

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

<u>EVERYONE</u>	<u>DATE</u>	<u>MEN ONLY</u>	<u>DATE</u>
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 pneumo)		<u>WOMEN ONLY</u>	
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?		<u>PATIENTS WITH DIABETES</u>	
		Last time eyes were checked?	

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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								

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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 patient)