# PATIENT DEMOGRAPHIC INFORMATION

DATE: ______________

Patient's Legal Name____________________________________________________________________________
Last First MI

Address____________________________________________________________________________
Street City State Zip

SS# ____________________________ Birth Date____________________ Age __________ Sex ________________

Home Phone # _______________________________ Cell Phone # ________________________________________

Email Address: ____________________________________________________________________
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IF THE PATIENT IS A MINOR OR STILL COVERED BY PARENT/SPOUSE(S) INSURANCE, PLEASE FILL OUT INFORMATION BELOW

Father's/Mothers Name ________________________Birth Date________________ SS#__________________

Father's/Mothers Address: ______________________________________________________________

Emergency Contact Name: ______________________________Phone: _________________________________
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## Please initial the following:

______I authorize MedStop One to use my email address to set up a portal for routine communications regarding my appointments, health advisories, lab results, and other administrative communications.

______The undersigned patient and/or responsible party hereby consent to and authorize MedStop One, its providers and medical personnel to administer and perform medical examinations, investigations, medical treatments, out-patient procedures, vaccinations and immunizations during the course of the patient's care, as an outpatient, as it is deemed advisable or necessary by the providers.

______The undersigned also consent to the use of medical information for research purposes, for insurance coverage and for authorization of insurance payments to MedStop One.

______The undersigned patient and/or responsible party, by signing this contract, also acknowledge that he/she is financially responsible for any amount not covered by his/her insurance.

______The undersigned also consent to MedStop One contacting them by telephone or patient portal if needed regarding appointments and follow-ups needs.

______Administrative services for the completion of forms/letter/releases and other administrative requirements beyond a normal office visit (i.e. insurance forms, FMLA paperwork, disability determination, release from jury duty, etc.); will incur a $25.00 administrative fee, payable upon completion and before pick-up or release of such documents.

______MedStop One reserves the right to charge a $25.00 "No Show" fee for any appointment which is not canceled 24 hours prior to the scheduled time. Multiple "No Shows" will constitute dismissal from the practice.

______________________________ ________________________________ ____________
Print Name Signature Date

MEDSTOP ONE PATIENT MEDICAL HISTORY FORM- Please complete this in its entirety.

**NAME:** ____________________________________________

Reason for today's visit: ___________________________________________________________________

Family Physician: ________________________________________________________________________

Other physicians/Specialists you are seeing: ___________________________________________________

Medications: (list all medications take, their dosages and how many times per day you take them:

MED: __________________________________DOSAGE_________________ TIMES A DAY______________

MED: __________________________________DOSAGE_________________ TIMES A DAY______________

MED: __________________________________DOSAGE_________________ TIMES A DAY______________

MED: __________________________________DOSAGE_________________ TIMES A DAY______________

MED: __________________________________DOSAGE_________________ TIMES A DAY______________

DRUG ALLERGIES: □ no □ yes if yes, please list; ______________________________________________

**Medical History**: Have you ever had any of the following conditions? IF YES, PLEASE CIRCLE & EXPLAIN

| | | |
|---|---|---|
| Bleeding Problems: | □ none | excess bleeding – blood clots - anemia - transfusions |
| Cancer: | □ none | ______________________________________________ |
| Endocrine: | □ none | diabetes – thyroid – other __________________________ |
| Digestive: | □ none | reflux – ulcers- gallstones- liver disease – pancreatitis – Crohn's disease – diverticulitis – colon polyps - IBS |
| Heart Disease: | □ none | chest pain – A. Fib or other arrhythmias – heart attack – heart disease – heart failure – high cholesterol – high blood pressure – peripheral vascular disease |
| Infectious Disease: | □ none | HIV – TB – STD – Hepatitis A, B, or C |
| Respiratory: | □ none | asthma – cystic fibrosis – emphysema – COPD |
| Neurologic: | □ none | dementia– depression– anxiety- seizures– stroke– migraines– multiple sclerosis |
| Skin: | □ none | acne – eczema – psoriasis – skin cancer |
| Urinary: | □ none | frequent UTI's– prostate problems- kidney stone– kidney disease – incontinence |
| Musculoskeletal | □ none | osteoporosis – arthritis - neck pain – back pain – other joint pain |
| HEENT | □ none | glaucoma – macular degeneration – seasonal allergies – frequent sinus infections – hearing loss |

**Surgical History**

| Surgery | Date | Physician |
|---|---|---|
| | | |
| | | |

**Social History**

Living status: □ alone □ with spouse □ with parents □ assisted living □ nursing home

Smoking: □ current every day smoker □ current some day smoker □ former □ never

Alcohol:□ no □ yes If yes, please circle one: frequent occasional social

Recreational Drugs: □ no □ yes ________________________________________________

Occupation: ___________________________________________________________________

Education: □ high school graduate □ college degree □ other

Sexuality: □ heterosexual □ homosexual □ bisexual □ transsexual

**Family History**: Please list any major medical problems (diabetes, high blood pressure, cancer, thyroid, heart disease) with parents, grandparents, children and/or siblings: ____Unknown ____Adopted

_____________________________________________________________________________________

Please provide dates and where if you have had any preventative tests performed.

Colonoscopy ________________________Bone Density ________________Pneumonia Vaccine________________

Shingle Vaccine _______________Tetanus Vaccine __________________

**Males only** PSA _______________________

**Females only** Pap Smear _____________________Mammogram ______________________________

**Carlos A. Rivas, MD * Lisa Kail, FNP-BC* Crystal Thomas, FNP-BC**

## AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

All portions of this form must be completed to constitute a valid authorization for release of health information.

Patient's Name: ___________________________________ Date of Birth:______________ Telephone:______________________

Address: ____________________________________________________________________________________________

I request and authorize ***MedStop One*** to: (please check one)***(Please list any other facilities we could obtain records from)***

[] release information to [] obtain information from [] exchange information with

Name:_______________________________________________________________________________

Address:_____________________________________________________________________________

Phone:_________________________Fax:___________________Email:_______________________________

This request and authorization applies to:

[] Healthcare information relating to the following treatment, condition or date: _______________________________________

[] All Healthcare information

Purpose of Disclosure: _____________________________________________________________________________________

I understand that the above-mentioned named receiving agency/person/facility has a right to inspect and copy the information disclosed. I further understand that if the receiving agency/person/facility is not covered by Health Insurance Portability and Accountability Act (HIPPA) privacy regulations, the information described above may be re-disclosed and may no longer be protected by HIPPA regulations. I understand I may revoke the release of information at any time, in writing, except where the facility has already made disclosures in reliance upon my prior authorization. I understand the no revocation of this consent shall be effective to prevent disclosure of records and communications until it is received by Rural Health, Inc. It is my understanding that the records and communication to be disclosed may contain information about diagnoses/evaluation/rehabilitation/treatment/recommendation for mental health, developmental disabilities, and/or substance abuse/use and that my signature indicates my informed consent.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if HIPPA prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

Definition: Sexually transmitted disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma, venereuem, HIV (Human Immunodeficiency Virus), AIDS (acquired Immunodeficiency Syndromes), and gonorrhea.

*[ ] Yes [ ] No* *I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above.*
*[ ]Yes [ ] No* *I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.*

Patient's (or Guardian's) Signature: ______________________________________________ Date: _______________

Relationship to Patient/Authority to Act on Patient's Behalf_____________________________________________

Witness Signature: _______________________________________________________ Date: _______________

*THIS AUTHORIZATION EXPIRES 180 DAYS AFTER IT IS SIGNED UNLESS REVOKED EARLIER*

*NOTICE TO WHOMEVER DISCLOSURE IS MADE: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY STATE AND FEDERAL LAW. THESE LAWS PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS. A GENERAL AUTHROIZATION FO RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE.*

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