

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 <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell
Date of Birth (mm/dd/yyyy)	Sex at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
Social Security Number	Employer/School Name and Address (City, State)		Zip Code
Employment Status <input type="checkbox"/> Self Employed <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired		Student Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Not a Student	
Race(s) <input type="checkbox"/> Native American/Alaska Native <input type="checkbox"/> Decline <input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Asian		Ethnicity <input type="checkbox"/> Decline <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	Language <input type="checkbox"/> English Other:
Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No	Migrant <input type="checkbox"/> Yes <input type="checkbox"/> No	Homeless <input type="checkbox"/> Yes <input type="checkbox"/> No	Deemed disabled by SSA <input type="checkbox"/> Yes <input type="checkbox"/> 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



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

**OTHER:**

**SURGERIES:**

Year:	Surgery/Type:	Hospital/Doctor:

**OTHER HOSPITALIZATIONS:**

Year:	Reason:	Hospital:

**FAMILY HEALTH HISTORY:**

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

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

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

**FOR MEN ONLY:**

<input type="checkbox"/> Get up at night to urinate? If yes, # of times: _____
<input type="checkbox"/> Pain or burning with urination
<input type="checkbox"/> Difficulty emptying bladder completely
<input type="checkbox"/> Force of urination decreased
<input type="checkbox"/> Kidney/bladder infection in the last 2 months?
<input type="checkbox"/> Blood in your urine?
<input type="checkbox"/> Burning in or discharge from your penis?
<input type="checkbox"/> Any testicle pain or swelling?
<input type="checkbox"/> Any difficulty with erection or ejaculation?
<input type="checkbox"/> Do you perform monthly testicular self-exam?
<input type="checkbox"/> Have you had a prostate and rectal exam? If yes, when and where?
<input type="checkbox"/> 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:
<input type="checkbox"/> Pelvic pain
<input type="checkbox"/> Vaginal discharge
<input type="checkbox"/> Currently pregnant or breastfeeding
<input type="checkbox"/> Had D&C, hysterectomy or cesarean (Circle all that apply)
<input type="checkbox"/> Urinary tract, bladder or kidney infections in the last year
<input type="checkbox"/> Blood in urine
<input type="checkbox"/> Leaking urine
<input type="checkbox"/> Hot flashes or night sweats
<input type="checkbox"/> Have heavy periods, irregularity, spotting
<input type="checkbox"/> Premenstrual tension, pain, bloating, irritability or other systems around the time of your period
<input type="checkbox"/> Breast lumps or nipple discharge? If yes, which breast?

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