Capital Medical Group

PATIENT MEDICAL HISTORY

today's date: _____

Patient Name: _____ DOB _____

SOCIAL HISTORY

Birthplace		Education		Retired	☐
Occupation		Employer		Disabled	☐

Marital Status ☐ Previously Widowed NO YES ☐ Previous Divorce NO ☐ YES ☐ # times ☐

Children NO ☐ YES ☐ Sons ☐ Daughters ☐

TOBACCO YES ☐ NO ☐ Former ○		ALCOHOL YES ☐ NO ☐ Former ○		CAFFEINE YES ☐ NO ☐	
Type		Frequency		Amount Daily	
packs/day	yrs smoked	Last Drink		Changes in Sleep Pattern? YES ☐ NO ☐	
Yr quit		Yr quit		Details:	

HOME/SAFETY	Smoke Detectors in Home?	Yes / No	Fire Arms at Home?	Yes / No	Home Heating Type:
	Carbon Monoxide Detectors?	Yes / No	Seat Belt Use	Yes / No	

Recent Travel		Advanced Directive in Place?			
out of state		None	☐	Living Will	☐
out of country		DNR	☐	Durable Power of Attorney	☐
COMMENTS:				Health Care Proxy?	☐

Past Medical: Please list past surgeries with date performed	List Current Medications:

FAMILY HISTORY

	Age	deceased ?	age at death		Age	deceased ?	age at death
Mother				Father			

Diagnosis: mark an "X" if you have the following — mark if Yes for your family member

	YES	NO	mother	father	brother	sister	other
ALZHEIMERS							
ASTHMA							
ALCOHOLISM							
BLOOD DISEASE							
CORONARY ARTERY DISEASE							
CANCER TYPE:							
DEPRESSION							
DEVELOPMENTAL DELAY							
DIABETES							
HEARING DEFICIENCY							
HIGH CHOLESTEROL							
HIGH BLOOD PRESSURE							
MENTAL ILLNESS							
TYPE:							
OBESITY							
POOR CIRCULATION							
KIDNEY FAILURE							
SEIZURE DISORDER							
SICKLE CELL DISEASE							
OTHER							

HEALTH MAINTENANCE UPDATE

Capital Medical Group

Please provide information regarding the preventive services you may have had below

Your Age _____ **today's date** _____

Have you had the following services? **If you do not remember the exact date, please put the year if possible.**

		Last	Date of Service performed	notes	or	date scheduled?	N/A	guidelines
1	PHYSICAL EXAM		/ /			/ /		annually
2	GYN / Pap exam		/ /			/ /		starting at age 18
3	Lipid Panel/ Cholesterol Bloodwork		/ /			/ /		every 5 years starting at age 45
4	Colonoscopy		/ /			/ /		physician preference
5	Sigmoidoscopy		/ /			/ /		every 5 years starting at age 50
6	Fecal Occult Blood Test/ Prostate Cancer Screening		/ /			/ /		annually starting at age 40
7	Mammogram		/ /			/ /		annually starting at age 40
8	Breast Exam by Health Care Provider		/ /			/ /		annually starting at age 18
9	Flu Shot		/ /			/ /		annually
10	Pneumococcal shot		/ /			/ /		once per lifetime starting at age 65
11	Tetnus Shot		/ /			/ /		every 10 years starting at age 19
12	DEXA Scan / Bone Density Test		/ /			/ /		Every 2 years after 60 for screening. Every year if treating bone loss
comments								

AUTHORIZATION/RESTRICTION AGREEMENT
RELEASE OF PATIENT INFORMATION CONSENT FORM

PATIENT NAME:_____ DOB:_____

Release information to:_____

_____

Reason for Release: _____

The information authorized to be released pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal law. Capital Family Physicians may not condition treatment, payment or eligibility for benefits on whether the patient signs this authorization.

Please Initial:

_____ I hereby authorize Capital Medical Group, to provide the above-named individual or company with the medical data and information they may request, as listed below, concerning my illness or injury.

_____ I hereby authorize Capital Medical Group to provide the above-named individual or company with specific elements of my medical data and information as designated below, concerning my illness or injury.

_____ I hereby refuse Capital Medical Group to provide the above-named individual or company with the medical data and information concerning my illness or injury.

MEDICAL DATA / INFORMATION

_____ Name, Address, Phone Number

_____ Social Security Number

_____ Date of Office Visit

_____ Diagnosis

_____ Findings of Examination

_____ Laboratory Data

_____ Reports of Diagnostic Tests

_____ Reports of Surgical procedures

_____ Listing of Medications

_____ Listing of Treatments

_____ Information from Physician Consults

_____ Billing Information

_____ Verification of Scheduled Appointments

_____ Ancillary personnel notes (check all those that apply)
_____ Nursing _____ Social Services _____ Pharmacy _____ Dietary
_____ Psychiatric Services

Signature of Patient or Guardian: _____ Date: _____

Signature of Witness: _____ Date: _____

(Original to be placed in patient's medical record)

ADULT PATIENTS

PATIENT INFORMATION UPDATE

DATE: _____
(PLEASE PRINT)

PATIENT LEGAL NAME OR AS LISTED ON INSURANCE CARD:_____

DATE OF BIRTH: _____ SSN: _____

ADDRESS: _____APT #: _____

CITY: _____ STATE: _____ZIP:_____

HOME PHONE: ( ) _____ CELL: ( ) _____

WORK PHONE: ( ) _____ EMAIL Address: _____

MARITAL STATUS: S M W D (PLEASE CIRCLE) NAMES OF SPOUSE: _____

PHARMACY _____

Employer _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

NAME OF POLICYHOLDER: _____ DOB:_____

POLICY#: _____GROUP#: _____

EMPLOYER: _____

SECONDARY INSURANCE COMPANY: _____

NAME OF POLICYHOLDER: _____ DOB:_____

POLICY#: _____GROUP#: _____

EMPLOYER: _____

(**MUST BE COMPLETED**)
EMERGENCY CONTACT: _____

PHONE #:_____ CELL PHONE#: _____

RELATIONSHIP TO YOU: SPOUSE PARENT CHILD OTHER:_____

DO YOU HAVE A LIVING WILL? YES_____ NO_____

I GIVE PERMISSION FOR _____ TO RECEIVE ANY/ALL INFORMATION RELATED TO MY MEDICAL AND BILLING RECORDS.

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Capital Medical Group's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

CONSENT TO TREAT / FINANCIAL AGREEMENT

By my signature, I consent for treatment at Capital Family Physicians. I understand that insurance co-pays are due at time of service. (Non-payment of co-pays are considered a breach of contract between you and your insurance company). I understand that I am responsible for any remaining charges not covered by my insurance company. I understand that if I am uninsured, payment is due at time of service.

GUARANTOR SIGNATURE:_____DATE:_____

Capital Medical Group

Authorization Form

Capital Family Physicians, P.S.C. is requesting _____ (patient)

To authorize the use and disclosure of confidential healthcare information to _____ for the following purposes:

List and describe the purposes: _____

List the information that is to be used: _____

_____

_____

CONDITIONS:

- The patient agrees to authorize the above named individuals/organization to access his/her confidential healthcare information only for the purpose listed above.
- The information authorized to be released pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by federal law.
- The practice will provide the patient with a copy of the confidential healthcare information for which this authorization is being sought.
- The patient is voluntarily signing this authorization.
- The patient reserves the right to refuse to sign this authorization. Capital Family Physicians may not condition treatment, payment, or eligibility for benefits on whether the patient signs this authorization.
- The patient reserves the right to revoke this authorization at any time. This revocation must be in writing.
- The patient will receive a copy of the signed authorization.
- The authorization will be maintained by Capital Family Physicians, P.S.C. for a period of six (6) years.
- This authorization is in effect from _____ to _____ (length of time). Upon the conclusion of that time period, this authorization is automatically revoked and no further use of the patient's confidential healthcare information is permitted beyond that date.

Signatures:

Patient/Legal Representative: _____ Date: _____

Medical Records Representative: _____ Date: _____