Cullman Primary Care OB/GYN

PATIENT MEDICAL HISTORY

PLEASE FILL OUT PAPERWORK **COMPLETELY**

NAME: _____DATE OF BIRTH: _____TODAY'S DATE: _____

ADDRESS:_____STATE:_____ZIP CODE:_____

HOME PHONE: ( )_____CELL PHONE: ( )_____SS#:_____

EMPLOYER:_____WORK PHONE #:_____

SPOUSE NAME:_____PHONE #:_____

PRIMARY INSURANCE:_____POLICY HOLDER DATE OF BIRTH:_____

SECONDARY INSURANCE:_____POLICY HOLDER DATE OF BIRTH:_____

MARTIAL STATUS: SINGLE MARRIED DIVORCED WIDOWED SEXUALLY ACTIVE: YES OR NO

NAME OF YOUR PHARMACY: _____

PLEASE LIST ANY ALLERGIES :_____(IF NO KNOWN ALLERGIES PLEASE WRITE N / A)

PLEASE LIST ALL MEDICATIONS INCLUDING HORMONES AND BIRTH CONTROL AND THEIR DOSAGE:

_____DOSE_____ _____DOSE_____ _____DOSE_____

_____DOSE_____ _____DOSE_____ _____DOSE_____

_____DOSE_____ _____DOSE _____ _____DOSE_____

PLEASE LIST ALL SURGERIES AND THE DOCTOR WHO PERFORMED THE SURGERY:

_____DR._____ _____DR._____ _____DR._____

_____DR._____ _____DR._____ _____DR._____

_____DR._____ _____DR._____ _____DR._____

TOTAL NUMBER OF PREGNANCIES YOU HAVE HAD: _____, # OF LIVING CHILDREN_____

TOTAL NUMBER OF MISCARRIAGES / ABORTIONS: _____

WHEN WAS LAST MENSTRAL PERIOD OR HYSTERECTOMY:_____

WHEN WAS YOUR LAST PAP SMEAR: _____DO YOU HAVE A HISTORY OF ABNORMAL PAPS: YES OR NO

WHEN WAS YOUR LAST MAMMOGRAM: _____DO YOU HAVE A HISTORY OF ABNORMAL MAMMO: YES OR NO

WHEN WAS YOUR LAST BONE DENSITY: _____COLONOSCOPY :_____(INCLUDE MONTH & YEAR)

ARE YOU A CURRENT SMOKER (IF SO HOW MUCH_____) FORMER SMOKER * NON-SMOKER (PLEASE CIRCLE ONE)

DO YOU USE ALCOHOL: YES * SOCIALLY * NOT AT ALL (PLEASE CIRCLE ONE)

PATIENT MEDICAL HISTORY CONTINUED

****FAMILY HISTORY** PLEASE LIST ANY CLOSE RELATIVE WITH A HISTORY OF THE FOLLOWING:**
(EXAMPLE: MOTHER, FATHER, GRANDMOTHER, GRANDFATHER, SIBLINGS, AUNTS, & UNCLES)

BREAST CANCER: _____OVARIAN CANCER: _____UTERINE CANCER:_____

COLON CANCER: _____HIGH BLOOD PRESSURE_____DIABETES:_____

THYROID: _____HEART DISEASE: _____BLOOD CLOTS: _____

LIST ANY OTHER CANCER: _____NONE OF THE ABOVE _____

***MEDICAL HISTORY* HAVE YOU (THE PATIENT) EVER HAD ANY OF THE FOLLOWING: (PLEASE CIRCLE ALL THAT APPLY)**

*HEART DISEASE * HIGH BLOOD PRESSURE *HIGH CHOLESTROL *THYROID PROBLEMS *URINARY INCONTINENCE

*JOINT OR MUSCLE PAIN *EPILEPSY / SEIZURES *MIGRAINES *DEPRESSION *ANXIETY *DIABETES (TYPE)

*CANCER (TYPE) _____ * OSTEOPOROSIS *OSTEOPENIA *OSTEOARTHRITIS *BLOOD CLOTS

*OTHER: _____

ARE YOU (THE PATIENT) CURRENTLY HAVING ANY OF THE FOLLOWING PROBLEMS: (PLEASE CIRCLE ALL THAT APPLY)

*RECENT WEIGHT GAIN *RECENT WEIGHT LOSS *BLOOD IN STOOL *FREQUENT URINATION *URGENCY

*ANY BURNING OR PAIN WITH URINATION *VAGINAL DISCHARGE *IRREGULAR VAGINAL BLEEDING *PELVIC PAIN

*PAINFUL INTERCOURSE *BREAST LUMPS *OTHER: _____

PLEASE LIST ALL PROBLEMS YOU WOULD LIKE TO BE SEEN FOR TODAY: _____

**If your insurance requires a referral for you to see a Cullman Primary Care, PC Provider, IT IS YOUR RESPONSIBILITY to provide our office with the referral. If your insurance company denies payment—DUE TO NO REFERRAL—You the patient agrees to pay Cullman Primary Care, PC in FULL for any charges incurred during your visit.
**I hereby authorize the office of Cullman Primary Care, PC to release to my insurance company any necessary information needed to file and expedite payment on my claim. I further assign any benefits payable on my behalf to Cullman Primary Care. I understand I am financially responsible for any balance not covered by my insurance carrier. I also understand that I am responsible for any fees or charges accrued in the process of collecting past due amounts on my account, including reasonable attorney's fees in the event my medical / surgical bills are placed with an attorney or other third party.

PATIENT SIGNATURE:_____DATE SIGNED:_____

Cullman Primary Care OB/GYN

PRIVACY COMPLIANCE

Please list the family members or other person, if any, we may inform about your general medical condition and your diagnosis which might include medical history, treatment, laboratory reports, x-rays, and treatment and/or reference to any mental or nervous disorders, drug and/or alcohol abuse, or sexually transmitted disease.

_____ Relationship, _____ Phone, _____

_____ Relationship, _____ Phone, _____

_____ Relationship, _____ Phone, _____

_____ Relationship, _____ Phone, _____

Please list the family members or other persons, if any, we may inform about your general medical condition and your diagnosis only in an emergency situation.

_____ Relationship, _____ Phone, _____

_____ Relationship, _____ Phone, _____

Please print the telephone number, if any, where you want to receive calls about your appointments, lab. x-ray results, and/or any other health information, if other than your home phone number: _____

Can confidential messages be left on your home answering machine or voicemail?

_____ Yes _____ No

_____ _____ _____

Patient or guardian signature | Birthdate | Date signed

CULLMAN PRIMARY CARE

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protecting your privacy

Protecting your privacy and your medical information is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper or the Internet. At CULLMAN PRIMARY CARE **(hereinafter referred to as "the Practice")**, privacy is one of our highest priorities.

Keeping your information

Keeping the medical and health information we have about you secure is one of our most important responsibilities. We value your trust and will handle your information with care. Our employees access information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims and otherwise meet your needs. We may also access information about you when considering a request from you or when exercising our rights under the law or any agreement with you.

We safeguard information during all business practices according to established security standards and procedures, and we continually assess new technology for protecting information. Our employees are trained to understand and comply with these information principles.

Working to meet your needs through information

In the course of doing business, we collect and use various types of information, like name and address and claims information. We use this information to provide service to you, to process your claims and to bring you health information that might be of interest to you.

Keeping information accurate

Keeping your health information accurate and up-to-date is very important. If you believe the health information we have about you is incomplete, inaccurate or not current, please call or write us at the telephone numbers or addresses listed below. We take appropriate action to correct any erroneous information as quickly as possible through a standard set of practices and procedures.

How - and why - information is shared

We limit who receives information and what type of information is shared.

- *Sharing information within the Practice.* We share information within our company to deliver you the health care services and the related information and education programs specified in your plan.

- *Sharing information with companies that work for us.* To help us offer you our services, we may share information with companies that work for us, such as claim processing and mailing companies and companies that deliver health education and information directly to you. These companies act on our behalf and are obligated contractually to keep the information that we provide them confidential.

- *Other.* Patient-specific personally identifiable data is released only when required to provide a service for you and only to those with a need to know, or with your consent. Data is released with the condition that the person receiving the data will not release it further, unless you give permission.

If we receive a subpoena or similar legal process demanding release of any information about you, we will attempt to notify you (unless we are prohibited from doing so). Except as required by law or as described above, we do not share information with other parties, including government agencies.

The Practice does not share any customer information with third-party marketers who offer their products and services to our patients.

Count on our commitment to your privacy

You can count on us to keep you informed about how we protect your privacy and limit the sharing of information you provide to us – whether it's at our office, over the phone or through the Internet.

CULLMAN PRIMARY CARE

CULLMAN, AL

(256) 734-1012

CULLMAN PRIMARY CARE

Patient Consent Form

I understand that as part of the provision of healthcare services, **CULLMAN PRIMARY CARE, P.C.** creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, and healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organizations is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent in writing, except where disclosures have already made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format are confidential and cannot be Disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy of fax of this consent is valid as this original.
3. I may revoke this consent at any time, except where information has already been released. This consent is valid until revoked by me in writing.
4. I have the right to request that the use of my Protected Health Information which is used or Disclosed for the purposes of treatment, payment or health care operations be restricted. Cullman Primary Care, P.C. is not bound by the restriction unless it is in agreement with the restriction.

_____ _____

(PATIENT'S NAME PRINTED) (DATE)

_____ _____

PATIENT'S SIGNATURE(OR GUARDIAN.IF MINOR) SSN#

_____ _____

WITNESS DATE