Patient Demographic

Are you here because of an injury? ☐ **Yes** ☐ **NO** **Date of Injury** ____/____/____ ☐ **Work** ☐ **Auto** ☐ **Other**

PATIENT INFORMATION

PATIENT NAME (Last, First, Middle Initial)		SOCIAL SECURITY NUMBER		DATE OF BIRTH	SEX ☐ **M** ☐ **F**
MAILING ADDRESS	APT/SUITE#	CITY	STATE	ZIP	
PHYSICAL ADDRESS (IF DIFFERENT)	APT/SUITE#	CITY	STATE	ZIP	
RACE	LANGUAGE	ETHNICITY	MARITAL STATUS		
HOME PHONE	CELL PHONE	EMAIL ADDRESS			
PRIMARY CARE PHYSICIAN	**PHONE NUMBER**	PREFERRED CONTACT NUMBER WHERE WE MAY LEAVE MESSAGES ABOUT YOUR HEALTHCARE? ☐ **Home Phone** ☐ **Work Phone** ☐ **Cell Phone**			
EMPLOYER	WORK PHONE	HOW WOULD YOU LIKE TO BE NOTIFIED OF FUTURE APPOINTMENTS? ☐ **TEXT** ☐ **PHONE CALL** ☐ **BOTH**			
EMPLOYER ADDRESS	SUITE#	CITY	STATE	ZIP	
EMERGENCY CONTACT (first name last name)		PHONE	DATE OF BIRTH	RELATIONSHIP	

INSURANCE INFORMATION

PRIMARY INSURANCE

POLICY HOLDER NAME	RELATIONSHIP TO PATIENT ☐ **Self** ☐ **Spouse** ☐ **Parent**	SOCIAL SECURITY NUMBER	DATE OF BIRTH	EFFECTIVE DATE
INSURANCE CARRIER	POLICY #	GROUP #	EMPLOYER	

SECONDARY INSURANCE

POLICY HOLDER NAME	RELATIONSHIP TO PATIENT ☐ **Self** ☐ **Spouse** ☐ **Parent**	SOCIAL SECURITY NUMBER	DATE OF BIRTH	EFFECTIVE DATE
INSURANCE CARRIER	POLICY #	GROUP #	EMPLOYER	

Medicare Patients only: Are you entitled to Medicare because □**AGE** □ **DISABILITY** □ **ESRD**
Is someone else or another entity responsible for the billing claim from this visit? ☐ YES ☐ NO WHO_____

PARENT/GUARDIAN INFORMATION *(please fill out the section below for any child under the age 18)*

NAME (last, first)	SOCIAL SECURITY NUMBER	DATE OF BIRTH		SEX ☐ **M** ☐ **F**
ADDRESS	CITY	STATE	ZIP	
RELATIONSHIP (check all that apply) ☐ **Mother** ☐ **Father** ☐ **Guardian** ☐ **Other** ☐ **Guarantor** (person financially responsible)	CELL PHONE	HOME PHONE		MARITAL STATUS
NAME (last, first)	SOCIAL SECURITY NUMBER	DATE OF BIRTH		SEX ☐ **M** ☐ **F**
ADDRESS	CITY	STATE	ZIP	
RELATIONSHIP (check all that apply) ☐ **Mother** ☐ **Father** ☐ **Guardian** ☐ **Other** ☐ **Guarantor** (person financially responsible)	CELL PHONE	HOME PHONE		MARITAL STATUS

The information provided above is complete and accurate to the best of my knowledge.

Patient/Guardian Signature_____***Date***_____

Saint Mary's Medical Group

Patient Demographics

PATIENT LABEL

8.22.18 LE

Patient Medical History

Do you have an Advance Directive?
☐ None ☐ Living Will ☐ DNR ☐ POLST ☐ Durable Power of Attorney

Medication/Dose/Frequency	Medication/Dose/Frequency	Pharmacy

Allergies & Reactions (please list any allergies or reactions to medication or food below)

Medication	Type of Reaction	Food	Type of Reaction

Past Medical History (please indicate if you have ever experienced any of the following conditions)

☐ Allergies	☐ Chronic Kidney Disease	☐ Heart Failure	☐ Osteoporosis
☐ Anemia	☐ Chronic Sinusitis	☐ Hepatitis C	☐ Rheumatoid Arthritis
☐ Angina (chest pain)	☐ COPD	☐ High Blood Pressure	☐ Sciatica
☐ Anxiety	☐ Depression	☐ High Cholesterol	☐ Seizures/epilepsy
☐ Arthritis	☐ Diabetes Type I	☐ Irregular heart rhythm	☐ Sleep Apnea
☐ Asthma	☐ Diabetes Type II	☐ Insomnia	☐ Stomach Ulcer
☐ Atrial Fibrillation	☐ Disc Degeneration	☐ Irritable Bowel Syndrome	☐ Stroke (CVA)
☐ Blood Clots	☐ Emphysema	☐ Kidney Stones	☐ Thyroid Disease
☐ Cancer: Type	☐ Esophageal reflux	☐ Liver Disease	☐ Tinnitus (ringing in ear)
☐ Chronic Blood Thinner Use	☐ Gallbladder disease	☐ Low Blood Pressure	☐ Tuberculosis (TB)
☐ Chronic Bronchitis	☐ Heart Attack	☐ Migraines	☐ Heart Murmur
☐ Chronic Hepatitis	☐ Heart Disease	☐ Obesity	☐ Episodes of passing out

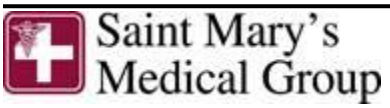
Please list other conditions not mentioned above:

Surgical History (please list any surgeries and date)	**Hospitalization** (please list any major hospitalizations & year)

Family History (please list any family history of medical problems)	

Social History

	Yes	No	Former	Type	Amount Daily	Amount Weekly	Years Used	Date/Year Quit
Tobacco Use								
Alcohol								
Caffeine								



Patient Medical History

PATIENT LABEL

Primary Care Health Maintenance					
	Date of Last	Where		Date of Last	Where
Lipid Panel			Mammogram		
FIT/Hemocult			DEXA Scan		
Colonoscopy			EKG		
Sigmoidscopy			Foot Exam		
Influenza Vaccine			Eye Exam		
Pneumococcal Vaccine			GYN Exam (Pap/Breast)		
Tetanus Vaccine			PSA/Rectal Exam		
Annual Wellness (Medicare)					

Review of Systems (*Place an "X" in the box indicating YES to all that apply)*					
	GENERAL		**GENITOURINARY**		
	Frequent colds/sore throats		Pain with urination		Frequent bleeding
	Hay fever/sinus problems		Difficulty with urination		**ENDOCRINE**
	Trouble swallowing		Blood in urine		Hair loss
	Weight gain/loss		Frequent urination		Hot flashes
	Visual problems		Urinary tract infections		Constant thirst
	Ringing in the ears		Erectile dysfunction		Lethargy
	Fatigue		**DIGESTIVE**		Heat/cold intolerance
	Fevers		Frequent heartburn		Sweating
	Loss of Hearing		Diarrhea		Hair loss
	CARDIOPULMONARY		Constipation		**SLEEP**
	Shortness of breath		Nausea		Difficulty falling asleep
	Difficulty lying flat		Difficulty swallowing		Difficulty staying asleep
	Chest pain		Dark stools		Snoring
	Dizziness		Blood in stool		Abnormal dreams
	Irregular Heartbeat		Frequent vomiting		Stop breathing at night
	Cough at night		Jaundice		Morning headaches
	Palpitations		**MUSCULOSKELTAL**		**NEURO/PSYCHIATRIC**
	Leg swelling		Swollen joints		Anxiety
	Difficulty sleeping		Painful joints		Tremor
	Lightheadedness		Back pain		Abnormal fears
	High blood pressure		Limited motion		Passing out
	Non-healing ulcers		Varicose veins		Forgetfulness
	Wheezing		Leg cramps		Balance problems
	Heart murmur		**BLOOD/COAGULATION**		Seizures
	Leg pain with walking		Frequent bruising		

I understand that it is my responsibility to keep all follow-up appointments, take medications as directed, and complete laboratory tests ordered in a timely fashion as directed by my provider. If I fail to follow these directives as instructed by my provider, I assume responsibility for the adverse repercussions that this may have on my health.

Patient/Guardian Name (please print) _____ **Date** _____ \ _____ \ _____

Patient/Guardian Signature _____ **Date** _____ \ _____ \ _____

Provider Signature _____ **Date** _____ \ _____ \ _____

Patient Medical History

PATIENT LABEL

PATIENT HEALTH QUESTIONNAIRE

Patient Name_____ Patient DOB_____ Today's Date_____

Patients 12 and older:

Tobacco Use:
__Current User Type_____ Date Start_____ Amount per Day_____
__Former User Type_____ Date Start_____ Date Quit_____ Amount per Day_____
__Never Used

Patients ages 50 and older:

Last Mammogram: Approximate Date_____ Where_____
Last Colonoscopy: Approximate Date_____ Where_____
Last Bone Density: Approximate Date_____ Where_____

Have you fallen in the past year? Yes___ No___
If so how many times?_____
Did the fall result in injury? Yes__ No__

Vaccines:

Influenza Vaccine: Approximate Date_____ Where_____
Pneumonia Vaccine (Age 65 & Older): Approximate Date_____ Where_____
Zoster Vaccine (Age 65 & Older): Approximate Date_____ Where_____

All Patients with diabetes:

Last eye exam: Date_____ Where_____
Last foot exam: Date_____ Where_____
Last lab work: Date_____ Where_____

Continued on Back

PATIENT HEALTH QUESTIONNAIRE-9

Over the **last 2 weeks,** how often have you been bothered by the following problems (Check mark to indicate your answer)	Not at all	Several Days	More than half the days	Nearly Every Day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself-or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

*Insurances will be billed for Patient Healthcare Questionnaire-9. Patients may be subject to copay or deductible.

Patient/Guardian Signature_____ Date_____

****Scan to Chart****

Saint Mary's Medical Group

PATIENT HEALTH QUESTIONNAIRE

PATIENT LABEL

PATIENT CONSENT & ACKNOWLEDGEMENT

PATIENT DOCUMENTS RECEIVED:

- Notice of Privacy Practices _____ (initial)
- Patient Financial Policy _____ (initial)
- Patient Portal Access and Use Agreement _____ (initial) **Email Address**: _____

TREATMENT: I consent to and authorize Saint Mary's Medical Group and Saint Mary's Urgent Care Providers to examine and provide treatment.

PALLIATIVE CARE PATIENTS: I consent to and authorize Saint Mary's Medical Group Palliative Care to review my medical records, discuss goals of care, advanced care planning, assist with appropriate referrals/coordination of care and provide recommendations to my attending/referring physician as necessary.

RELEASE OF INFORMATION

- I authorize a copy of my record to be sent to my family provider or provider of referral following my appointment. **Preservation of Records Notice**: The Medical Group is authorized to dispose of patient's medical record after the 10th anniversary of the date the patient was last treated. For minor patients (less than 18 years of age) the medical group is authorized to dispose of patient's medical records after patient's 23rd birthday for those records which have been retained for at least 5 years or for any longer period provided by federal law.
- I authorize Saint Mary's Medical Group and Saint Mary's Urgent Care to speak to the named person (s) listed below regarding my medical condition(s) and care. Please be aware that we will not be able to speak to anyone other than the patient unless named below.

Name _____ Relationship_____ Phone _____

Name _____ Relationship _____Phone _____

PRESCRIPTIONS: I authorize Saint Mary's Medical Group and Saint Mary's Urgent Care and its designees to view my pharmaceutical history from external sources. Our practice uses Surescripts for this purpose.

PALLIATIVE CARE PATIENTS: Saint Mary's Palliative Care physicians do not prescribe medications. Medications may be filled at the discretion of your attending/referring physicians.

EMPLOYEE OR PROVIDER EXPOSURE TO BLOOD AND BODY FLUIDS: Patient understands that in the event an employee or provider is exposed to patient's blood or body fluids, a blood sample for HIV (AIDS), Hepatitis B and Hepatitis C antibodies will be obtained. Patient understands that the patient will be notified of testing. Patient understands that the results are confidential and will not be released to a third party without patient's permission except as permitted or required by law

INTERPRETER INFORMATION: If the patient speaks a language other than English or is communicatively disabled, I have accurately and completely read the forgoing documents to _____ (name of patient/person legally authorized to give consent) in the patient's or patient's representative primary language. He/she understood all the terms and conditions and acknowledged his/her agreement thereto by signing this document in my presence.

_____	_____	_____	_____ AM / PM
(SMMG Representative Name)	(SMMG Representative Signature)	(Cyracom ID #)	(Time)

By signing below, I agree to abide by the terms and conditions outlined above including the patient documents received.

Patient/Representative Name (Please Print) _____ Date _______________

Patient/Representative Signature _____ Date _______________

Saint Mary's Medical Group

Patient Consent & Acknowledgement

PATIENT LABEL

PARENT CONSENT FOR TREATMENT OF MINOR CHILD
PARENT OR LEGAL GUARDIAN NOT PRESENT

In the event that the parent(s) or legal guardian(s) of the patient named below is/are not available at the time of service and at the sole discretion of the Provider of Care and/or Management, this form may be used to document authorization for treatment received by phone if patient is accompanied by an authorized person 18 years or older.

Parent or person having legal custody/legal guardianship authorizes:

_____ _____
(name of person accompanying patient) (*date of birth)*

To consent for treatment for _____ _____
(patient's name) *(patient's Date of Birth)*

We spoke with _____ _____
(parent or legal guardian name) *(date of birth)*

Identification on file _____
(*indicate relationship)*

at (_____) _____ - _____ *(number called)* at _____ am / pm *(circle one)*

We further acknowledge that we obtained verification of the identity of the patient's parent or legal guardian using established standard operating procedure.

Verified all information as above. Verbal consent obtained

Staff Member #1: Print Name_____

Signature_____ Date_____

Staff Member #2: Print Name_____

Signature_____ Date_____