy, you must make an appointment to be seen.

**Lab/Test Results:** if you have any tests performed and there are urgent results you will be notified the same day results are received, otherwise please allow up to one week for follow-up regarding results.

**Same Day sick Appointments:** We make every effort to accommodate patients who are sick, we have limited appointment spots. Same day sick appointments are only for acute illnesses such as coughs, colds, infections, lacerations. Please note you may be advised to go to the nearest ER if the provider feels it is appropriate. Wellness visits, chronic conditions, weight loss are not appropriate for same day sick appointments.

Patient/ Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_