MEDICAL PATIENT INFORMATION			
Last Name	**First Name**	**Middle Initial**	**Email for Patient Portal**
Street Address	**Mailing Address**	**City, State**	**Zip Code**
Home Phone	**Work Phone**	**Cell Phone**	**Best way to contact you** ☐Home ☐Work ☐Cell
Date of Birth (mm/dd/yyyy)	**Sex at Birth** ☐ Male ☑ Female	**Marital Status:** ☐Married ☑Single ☐ Divorced ☐Separated ☐ Widowed	
Social Security Number	**Employer/School Name and Address** (City, State)		**Zip Code**
Employment Status ☐Self Employed ☐Full Time ☐Part Time ☐Unemployed ☐Retired		**Student Status** ☐Full Time ☐Part Time ☐Not a Student	
Race(s) ☐ Native American/Alaska Native ☐ Decline ☐White ☐ African American ☐Pacific Islander ☐Asian		**Ethnicity** ☐Decline ☐Hispanic ☐Non-Hispanic	**Language** ☐English Other:
Veteran ☐Yes ☑No	**Migrant** ☐Yes ☑No	**Homeless** ☐Yes ☑No	**Deemed disabled by SSA** ☐Yes ☑No
RESPONSIBLE PARTY **Legal guardian if a minor AND/OR person to be billed if other than the above patient.**			
Last Name	**First Name**	**Date of Birth** (mm/dd/yyyy)	
Address (if different from patient)	**City**	**State**	**Zip Code**
Primary Phone		**Relationship to Patient**	

CONSENT FOR TREATMENT/CARE

I consent to treatment and care by Highland Medical Center (HMC) health care providers. I understand that my treatment and care may include routine care, such as immunizations, and a variety of other medical services depending on my condition, such as laboratory testing. I can receive a list of services and care from my health care provider. I am aware that the practice of medicine is not an exact science, and no one has made any guarantees about the results of my treatments, examinations, or procedures.

FINANCIAL:

Due to the increased cost of mailing statements, and to help keep our fees as low as possible, we find it necessary to expect our patients to pay their co-pay/coinsurance/deductible or non-insurance expenses at the time of service. Bills over 60 days past due may be turned over to a collection agency. I understand that I am financially responsible for all charges for services to me, including the balance remaining after payment of possible insurance benefits.

ASSIGNMENT OF BENEFITS:

I authorize payment of medical benefits for professional services rendered to Highland Medical Center, Inc.

_____

PRINTED PATIENT NAME

_____ DATE: _____

PATIENT **SIGNATURE** (or Authorized Representative)

Understanding Health Information Privacy

The HIPAA Privacy Rule provides federal protections for individually identifiable health information held by covered entities and their business associates and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of health information needed for patient care and other important purposes. HMC can receive and share health information with other health professionals and hospitals who are treating you.

The Security Rule specifies a series of administrative, physical, and technical safeguards for covered entities and their business associates to use to assure the confidentiality, integrity, and availability of electronic protected health information.

By completing below, I am acknowledging that I have read the Highland Medical Center's Privacy Notice, have been offered a copy, and had an opportunity to ask question.

Printed Name of Patient: _____

Date of Birth of Patient: _____

Printed Name of Guardian, if appropriate: _____

Signature of Patient or Guardian:_____Date:_____

RELEASE OF INFORMATION

Often it is difficult to reach a patient to convey physician orders or test results. In this event, with your signed authorization, we would release such information to a person you designate. Please complete the section below.

I authorize Highland Medical Center, Inc. to release any information required in the course of my examination or treatment to the following designated person(s):

Emergency Contact:_____Relationship & Phone #:_____

Name:_____Relationship & Phone #:_____

Name:_____Relationship & Phone #:_____

ADVANCE DIRECTIVE (Living Will/ Medical Power of Attorney)

An Advance Directive is a legal document that states your wishes regarding medical treatment in the event that you are unable to communicate these decisions. *It is very important that all of your healthcare providers have a current copy of these documents.*

☐ I HAVE completed an Advance Directive. **Copy provided to HMC? Yes / No**

☑ I HAVE NOT completed an Advance Directive. I would like more information. Yes / No

HMC
HIGHLAND MEDICAL CENTER
Caring for the health of the Highlands

Date of Visit:

HEALTH HISTORY QUESTIONNAIRE

All answers contained in this questionnaire are strictly confidential
and will become part of your medical record

NAME: (Last, First, MI): **Date of Birth**:

Previous or Referring Provider/Doctor*:* **Date of last visit***:*

PERSONAL HEALTH HISTORY

CURRENT MEDICATIONS: List ALL prescribed & over-the-counter drugs (vitamins, supplements, inhalers, etc.)

Name of medication	Strength/Dose	Frequency Taken

ALLERGIES TO MEDICATIONS:

Medication	Reaction

CHILDHOOD ILLNESS: Check if you had any of the following as a child

☐ Measles ☐ Mumps ☐ Rubella ☐ Chicken Pox ☐ Rheumatic Fever ☐ Polio

IMMUNIZATIONS: Circle any immunizations that you have taken and list date if known.

Tetanus	Influenza	Pneumovax 23 and/or Prevnar 13
Hepatitis	Chicken Pox	MMR (Measles, Mumps, Rubella)

MEDICAL HISTORY: List any past or present medical diagnoses and year diagnosed.

Diagnosis	Year	Diagnosis	Year
☐ High Cholesterol		☐ Tested Positive for Tuberculosis (TB)	
☐ Heart Attack		☐ Asthma	
☐ Blood clots (DVT or PE)		☐ Emphysema	
☐ Congestive Heart Failure (CHF)		☐ Other Lung Disease:	
☐ Other Heart/Vascular:		☐ Depression	
☐ Diabetes		☐ Anxiety	
☐ Hyper-/ Hypo-thyroidism		☐ Other Mental Illness:	
☐ Kidney Disease:		☐ Arthritis	
☐ Liver Disease:		☐ Other Bone/Muscular:	
☐ Stroke		☐ Glaucoma	
☐ Dementia/ Alzheimer's		☐ Prostate Disease	
☐ Other Neurological:		☐ Stomach/Intestinal:	

OTHER:

SURGERIES:

Year:	Surgery/Type:	Hospital/Doctor:

OTHER HOSPITALIZATIONS:

Year:	Reason:	Hospital:

FAMILY HEALTH HISTORY:

			Check if applies:								
	Year of Birth	Living?	Diabetes	High BP	Cancer	Coronary Artery Disease	Dementia	Thyroid Problems	Depression, Anxiety or Mental Illness	Stroke	Other:
Father											
Mother											
Son(s)											
Daughter(s)											
Brother(s)											
Sister(s)											
Paternal Grand Mother											
Paternal Grand Father											
Maternal Grand Father											
Maternal Grand Mother											
Other:											

HEALTH HISTORY: Do you **currently** experience any of the following symptoms?

CONSTITUTIONAL	**NEUROLOGY**	**CARDIOVASCULAR**
☐ Unexplained weight loss ☐ Unexplained weight gain ☐ Fevers ☐ Chills ☐ Nausea and/or vomiting	☐ Stroke symptoms ☐ Change in memory ☐ Dizziness ☐ Headaches ☐ Imbalance or falling ☐ Numbness ☐ Weakness ☐ Tremors or shaking ☐ Seizures	☐ Chest pain/Pressure ☐ Heart problems ☐ Calf pain with walking ☐ Chest discomfort or trouble breathing with exertion/exercise ☐ Swelling (edema) in legs ☐ Trouble breathing while lying flat ☐ Passing out/fainting
EARS/NOSE/THROAT/MOUTH	**ENDOCRINE**	**RESPIRATORY**
☐ Bleeding gums ☐ Problems with hearing ☐ Change in your voice ☐ Dentures (full or partial) ☐ Nose bleeds ☐ Sinus problems ☐ Ringing in ears (tinnitus) ☐ Mouth ulcers	☐ Problems with heat ☐ Problems with cold ☐ Swelling in neck (goiter) ☐ Frequent urination ☐ Excessive thirst ☐ Changes to hair	☐ Asthma ☐ Persistent cough ☐ Coughing up blood ☐ Shortness of breath ☐ Wheezing
HEMATOLOGY/ONCOLOGY	**EYES**	**SKIN**
☐ Anemia or low blood counts ☐ Bruise easily ☐ Swollen lymph glands ☐ Cancer(s): Type:	☐ Change in vision ☐ Glasses or contacts ☐ Irritated Eyes	☐ Changes to skin or lesions Where? ☐ Itchy skin or rashes Where?
GASTROINTESTINAL	**MUSCULOSKELETAL**	**OTHER:**
☐ Blood in stool/black tarry stools ☐ Change in bowel movements ☐ Constipation ☐ Diarrhea ☐ Difficulty swallowing ☐ Heartburn or reflux ☐ Hemorrhoids ☐ Nausea or vomiting	☐ Back pain Where: ☐ Neck pain ☐ Injury to arms/legs ☐ Joint pain or stiffness Which joints: ☐ Locking joints Which joints: ☐ Gout ☐ Red or swollen joints	

FOR MEN ONLY:

□ Get up at night to urinate? If yes, # of times:_____ □ Pain or burning with urination □ Difficulty emptying bladder completely □ Force of urination decreased
□ Kidney/bladder infection in the last 2 months?
□ Blood in your urine? □ Burning in or discharge from your penis?
□ Any testicle pain or swelling? □ Any difficulty with erection or ejaculation?
□ Do you perform monthly testicular self-exam? □ Have you had a prostate and rectal exam? If yes, when and where? □ Do you see a urologist? If yes, whom?

FOR WOMEN ONLY:

Age at onset of menstruation: Date of last menstrual period: Frequency of periods: every ___ month(s) for ____ day(s)
Number of pregnancies: Number of live births:
□ Pelvic pain □ Vaginal discharge
□ Currently pregnant or breastfeeding
□ Had D&C, hysterectomy or cesarean (Circle all that apply)
□ Urinary tract, bladder or kidney infections in the last year □ Blood in urine □ Leaking urine
□ Hot flashes or night sweats
□ Have heavy periods, irregularity, spotting □ Premenstrual tension, pain, bloating, irritability or other systems around the time of your period
□ Breast lumps or nipple discharge? If yes, which breast?

LIST ANY ADDITIONAL INFORMATION THAT YOU WOULD LIKE FOR US TO KNOW: