# PATIENT INFORMATION FORM

## PLEASE PRINT

**Patient Name** _____ _____ **Date of Birth**_____/_____/_____
Last First MI

**Street Address** _____ **City**_____ **State**_____ **Zip**_____

**Home#** (  ) _____-_____ **Work#** (  ) _____-_____ **Cell#** (  ) _____-_____

**Sex:** M_____ F_____ **Marital Status:** S____ M____ D____ W____ Sep____ **SS#:** _____

**Occupation**_____ **Employer:** _____ **Primary Physician:**_____

**IF PATIENT IS A MINOR**

**Guarantor's name:** _____ **Relationship to patient:**_____

**Address:** _____ **Date of Birth:** _____

**SS#:** _____ **Employer:** _____

**PRIMARY INSURANCE** _____

**Employer**_____ **Employer's Phone#**_____

**Name Guarantor**_____ **Relationship to patient**_____

**Guarantor's SS#**_____ **Guarantor's Date of Birth**_____

**SECONDARY INSURANCE** _____

**Employer**_____ **Employer's Phone#**_____

**Name Guarantor**_____ **Relationship to patient**_____

**Guarantor's SS#**_____ **Guarantor's Date of Birth**_____

**HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY BEEN TREATED BY DR. LOWERY BEOFRE? YES or NO**

**If yes, Name** _____

**FAMILY PHYSICIAN**_____ **REFERRING PHYSICIAN**_____

**EMERGENCY CONTACT PERSON**_____ **PHONE#**_____

Payment is expected at the time the services are provided. All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, you, not the insurance company, are responsible for the payment of your bill. There will be a $20.00 fee assessed to your account in the event of a returned check.

**24 hour advanced notice is required if you are not going to be able to keep you appointment. A fee will be charged if you fail to do so.**

Insurance authorization and assignment: I request that payment of authorized medicare/other insurance company benefits be made on my behalf to Lisa Lowery, M.D. for all services furnished to me. I authorize any holder of medical information needed about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown.

Signature_____ Date_____

# MEDICAL HISTORY FORM

Name_____Date of Birth_____Age_____

Height:_____

Weight:_____

Have you seen Dr. Lowery before? Yes/No

Are you currently working? Yes/No
If no, when was the last day that you worked?_____

Is your current problem the result of: (circle all that apply)
Auto accident Work-related injury Accident Other_____

What is the reason for this visit?
Major complaint:_____
_____

Please describe your symptoms:_____
_____
_____

How and when did your symptoms begin?_____
_____

What makes it worse?_____

What gives you relief?_____

Associated symptoms: (circle all that apply) pain, weakness, numbness, ache, stiffness, swelling, popping, clicking, instability, bowel or bladder problems, headaches, limping, falling, stumbling, trouble with stairs, pain with reaching

Sports: Occasional_____ Regular_____ Recreational_____ Competitive_____

Which sports do you participate in? _____

Today's Date_____

Please list any past treatments you have received for your current problem (including any medications, injections, physical therapy, chiropractic care, surgery, etc.):

_____

_____

_____

Pharmacy names and phone number:_____

Please provide a list of your current medications and vitamins / herbal supplements:

| Name | Dose | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Do you currently take aspirin or products containing aspirin? Yes/No
If yes, what is the name of the medication?_____

Are you taking any blood thinning medications, such as Coumadin, Plavix, or Lovenox? Yes/No
If yes, what is the name of the medication?_____

Do you have any allergies to medication or food? Yes/No
If yes, please list:_____

Are you allergic to latex? Yes/No

Are you allergic to IV contrast? Yes/No

Which hand do you write with? (Please check one): Right____ Left____ Ambidextrous (both)____

Do you have any metal in your body? Yes/No

Are you claustrophobic? Yes/No Can you have a closed MRI scan? Yes/No

Have you ever had any of the following procedures?: (if yes, provide date)

CT Scan: Head_____ Neck_____ Back_____ Shoulder_____ Knee_____ Hip_____
MRI: Head_____ Neck_____ Back_____ Shoulder_____ Knee_____ Hip_____
Meylogram: Neck_____ Back_____
Plain X-rays: Neck_____ Back_____ Shoulder_____ Knee_____ Hip_____
EMG_____ Nerve conduction study_____ Stress test_____ Angiogram_____ Angioplasty_____
Open Heart surgery_____ Carotid / Coronary artery stenting_____ Catheterization_____

Today's Date_____

**Social History:**

**What is your current occupation?:**_____

**What is your marital status? (circle one):** **Single / Married / Separated / Divorced / Widowed**

**Do you have any children? Yes/No** **If yes, how many?:**_____

**Do you live alone? Yes/No** **If no, who lives with you?:**_____

**Choose the statement that applies to you about <u>tobacco use</u>:**
**___Yes, I've smoked_____packs of cigarettes per day for _____years.**
**___Yes, I smoke cigars or a pipe.**
**___No, I have never smoked.**
**___No, I quit_____years ago, but at the time I was smoking____packs per day for ____years.**

**Choose the statement that applies to you about <u>alcohol use</u> and circle the appropriate response:**
**___Yes, I drink: Daily / One or more times per week / One or more times per month / Rarely**
**___No, I do not drink.**
**___I have a history of alcohol and/or drug abuse.**

**Do you drink caffeinated beverages? Yes/No** **If yes, how many cups per day?:**_____

**Do you use any illicit drugs: Yes/No** **If yes, what substance?:**_____

**Are you at risk for AIDS/HIV? Yes/No**
**If yes, please explain:**_____

**<u>What physician referred you here?</u>**
**Doctor's Name:** _____
**Address:** _____
**Phone Number:** _____

**<u>Who is you primary care physician?</u>**
**Doctor's Name:** _____
**Address:** _____
**Phone Number:** _____

**What other doctor's do you see? (i.e.: Cardiologist, endocrinologist)**
_____
_____

**Is there any special information the doctor should know about you that has not already been addressed?**
**(i.e. do you have a pacemaker, rare blood disorder, are you a Jehovah's Witness, etc) Yes/No**
**If yes, please explain:**_____
_____

**The information provided above is accurate to the best of my knowledge.**
**Patient signature**_____**Date:**_____

**REVIEW OF SYSTEMS: Are you currently, or have you in the past 3 years, had problems with any of the following:**

**Constitutional**
- Fever Yes No
- Weight loss Yes No
- Excessive fatigue Yes No
- Night sweats Yes No

**HEENT**
- Eye injuries Yes No
- Wear glasses Yes No
  - If yes, date of last exam_____
- Double or blurred vision Yes No
- Wear a hearing aid Yes No
  - If yes, date of last exam_____
- Hearing loss Yes No
- Balance disturbance (vertigo/spinning) Yes No
- Inability to smell Yes No

**Cardiovascular**
- Chest pain or angina Yes No
  - If yes, date of last EKG_____
- High blood pressure Yes No
- Irregular pulse Yes No
- Heart murmur Yes No
- Congestive heart failure Yes No
- High cholesterol Yes No
- Swelling in feet or hands Yes No
- Leg pain while walking Yes No

**Respiratory**
- Asthma Yes No
- Chronic cough Yes No
- Emphysema Yes No
- Shortness of breath Yes No
- Tuberculosis Yes No
- Bloody sputum Yes No
  - If yes, date of last chest x-ray _____

**Gastrointestinal**
- Loss of appetite Yes No
- Frequent nausea/vomiting Yes No
- Vomiting blood Yes No
- Liver disease Yes No
- Abdominal pain Yes No
- Jaundice (yellow skin) Yes No
- Change in bowel habits Yes No

**Genitourinary**
- Blood in urine Yes No
- Incontinence Yes No
- Painful urination Yes No

**Musculoskeletal**
- Back pain Yes No
- Arm or leg pain Yes No
- Arm or leg weakness Yes No
- Joint pain or swelling Yes No
- Arthritis Yes No
- Osteoporosis Yes No

**Integumentary**
- Skin disease Yes No
- Recurrent skin infections Yes No

**Neurological**
- Syncope (fainting) Yes No
- Seizures Yes No
- Memory impairment Yes No
- Disorientation Yes No
- Difficulty with speech Yes No
- Inability to concentrate Yes No
- Facial weakness Yes No
- Lack of coordination Yes No
- Frequent headaches Yes No

**Psychiatric**
- Anxiety Yes No
- Depression Yes No
- Personality change Yes No

**Endocrine**
- Diabetes Yes No
- Thyroid disease Yes No
- Increased appetite Yes No
- Excessive thirst or urination Yes No
- Nipple discharge Yes No

**Hematologic/Lymphatic**
- Anemia Yes No
- Hemophilia Yes No
- Bleeding tendency Yes No
- Abnormal bruising Yes No
- Persistent swollen glands/lymph nodes Yes No

**Immunologic**
- Immunologic disorder Yes No

**If you answer yes to any of the above, please explain:**

_____

_____

_____

• Are you currently being treated for any medical conditions (i.e.: diabetes, hypertension)? Yes / No
If yes, please explain: _____

• Have you ever been diagnosed with any type of cancer? Yes / No
If yes, please list the type and approximate date of diagnosis: _____

• Do you have sleep apnea? Yes / No
If yes, do you use a CPAP machine? Yes / No

• Please list any previous surgeries or hospitalizations:

| Surgery / Hospitalization | Approximate Date | Treating Doctor |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

• Have you ever had any surgical complications? Yes / No
If yes, please describe: _____

• Have you ever had an adverse reaction to general anesthesia? Yes / No
If yes, please describe: _____

• Have any immediate family members ever had an adverse reaction to general anesthesia? Yes / No
If yes, please describe: _____

• Have you ever had a blood transfusion? Yes / No If yes, list approximate date: _____

• Is there any reason you could not receive blood if needed during surgery? Yes / No
If yes, please explain: _____

• If female, are you currently pregnant? Yes / No

• Family History: Please provide information about your immediate family:

| | Alive or Deceased | Age | Health Status or Cause of Death |
|---|---|---|---|
| Mother | | | |
| Father | | | |
| Sister / Brother | | | |
| Sister / Brother | | | |
| Sister / Brother | | | |
| Sister / Brother | | | |

# CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Lisa Lowery, M.D., Inc. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Lisa Lowery, M.D., Inc. I understand that diagnosis or treatment of me by Dr. Lisa Lowery may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Lisa Lowery, M.D., Inc. is not required to agree to the restrictions that I may request. However, if Lisa Lowery, M.D., Inc. agrees to a restriction that I request, the restriction is binding on Lisa Lowery, M.D., Inc. and Lisa Lowery, M.D.

I have the right to revoke this consent, in writing, at any time, except to the extent that Lisa Lowery, M.D. or Lisa Lowery, M.D., Inc. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information my identify me.

I understand I have a right to review Lisa Lowery, M.D., Inc.'s Notice of Privacy Practices prior to signing this document. Lisa Lowery, M.D., Inc.'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Lisa Lowery, M.D., Inc. The Notice of Privacy Practices for Lisa Lowery, M.D., Inc. is also provided in the waiting room of the office. This Notice of Privacy Practices also describes my rights and Lisa Lowery, M.D., Inc.'s duties with respect to my protected health information.

Lisa Lowery, M.D., Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____

Signature of Patient or Personal Representative

_____

**Print Name of Patient**

_____

Date

_____

Description of Personal Representative's Authority