Name: _____ DOB: ____ / ____ / _____

Nursing: _____

Personal Information

First: _____ Middle: _____

Last: _____ Preferred Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____-_____-_____

Cell Phone: ____-____-_____ Email: _____

SS#:____-___-____ DOB: _____

Emergency Contact

Name: _____ Phone Number: _____-_____-_____

Relationship to patient: _____

Insurance Information

Primary Insurance: _____

Member ID: _____ Group #: _____

Insured's Name: _____ DOB: _____ / _____ / _____

Secondary Insurance (if applicable): _____

Member ID: _____ Group #: _____

Insured's Name: _____ DOB: _____ / _____ / _____

Tertiary Insurance (if applicable): _____

Member ID: _____ Group #: _____

Insured's Name: _____ DOB: _____ /_____ /_____

Name: _____ DOB: ____ / ____ / _____

Reason for visit: _____

Prescriptions

_____

Drug Name	Dose	Times/Day

Non-Prescriptions

(Vitamins, Home Remedies, and Herbal Supplements)

Drug Name	Dose	Times/Day

Allergies

Medication, Food, or Agent	Reaction

Surgical History: Please list all prior operations and dates.

- _____ Date: ____ / ____ / _____
- _____ Date: ____ / ____ / _____
- _____ Date: ____ / ____ / _____
- _____ Date: ____ / ____ / _____

Personal and Family Medical History

EVERYONE	DATE	MEN ONLY	DATE
Last colonoscopy?		For those who are 65-75 and have smoked more than 100 cigarettes in a lifetime → Have you been screened for abdominal aortic aneurysm?	
Last tetanus vaccine?			
Last pneumovax? (Vaccine to prevent pneum		**WOMEN ONLY**	
Last flu vaccine?		Number of pregnancies?	
Meningococcal vaccine?		Last mammogram?	
HPV vaccine? (Gardasil)		Last pap smear?	
Use recreational drugs?	Yes or No	Last osteoporosis screening? (Bone Density)	
Have you ever used needles?	Yes or No	Hysterectomy? (Partial or Total)	
Do you exercise regularly?	Yes or No		
If yes, how many times per week?		**PATIENTS WITH DIABETES**	
		Last time eyes were checked?	

Name: _____ DOB: ____ / ____ / _____

Tobacco Usage

Type	Usage Status	Daily Usage	# Of Years
Cigarettes	Current ____ Former ____ Never ____	_____ # Of cigarettes per day or week.	
Cigars	Current ____ Former ____ Never ____	_____ # Of cigars per day or week.	
Pipe	Current ____ Former ____ Never ____	____ # Of pipes per day or week.	
Chewing Tobacco	Current ____ Former ____ Never ____	_____ # Of chewing tobacco per day or week.	
Dipping Tobacco	Current ____ Former ____ Never ____	_____ # Of dipping tobacco per day or week.	

- Are you interesting in quitting? **Yes** _____ **No** _____
- Have you attempted to quit in the past? **Yes** _____ **No** _____
- Were you successful? **Yes** _____ **No** _____ If **yes**, what was the date? **_____ / _____ / _____**

Alcohol Usage

Type	Number Of Drinks
Beer	_____ per day or week.
Wine	_____ per day or week
Hard Liquor	_____ per day or week

- Is alcohol a concern for yourself or others? **Yes** _____ **No** _____

Personal and Family Medical History

Disease	Self	Mother	Father	Sister	Brother	Daughter	Son	Other
High Blood Pressure								
Heart Attack (Age)								
High Cholesterol								
Diabetes								
Stroke								
Cancer (Type)								
Thyroid Disorders								
Asthma								
Depression								
Anxiety								
Substance Abuse								
Heart Failure								
COPD								
Colon polyps								
Osteoporosis								
Stomach Ulcers								
Headaches								
Arthritis								

Name: _____ DOB: ____ / ____ / _____

Medical Information Release Form- HIPAA

Patient Name: _____ **DOB:** _____

Release of Information

I authorize the release of information including results of labs/radiology, records of examination rendered to me, and financial and insurance information to:

☐ **Spouse:** _____ ☐ **Child(ren):** _____

Phone Number: _____ **Phone Number:** _____

☐ **Parent:** _____ ☐ **Other:** _____

Phone Number: _____ **Phone Number:** _____

☐ **Email:** _____ ☐ **Information is not to be released to anyone.**

Messages

Please call (can leave multiple numbers):

☐ Cell Phone: _____ ☐ Home Phone: _____ ☐ Work Phone: _____

- The best time of day to reach me is (hours): _____.

If unable to reach me:

☐ You may leave a detailed voicemail.
☐ Leave a message asking me to return your call.
☐ Email
☐ Do not leave a voicemail.

- I understand that the information in my medical record may include information relating to treatment for drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), and AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).
- I understand that I may revoke this authorization at any time by notifying Vista Health and Wellness in writing, but if I do it won't have any effect on any actions Vista Health and Wellness took before it received the revocation.
- Vista Health and Wellness, its employees, and providers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that by signing below, I am agreeing to, and certifying my understanding of all statements above.
- I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ _____

Patient or Legal Representative Signature **Date**

_____ _____

Print Patient's Name **Relationship (if signed by person other than patien**