Southern Health Associates

PATIENT INFORMATION

Name _____
FIRST MIDDLE LAST

SSN _____ GENDER MALE FEMALE BIRTHDATE _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

ADDRESS _____
STREET CITY STATE ZIP

MARITAL STATUS MARRIED WIDOWED DIVORCED SEPARATED SINGLE

LOCAL PHARMACY _____ E-MAIL ADDRESS: _____

BILLING INFORMATION/RESPONSIBLE PARTY/GUARANTOR FOR ENCOUNTER

Name _____
FIRST MIDDLE LAST

SSN _____ GENDER MALE FEMALE BIRTHDATE _____

HOME PHONE _____ WORK PHONE _____ EMPLOYER _____

ADDRESS _____
STREET CITY STATE ZIP

INSURANCE COVERAGE INFORMATION/PRIMARY

NAME OF INSURANCE _____ POLICY NO. _____

GROUP NO. _____ NAME OF INSURED _____

BIRTHDATE _____ SSN _____ GENDER M F

ADDRESS _____
STREET CITY STATE ZIP

INSURANCE COVERAGE INFORMATION/SECONDARY

NAME OF INSURANCE _____ POLICY NO. _____

GROUP NO. _____ NAME OF INSURED _____

BIRTHDATE _____ SSN _____ GENDER M F

ADDRESS _____
STREET CITY STATE ZIP

EMERGENCY CONTACT INFORMATION

NAME _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

Southern Health Associates Privacy and Consent Form

I hereby authorize the release of any or all medical information to the following persons. I understand that my signature below will dismiss any "breach of patient confidentiality" issues that would normally apply. I also understand that anyone named below can obtain any and all my medical information at any time, regardless of my knowledge.

_____

_____

_____

_____

I hereby give my consent for Southern Health Associates (SHA) to use and disclose protected health information about me to carry out treatment, payment and health care operations. (The Notice of Privacy Practices provided by SHA describes such uses and disclosures most completely and will be provided by request). I have the right to review the Notice of Privacy Practices prior to signing this consent. SHA reserves the right to revise its notice of privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to *Office Manager, P.O. Box 1185, Troy, AL 36081*. With this consent, SHA may call my home or any other alternative location and leave a message on voicemail or in person in reference to any items including laboratory test results, among others. With this consent, SHA may mail to my home or other alternative location any time that assist the practice in carrying out TPO. I have the right to request SHA restrict how it uses or discloses my Protected Health Information (PHI) to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to allow SHA to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, SHA may decline to provide treatment to me.

I, the undersigned, give prior express consent to Southern Health Associates, its employees and/or agents, to contact me at any/all phone numbers, including cell phone numbers, for the purpose of treatment, insurance, and/or payment.

I hereby authorize the undersigned Physician to Release any information acquired in the course of examination or treatment. I also authorize payment directly to the undersigned physician of the surgical and/or medical benefits. It is understood that monies received from the insurance company over and above my indebtedness will be refunded to me when bill is paid in full. I understand that I am financially responsible for any collection fees, or court costs should my account become delinquent. I understand that any procedure denied by insurance as a "non-covered service" will be billed to the responsible party.

Signature of Patient/ Guardian _____ Date _____

Printed Patient Name _____ Date of Birth _____

Medical History Form _____

PRESENT HEALTH CONCERNS: _____

_____

_____

_____

_____

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs:

Medication	Dose	Times per day	Medication	Dose	Times per day

ALLERGIES:

_____

_____

_____

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems

___ Congenital Heart Disease
___ Myocardial Infarction (Heart Attack) (Date _____)
___ Diabetes
___ High Cholesterol
___ Stroke
___ Thyroid Problem
___ Coagulation Disorder (Bleeding/clotting)
___ Cancer _____ (Type)
___ Depression/suicide Attempt
___ Alcoholism
___ Blood Transfusion
___ Abnormal Pap Smear
___ Neurological Problems _____ (type)

HEALTH MAINTENANCE: Please indicate date of testing

Pap Smear _____ Colonoscopy _____ PSA _____ Mammogram _____ DXA Bone Scan _____

Flu Vaccine _____ Pneumonia Vaccine _____ Tetanus Vaccine _____ Shingles Vaccine _____

SURGICAL HISTORY: Please list all prior operations and dates

Operation	Date	Operation	Date

WOMEN'S GYNECOLOGIC HISTORY:

Pregnancies: ___ # Deliveries: ___ # Abortions: ___ # Miscarriages: ___
1st day of most recent period: _____ Age at 1st period: ___ Frequency of periods: ____
Length of bleeding: ____ Any concerns about your periods? _____

Medical Condition	Mom	Dad	Sist.	Bro.	Daug.	Son	Other
Alcoholism							
Anemia							
Asthma							
Birth Defects							
Bleeding Problem							
Breast Cancer							
Colon Cancer							
Melanoma							
Ovarian Cancer							
Prostate Cancer							
Cancer, other							
Depression							
Diabetes, Type 1 (childhood)							
Diabetes, Type 2 (adult)							
Eczema							
Epilepsy (Seizures)							
Genetic Diseases							
Glaucoma							
Heart Attack							
High Blood Pressure							
High Cholesterol							
Kidney Disease							
Lupus							
Migraine Headache							
Mitral Valve Prolapse							
Osteoarthritis							
Osteoporosis							
Rheumatoid Arthritis							
Stroke							
Thyroid Disorders							
Tuberculosis							
Other:							

SOCIAL HISTORY:

Tobacco Use:

Cigarettes
- ____ Current Smoker
- ____ Formed Smoker
  - Quit Date: ____
- ____ Never Smoked
- ____ Pipe Use
- ____ Cigar Use
- ____ Snuff Use
- ____ Chewing Tobacco

Are you interested in quitting? _____

Alcohol Use:
- ____ No alcohol intake
- ____ # Drinks per week
- ____ Alcohol is a concern for others

Drug Use:
- ____ Recreational drug use
- ____ I have used needles

Do you exercise regularly? _____

Occupation: _____ Education Completed: _____

Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed ___ Cohabitating

Spouse/Partner's Name: _____ Number of children: _____

Are you sexually active?_____ Current sex partners: ____Male ____ Female

Birth control method: _____ Have you been tested for STD's?_____

Are you interested in being screened for STD's?_____

Emotions:

1. In the past year, have you had 2 weeks or more during which you felt sad, blue or depressed; or when you lost all interested or pleasure in things that you usually cared about or enjoyed?_____
2. Have you had 2 years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes? _____
3. Have you felt depressed or sad much of the time in the past year? _____

REVIEW OF SYSTEMS: Please check any current problems you have on the list below

General:
- ___ FeverChills/Sweats
- ___ Unexplained wt change
- ___ Fatigue/Weakness
- ___ Excessive thirst/urination

ENT:
- ___ Change in Vision
- ___ Difficult Hearing/ringing
- ___ Problems with teeth/gum
- ___ Muscle/joint pain

Chest:
- ___ Chest pain/discomfort
- ___ Leg pain w/exercise
- ___ Palpitations

Respiratory:
- ___ Breast lump/discharge
- ___ Cough/wheeze
- ___ Difficulty Breathing

Gastrointestinal
- ___ Blood in stool
- ___ Nausea/vomiting/diarrhea
- ___ Nighttime urination
- ___ Abdominal Pain

Genitourinary:
- ___ Leaking Urine
- ___Unusual Vaginal Bleeding
- ___ Discharge: Penis or vagina
- ___ Sexual function problem

Dermatology:
- ___Rash or change in mole
- ___ Headaches
- ___ Dizziness/light-headed
- ___ Memory Loss

Neuro:
- ___ Loss of coordination
- ___ Anxiety/stress
- ___ Numbness

Psych:
- ___ Problems with sleep
- ___ Depression
- ___ Unexplained Lumps
- ___ Easy bruising/bleeding

Other: _____