



NEW PATIENT
Forms

The Villages Health®
www.TheVillagesHealth.com

Please do not complete these forms before scheduling an appointment.


If you would like to schedule an appointment, please call:

(844)TVH-WELL (844) 884-9355

Once this form has been completed, please return to _____ on or before _____.

*Please bring a photo I.D., insurance card and all prescription medications
in the original containers to your appointment.*

TABLE OF
contents

	Notice of Privacy Practices.....	2
	Patient Financial Responsibility.....	5
	Universal Patient Authorization Form	7
	Consent to Medical Treatment	9
	Acknowledgement of Receipt of Privacy Practices.....	10
	Patient Demographic Information.....	11
	Insurance Information.....	12
	Prescription History and Medication Information.....	13
	Family History	14
	Social History.....	15
	Surgical History Implant History OB/GYN History	16
	Past Medical History	17



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At The Villages Health, we are committed to handling and using your protected health information with care. This Notice of Privacy Practices (“Notice”) describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information (“PHI”). This Notice is effective August 2019.

Understanding Your Health Record/Information

A record of your visit is made each time you visit The Villages Health. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of this state and the nation
- A source of data for our planning and marketing
- A tool we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of The Villages Health, the information belongs to you.

You have the right to:

- Obtain a paper copy of this Notice
- Inspect and copy your health record, or request that we share it with a third party
- Request an amendment to your health record
- Obtain an accounting of certain disclosures of your health information

- Request communications of your health information by alternative means or at alternative locations
- Request a restriction of PHI regarding care and services you pay for out-of-pocket (in writing)
- Request a copy of your health record in an electronic format if applicable
- Request a restriction on certain uses and disclosures of your information
- Revoke your authorization to use or disclose health information, except to the extent that action has already been taken
- Be notified of a breach of your PHI

Our Responsibilities

The Villages Health System is required to:

- Maintain the privacy of your health information
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this Notice as currently in effect
- Notify you following a breach of your unsecured PHI
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change this Notice and to make the new Notice effective for all PHI we maintain. We will not use or disclose your health information without your authorization, except as described in this Notice. The current version of this Notice in effect will be posted on our website and at our office. You may also contact the Privacy Officer for a copy.

Required Authorization

We will not disclose your health information without your authorization except as provided for in this Notice or provided by law. Additionally, we will require your written authorization for the following disclosures:

- Disclosing of psychotherapy notes
- Use of PHI in marketing
- Sales of PHI

You have the right to revoke your authorization by submitting your revocation in writing to the practice where you signed your authorization or to our Privacy Officer. However, your revocation does not apply to actions already taken based on your authorization or disclosures already made.

Examples of Disclosures for Treatment, Payment and Health Operations (TPO)

We will use your health information for treatment.

For example, information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will

know how you are responding to treatment. We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you.

We will use your health information for payment.

For example, a bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used or other information as needed for payment purposes.

We will use your health information for regular health operations.

For example, members of the medical staff, the risk or quality improvement manager or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

Business Associates

There are some services provided to our organization through contracts with Business Associates. Examples include an Electronic Medical Record (EMR) system, billing company, or legal services. When these services are contracted, we may disclose your health information to our Business Associate so that they can perform the job we've asked them to do. To protect your health information, we require the Business Associate to agree to safeguard your information.

Notification

We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care. If your information is used for such notification, it would typically be limited to your name, general condition, and location.

Communication from Offices

We may call your home or other designated location and leave a message on voice mail or in person in reference to any items that assist the Practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to your clinical care. We may mail to your home or other designated location any items that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements. If you choose to provide an email account to us or communicate with us via email, we will reply to you via email or communicate other information needed to assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements. Before using email to communicate with us, you should understand that there are certain risks associated with the use of email. It may not be secure and messages can easily be misdirected. Text messaging presents similar risks. If you choose to contact us via text messaging, we may respond to you in the same manner or choose to refrain from text messaging with you, or otherwise limit the information included if we are not able to verify your identity. Additionally, you should understand that use of email and/or other electronic communications is not intended to be a substitute for professional medical advice, diagnosis or treatment and should never be used in a medical emergency.

Communication with Family

Unless you object or in the health professional's best judgment, we may disclose your health information to a family member or friend to the extent of their involvement in your care or payment related to your care.

Health Information Exchanges

The Villages Health participates in one or more health information exchanges ("HIE") that allow us to share information that we obtain or create about you with other health care providers or other health care entities, for your treatment or otherwise as permitted by law. For example information about your past medical care and current medical conditions and medications can be available to us or to your other health care providers, if they participate in the same HIE. You will have the chance to opt-in to participate in the HIE before your information is shared.

Open Treatment Areas

We will implement reasonable safeguards to protect your information. However, sometimes patient care is provided in an open treatment area. While special care is taken to maintain patient privacy, some patient information may be incidentally overheard by others while receiving treatment. Should you be uncomfortable with this, please bring this to the attention of our Privacy Officer or your health care provider.

Research

We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral Directors

We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ Procurement Organizations

Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

Marketing & Fundraising

We may contact you to provide information about treatment alternatives or other health-related benefits and services that we provide that may be of interest to you. However, for services that are not provided by us and are not related to your treatment, or that are otherwise considered "marketing" under HIPAA, we would first obtain your authorization for this type of communication. We may also use your information for fundraising purposes. If we do contact you for fundraising activities, you will have an opportunity to opt out of such communications. If you prefer to opt-out now and not be contacted for fundraising efforts, you may submit your request to opt-out in writing to the practice where you signed your authorization, or to our Privacy Officer at the address listed at the end of this Notice.

Food and Drug Administration (FDA)

We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs or replacement.

Workers' Compensation

We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health

As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law Enforcement

We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the Practice's Privacy Officer at (352) 674-8905. If you believe that your privacy rights have not been followed as directed by applicable law or as explained in this Notice, you may file a complaint with us. Please send any complaint to The Villages Health Privacy Officer at the address provided below. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. **You will not be penalized for filing a complaint.**

The Villages Health
Attention: Privacy Officer
1020 Lake Sumter Landing
The Villages, FL 32162

Telephone: (352) 674-8905

Email: tvhprivacyofficer@thevillageshealth.com



FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

Patient Financial Responsibility. I understand that in consideration of the services provided, I am directly and primarily responsible to pay for services and procedures rendered at **The Villages Health**. I understand that I am responsible for any applicable deductible or co-payments.

Assignment of Insurance Benefits. I hereby authorize **The Villages Health** to file a claim for payment with my insurance company and/or Medicare (if applicable) for services provided to me and I request that payments for such services be made directly to **The Villages Health** and/or any physician providing services to me. If the insurance company fails to pay for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to **The Villages Health**.

Responsibility to Provide Proof of Insurance. I understand that it is my responsibility to provide **The Villages Health** with a copy of my current insurance card. I will notify The Villages Health immediately upon any change in my insurance.

Insurance Waiver and Non-Covered Services Waiver. There may be a service I desire, suggested or provided that is not covered under my insurance plan or Medicare (“Non-Covered Services”). I understand I must pay for “Non-Covered Services”. If feasible, a waiver will be completed for each “Non-Covered Service.”

Release of Information. I authorize **The Villages Health**, any physician examining and/or treating me, and their business associates to release to any third party payer (such as UnitedHealthcare or Blue Cross) any medical and psychiatric information and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment. I specifically consent to the release of any material in your possession, including, if any exists, results of HIV (AIDS) tests, and any that might address chemical dependence, depression or other psycho-emotional issues. I understand that if I do not consent to the release of information for payment purposes, **The Villages Health** and other health care providers will not be able to bill my insurance other third party and I may be billed directly for these services.

Medicare — Patient’s Certification/Authorization to Release Information and Payment Request. I certify that the information given by me in applying for payment under title XVII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration Division of Family Services or its intermediaries or carriers any information needed for this or a related Medicare claim. I hereby certify all insurance pertaining to the treatment shall be assigned to the physician treating me. I permit a copy of these authorizations and assignments to be used in place of the original, which is on file at The Villages Health Care Center’s office.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS (CONT.)

The Villages Health accepts payments in: Cash, Check and Credit Cards. In the event I receive payment from my insurance carrier, I agree to endorse any payment due for services rendered to **The Villages Health**, and send to **The Villages Health**.

By signing, I acknowledge understanding the above patient information.

Patient's Name

First Name _____ MI _____ Last Name _____

Patient's Date of Birth _____
MONTH DAY YEAR

SIGN HERE **Patient's Signature** _____ **Date** ____/____/____

SIGN HERE **Guardian/Power of Attorney Signature** _____

Person responsible for payment if different than above

Please sign as self if you are the responsible party. If not, please have responsible party sign, such as parent, guardian, etc.

First Name _____ MI _____ Last Name _____

Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

SIGN HERE **Responsible Party's Signature** _____

**UNIVERSAL PATIENT AUTHORIZATION FORM FOR
FULL DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT AND QUALITY OF CARE**

PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW

Patient (name and information of person whose health information is being disclosed):

Name (First Middle Last): _____

Date of Birth (mm/dd/yyyy): _____

Address: _____ City: _____ State: _____ Zip: _____

You may use this form to allow your healthcare provider to access and use your health information. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.

By signing this form, I voluntarily authorize, give my permission and allow use and disclosure:

OF WHAT: ALL MY HEALTH INFORMATION including any information about sensitive conditions (if any) [See page 2 for details]

FROM WHOM: ALL information sources [See page 2 for details]

TO WHOM: Specific person(s) or organization(s) permitted to receive my information (must be a healthcare provider):

Person/Organization Name: The Villages Health Phone: (844) TVH-WELL (844-884-9355)

Address: Please deliver to your care center (see last page of this packet for address) Fax: (855) 604-6305

PURPOSE: To provide me with medical treatment and related services and products, and to evaluate and improve patient safety and the quality of medical care provided to all patients.

EFFECTIVE PERIOD: This authorization/permission form will remain in effect until my death or the day I withdraw my permission.

REVOKING MY PERMISSION: I can revoke my permission at any time by giving written notice to the person or organization named above in "To Whom."

In addition:

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other persons [See page 2 for details].
- **I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.**
- **I have read all pages of this form and agree to the disclosures above from the types of sources listed.**

X _____
Signature of Patient or Patient's Legal Representative

Date Signed (mm/dd/yyyy)

Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

Parent of minor

Guardian

Other personal representative (explain: _____)

NOTE: This form is invalid if modified. You are entitled to get a copy of this form after you sign it.

Explanation of Form Florida AHCA FC4200-004

“Universal Patient Authorization for Full Disclosure of Health Information for Treatment & Quality of Care”

Laws and regulations require that some sources of personal information have a signed authorization or permission form before releasing it. Also, some laws require specific authorization for the release of information about certain conditions and from educational sources.

“Of What”: includes ALL YOUR HEALTH INFORMATION, INCLUDING:

- 1. All records and other information regarding your health history, treatment, hospitalization, tests, and outpatient care. This information may relate to sensitive health conditions (if any), including but not limited to:**
 - a. Drug, alcohol, or substance abuse
 - b. Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excludes “psychotherapy notes” as defined in HIPAA at 45 CFR 164.501)
 - c. Sickle cell anemia
 - d. Birth control and family planning
 - e. Records which may indicate the presence of a communicable disease or noncommunicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis
 - f. Genetic (inherited) diseases or tests
- 2. Copies of educational tests or evaluations, including Individualized Educational Programs, assessments, psychological and speech evaluations, immunizations, recorded health information (such as height, weight), and information about injuries or treatment.**
- 3. Information created before or after the date of this form.**

“From Whom” includes: **All information sources** including but not limited to medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, Veterans Affairs health care facilities, state registries and other state programs, all educational sources that may have some of my health information (schools, records administrators, counselors, etc.), social workers, rehabilitation counselors, insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker’s compensation programs, state Medicaid, Medicare and any other governmental program.

“To Whom”: For those health care providers listed in the “TO WHOM” section, your permission would also include physicians, other health care providers (such as nurses) and medical staff who are involved in your medical care at that organization’s facility or that person’s office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purpose(s) permitted by this form for that organization or person that you specified. Disclosure may be of health information in paper or oral form or may be through electronic interchange.

“Purpose”: Your signature on this form does NOT allow health insurers to have access to your health information for the purpose of deciding to give you health insurance or pay your bills. You can make that choice in a separate form that health insurers use.

“Revocation”: You have the right to revoke this authorization and withdraw your permission at any time regarding any future uses by giving written notice. This authorization is automatically revoked when you die. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

“Re-disclosure of Information”: Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

Limitations of this Form: If you want your health information shared for purposes other than for treating you or you want only a portion of your health information shared, you need to use Form Florida AHCA FC4200-005 (Universal Patient Authorization Form For Limited Disclosure of Health Information), instead of this form. Also, this form cannot be used for disclosure of psychotherapy notes. This form does not obligate your health care provider or other person/organization listed in the “From Whom” or “To Whom” section to seek out the information you specified in the “Of What” section from other sources. Also, this form does not change current obligations and rules about who pays for copies of records.

CONSENT TO MEDICAL TREATMENT

Consent to Treatment. I, or my authorized representative, consent to providers at **The Villages Health**, to evaluate and treat my medical condition as may be deemed necessary or advisable in the judgment of my physician or other provider. Absent an emergency, if the treatment has significant risks, then an additional consent would be obtained by **The Villages Health**. I understand that providing medical care is not an exact science and no guarantees have been given to me by anyone as to the results or outcomes that may be obtained from examinations, treatments or other healthcare services.

Communications About My Treatment. I agree that by providing my landline or cell phone number(s), I am giving express consent for **The Villages Health**, its staff, employees, independent contractors, assignees, successors, and agents, to contact me at these numbers, or any number that is later acquired for me and to leave live or pre-recorded messages or text messages regarding my healthcare-related matters, my account, or my bill related to any services I receive. I confirm that any phone number I provide is associated with me and not a third-party. For greater efficiency, calls may be delivered by an auto-dialer. Providing a telephone or cell phone number is not a condition of receiving services.

Consent to Obtain Prescription History. I authorize **The Villages Health** and its affiliated providers to view my external prescription history via the RX History service. I understand that my history from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers may be viewable by my providers and staff of TVH, and it may include prescriptions back in time for several years. My signature certifies that I have read and understand the scope of my consent and I authorize access.

Consent to Obtain Vaccination History. I authorize the Villages Health and its affiliated providers to view my vaccination history via Florida Shots. I understand that my history from multiple other unaffiliated medical providers or pharmacies may be viewable by my providers and staff and TVH, and it may include vaccination history back in time for several years. My signature certifies that I have read and understand the scope of my consent and I authorize access.

I certify that I have read the forgoing, received a copy thereof and I am the patient or am duly authorized by the patient as patient's authorized representative to execute this Consent to Medical Treatment.

Date _____ / _____ / _____

SIGN HERE  **Patient's Signature** _____ PRINT NAME

SIGN HERE  **Guardian/Power of Attorney Signature** _____

Relationship to Patient _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND COMPLIANCE WITH HIPAA STANDARDS

Notice to Patient

We are required to provide you with a copy of our Notice of Privacy Practices (pages 2 and 3), which states how we may use and/or disclose your health information. Your signature on this form is to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement if you wish.

I authorize The Villages Health to leave medical information pertaining to my care by the following methods:

Home Telephone	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> OK to leave voice mail?	SMS/Text	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Work Telephone	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> OK to leave voice mail?	E-mail	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cell Phone	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> OK to leave voice mail?			

I authorize The Villages Health, and hospitals where I may be a patient, to leave medical information pertaining to my care with the following people:

Spouse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	()	_____	_____
			PRINT SPOUSE'S NAME	SPOUSE'S PHONE NUMBER		SPOUSE'S DOB
Other			_____	()	_____	_____
			PRINT NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER	DOB
Other			_____	()	_____	_____
			PRINT NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER	DOB
Other			_____	()	_____	_____
			PRINT NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER	DOB

I acknowledge that I have been offered and/or received a copy of this office's Notice of Privacy Practices. I understand that at the discretion of The Villages Health I may be asked to update this information periodically.

SIGN HERE	Patient's Signature	_____	_____
			PRINT NAME
SIGN HERE	Guardian/Power of Attorney Signature	_____	_____
	Relationship to Patient	_____	Date _____ / _____ / _____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this Patient. It could not be obtained because:

The Patient refused to sign. Due to an emergency situation it was not possible. We could not communicate with the Patient.

Other. Explain _____

EMPLOYEE'S PRINTED NAME EMPLOYEE SIGNATURE DATE

PATIENT DEMOGRAPHIC INFORMATION

General Information

Last Name _____ First Name _____ MI _____
Nickname/Preferred Name _____ Previous Name _____
Date of Birth ____/____/____ Social Security Number ____-____-____ Driver's License Number _____
Driver's License State _____ Driver's License Expiration Date ____/____/____
Mailing Address _____ City _____ State _____ Zip _____
Home Phone (____) _____ Cell Phone (____) _____ SMS/Text Yes No
Work Phone (____) _____ Email _____
Preferred Contact Method HOME PHONE WORK PHONE MOBILE PHONE MAIL PORTAL

Race

WHITE/CAUCASIAN BLACK/AFRICAN AMERICAN ASIAN OTHER _____ DECLINED TO ANSWER

Ethnicity

HISPANIC/LATIN NOT HISPANIC/LATIN DECLINED TO ANSWER Preferred Language: _____

Gender

MALE FEMALE

Marital Status

MARRIED SINGLE DIVORCED SEPARATED WIDOWED PARTNER

Seasonal

If Seasonal, Enter Dates _____ Seasonal Address _____ Seasonal City _____
Seasonal State _____ Seasonal Zip _____ Villages ID _____ Villages Neighborhood _____

Miscellaneous Information

How Did You Hear About Us? _____ Guardian _____
Emergency Contact _____ Relationship _____
Home Phone (____) _____ Cell Phone (____) _____
Next of Kin _____ Relationship _____ Phone (____) _____
Occupation: Employer Name _____ Phone (____) _____ RETIRED DISABLED
Current or Former Occupation _____ Current or Former Industry _____
Guarantor (Person to Whom Statements are Sent) _____
Guarantor DOB _____ Relationship to Patient _____
Guarantor Mailing Address _____ City _____ State _____ Zip _____

Pharmacy Contact

Primary Pharmacy Name _____
Primary Pharmacy Phone (____) _____ Primary Pharmacy Fax (____) _____
Primary Pharmacy Address _____ City _____ State _____ Zip _____
Secondary Pharmacy Name _____
Secondary Pharmacy Phone (____) _____ Secondary Pharmacy Fax (____) _____
Secondary Pharmacy Address _____ City _____ State _____ Zip _____
Referring Provider Name _____ Referring Provider Phone (____) _____

PATIENT DEMOGRAPHIC INFORMATION (CONT.)

Current or Previous Primary Care Physician

Name, City/State, Phone, () CURRENT

Current or Previous Specialists

Table with 5 rows for Name, Specialty, City/State, Phone, (), CURRENT

INSURANCE INFORMATION

Primary Insurance

REQUIRED INFORMATION: PLEASE NOTE: Insurance is considered a method of reimbursing the member fees paid by you to the doctor and it is not a substitute for payment, unless our office is a provider for your insurance company.

Insurance Company, Member ID#, Group Number, Group Name, Issue Date, Expiration Date

Policy Holder's

Last Name, First Name, MI, Mailing Address, City, State, Zip, Social Security Number, Date of Birth, Relationship to Patient

Secondary Insurance

Insurance Company, Member ID#, Group Number, Group Name, Issue Date, Expiration Date

Policy Holder's

Last Name, First Name, MI, Mailing Address, City, State, Zip, Social Security Number, Date of Birth, Relationship to Patient

Prescription Drug Coverage Plan Name, Medicare Part D Plan Name

All co-pays, coinsurance, and deductibles are expected to be paid in full at the time of your visit. If this account is assigned to an attorney for collections and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and/or cost of collection. If this account is assigned to a collection agency, an administrative fee will be applied.

SIGN HERE Patient's Signature Date

SIGN HERE Guardian/Power of Attorney Signature

MEDICATION INFORMATION

Note: Please bring **ALL** medications you are currently using (in their original containers) to your **FIRST** appointment.

Allergies/Intolerances

Type of Medication	Type of Reaction
<i>Example: Penicillin</i>	<i>Rash</i>

Current Prescription Medications

This may include ointments, creams, inhalers or any items for which you would need a prescription. This may include items that are used only rarely.

Name	Strength [Formulation]	Frequency	Refill required in the next 90 days?		
			Supply	Supply	Supply
<i>Example: Lisinopril</i>	<i>10 mg [tablets]</i>	<i>Once daily</i>	<input type="checkbox"/> No	<input type="checkbox"/> 90 day	<input type="checkbox"/> 30 day
			<input type="checkbox"/> No	<input type="checkbox"/> 90 day	<input type="checkbox"/> 30 day
			<input type="checkbox"/> No	<input type="checkbox"/> 90 day	<input type="checkbox"/> 30 day
			<input type="checkbox"/> No	<input type="checkbox"/> 90 day	<input type="checkbox"/> 30 day
			<input type="checkbox"/> No	<input type="checkbox"/> 90 day	<input type="checkbox"/> 30 day
			<input type="checkbox"/> No	<input type="checkbox"/> 90 day	<input type="checkbox"/> 30 day
			<input type="checkbox"/> No	<input type="checkbox"/> 90 day	<input type="checkbox"/> 30 day
			<input type="checkbox"/> No	<input type="checkbox"/> 90 day	<input type="checkbox"/> 30 day

Current Non-Prescription Medications

Name	Strength [Formulation]	Frequency	Purpose
<i>Example: Advil</i>	<i>200 mg [capsules]</i>	<i>1 capsule every 6 hours</i>	<i>Headaches</i>

Current Supplements

Name	Strength [Formulation]	Frequency	Purpose
<i>Example: Fish Oil</i>	<i>500 mg [tablets]</i>	<i>1 tablet twice daily</i>	<i>Heart Health</i>

Discontinued Medications

It would be helpful for us to know of any medication you have previously used that has been stopped for any reason, besides those you have listed under the “allergies/intolerances” section above, such as those that may have been ineffective, or simply no longer needed.

Name	Reason Discontinued
<i>Example: Lisinopril</i>	<i>My ankles became swollen</i>
_____	_____
_____	_____
_____	_____

Medical Supplies I Use

These are items for which you may need a prescription, such as diabetic shoes, oxygen, prosthetics, etc.

Name	Purpose
<i>Example: Insulin Syringes</i>	<i>To take insulin for diabetes</i>
_____	_____
_____	_____
_____	_____

IMMUNIZATIONS *Please indicate month, day and year last received.*

INFLUENZA VACCINE	PNEUMONIA VACCINE	PREVNAR VACCINE	TETANUS BOOSTER	TDAP	SHINGRIX (SHINGLES) VACCINE
/ /	/ /	/ /	/ /	/ /	/ /
_____	_____	_____	_____	_____	_____

FAMILY HISTORY

Family Member with a History of *(Please define who had history and what age if applicable):*

<input type="checkbox"/> Abdominal Aortic Aneurysm _____	<input type="checkbox"/> Hypertension _____
<input type="checkbox"/> Breast Cancer _____	<input type="checkbox"/> Mental Illness _____
<input type="checkbox"/> Colon Cancer _____	<input type="checkbox"/> Ovarian Cancer _____
<input type="checkbox"/> Coronary Artery Disease _____	<input type="checkbox"/> Prostate Cancer _____
<input type="checkbox"/> Diabetes Mellitus _____	<input type="checkbox"/> Stroke _____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

SOCIAL HISTORY

Please complete the following social history information. Please check all that apply. If in doubt, leave blank.

Advance Directives

Note: Please bring a copy of these documents to your **FIRST** appointment.

DNR FIVE WISHES GUARDIAN HEALTH CARE SURROGATE LIVING WILL POWER OF ATTORNEY NONE

If none, would you like additional information explaining what these mean? Yes No

Tobacco Use

NEVER SMOKED FORMER SMOKER CURRENT SMOKER EVERY DAY SOME DAYS

How much do you or did you smoke? _____ Packs Per Day Week

Do you currently use smokeless tobacco? Yes No Type: _____

Used smokeless tobacco in the past? Yes No Type: _____

Most Recent Tobacco or Smokeless Tobacco Use _____ / _____ / _____ Number of Years Tobacco Used _____

E-Cigarette/Vape Use CURRENT FORMER NEVER USED Passive Smoke Exposure Yes No

Are you interested in quitting? Yes No Ready to quit? Yes No

General

Total Number in Household _____ Are you currently employed? Yes No Occupational Exposures Yes No

Current/Former Occupation _____

Education LESS THAN 8TH GRADE 8 9 10 11 12 2 YEAR COLLEGE 4 YEAR COLLEGE POST GRADUATE

Where are you from? _____ City/Neighborhood In Which You Live _____

Do you have local family? Yes No Number of Children _____ Pets? Yes No Able to care for self? Yes No

General Stress Level LOW MEDIUM HIGH Caregiver FAMILY FRIENDS OTHER NONE

Sexually Active Yes No Sexual Orientation HETEROSEXUAL HOMOSEXUAL BISEXUAL DECLINE TO ANSWER

Caffeine Intake NONE OCCASIONAL MODERATE HEAVY Exercise NONE OCCASIONAL MODERATE HEAVY

Type of Exercise _____ Hobbies/Activities _____

Diet REGULAR VEGETARIAN VEGAN GLUTEN FREE CARDIAC DIABETIC OTHER: _____

Smoke Alarm In Home Yes No Seat Belts Used Routinely Yes No Sunscreen Used Routinely Yes No

Domestic Violence Yes No Religious Preference _____

Drugs/Alcohol

Alcohol Intake NONE OCCASIONAL MODERATE HEAVY

During the past 4 weeks, how many drinks of wine, beer, or other alcoholic beverages have you consumed? _____

Illicit/Recreational Drug Use NEVER IN PAST CURRENT TYPE: _____

Medication Adherence

Do you understand all the medications as you are taking them? Yes No

Do you have any financial concerns related to the medication you are taking? Yes No

Do you have any other barriers related to the medications you are taking? Yes No

Communication Provisions

Do you have any communication barriers? None Cognitive Vision Language Hearing

Does the family/caregiver have any communication barriers? None Cognitive Vision Language Hearing

SURGICAL HISTORY

Please provide dates in the space below.

	YEAR OF SURGERY		YEAR OF SURGERY
Appendix Removal	_____	Hernia Repair	_____
Breast Biopsy/Breast Surgery	_____	Hysterectomy	_____
Cardiac Bypass	_____	Ovarian Removal (<i>one or both</i>)	_____
Carotid Artery Surgery	_____	Other (<i>Type</i> _____)	_____
Cataract Surgery	_____	Other (<i>Type</i> _____)	_____
Gallbladder Surgery	_____	Other (<i>Type</i> _____)	_____

IMPLANT HISTORY

List any implants, date implanted, and the UDI for the device.

Device Type _____ Date of Implant ____/____/____ UDI _____ Site _____ Side Left Right Bilateral

Device Type _____ Date of Implant ____/____/____ UDI _____ Site _____ Side Left Right Bilateral

Device Type _____ Date of Implant ____/____/____ UDI _____ Site _____ Side Left Right Bilateral

OB/GYN HISTORY

Date of Last Pap Smear ____/____/____ Normal Abnormal Unknown

Date of Last Mammogram ____/____/____ Normal Abnormal Unknown

Date of Last Bone Density ____/____/____ Normal Abnormal Unknown

Date of Last Menstrual Period ____/____/____ Normal Abnormal Unknown

Age at First Period ____ Age at First Child ____ Age at Menopause ____ Current Birth Control Method _____

Number of Pregnancies ____ Number of Living Children ____

PAST MEDICAL HISTORY

Please complete the following in as much detail as possible. If you cannot recall certain information, that is okay.

DIAGNOSES/CONDITIONS *Please check all that apply.*

- Cardiovascular**
- | | | |
|---|--|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Cardiac Catheterization |
| <input type="checkbox"/> Heart Valve Disorder | <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Stent Placement/Angioplasty |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Implantable Defibrillator | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Elevated Cholesterol | <input type="checkbox"/> Vascular Disease | <input type="checkbox"/> Peripheral Arterial Disease |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Blood Clotting Disorder | <input type="checkbox"/> Deep Venous Thrombosis |
| <input type="checkbox"/> Abdominal Aortic Aneurysm Screening [AAA Ultrasound] (DATE OF LAST EXAM) _____ | | |
| <input type="checkbox"/> Other _____ | | |

- Endocrine**
- | | | |
|---|--|--|
| <input type="checkbox"/> Diabetes (Type 2) | <input type="checkbox"/> Diabetes (Type 1) | <input type="checkbox"/> Osteoporosis (weak bones) |
| <input type="checkbox"/> Overactive Thyroid | <input type="checkbox"/> Underactive Thyroid | |
| <input type="checkbox"/> Fractures (please specify date and type of fracture) _____ | | |
| <input type="checkbox"/> Other _____ | | |

- Gastrointestinal**
- | | | | |
|---|---------------------------------------|---|--------------------------|
| <input type="checkbox"/> Heartburn/Reflux | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Cirrhosis | |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Hepatitis C | |
| <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Inflammatory Bowel Disease | |
| <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Constipation | | |
| <input type="checkbox"/> Other _____ | | | |
| Last Colonoscopy (DATE OF LAST EXAM) _____ | NORMAL | ABNORMAL | UNKNOWN |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis C Screening in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |

- Genitourinary**
- | | |
|---|---|
| <input type="checkbox"/> Overactive Bladder/Incontinence | <input type="checkbox"/> Urinary Tract Infections |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Chronic Kidney Disease |
| <input type="checkbox"/> Kidney Cysts | <input type="checkbox"/> Enlarged Prostate |
| <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> PSA Screen (DATE OF LAST EXAM) _____ |
| Are you sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| <input type="checkbox"/> Sexually Transmitted Diseases (Chlamydia, Gonorrhea, Genital Herpes) | |

- Gynecological**
- | | | | |
|---|----------------------------|--------------------------|--------------------------|
| Cervical Cancer Screening (Pap) (DATE OF LAST EXAM) _____ | NORMAL | ABNORMAL | UNKNOWN |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dexa (DATE OF LAST EXAM) _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mammogram (DATE OF LAST EXAM) _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Menstrual Period (DATE OF LAST) _____ | | | |
| Number of Pregnancies _____ | Number of Deliveries _____ | | |

- Neurologic/
Psychiatric**
- | | | |
|---|--|-------------------------------------|
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Post-Traumatic Stress Disorder | <input type="checkbox"/> Stroke | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Transient Ischemic Attacks (TIA) | <input type="checkbox"/> Depression | |
| <input type="checkbox"/> Other _____ | | |

Oncologic (Cancer) and Hematologic (Blood Disorders) *Please provide year of diagnosis and check if disease is in remission or active.*

	YEAR OF SURGERY	REMISSION	ACTIVE		YEAR OF SURGERY	REMISSION	ACTIVE
Lung Cancer	_____	<input type="checkbox"/>	<input type="checkbox"/>	Colon/Rectal Cancer	_____	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	_____	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Cancer	_____	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	_____	<input type="checkbox"/>	<input type="checkbox"/>	Other (<i>Type</i> _____)	_____	<input type="checkbox"/>	<input type="checkbox"/>

Pulmonary

<input type="checkbox"/> Asbestos Exposure/Asbestosis	<input type="checkbox"/> Asthma	<input type="checkbox"/> COPD
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Pulmonary Nodules	<input type="checkbox"/> Other _____

Rheumatologic/ Joint Disease

<input type="checkbox"/> Cervical Disc Disease	<input type="checkbox"/> Gout	<input type="checkbox"/> Lumbar Disc Disease
<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Rheumatoid Arthritis	

HOSPITALIZATIONS *Please list all dates, reasons and complications for hospitalizations below.*

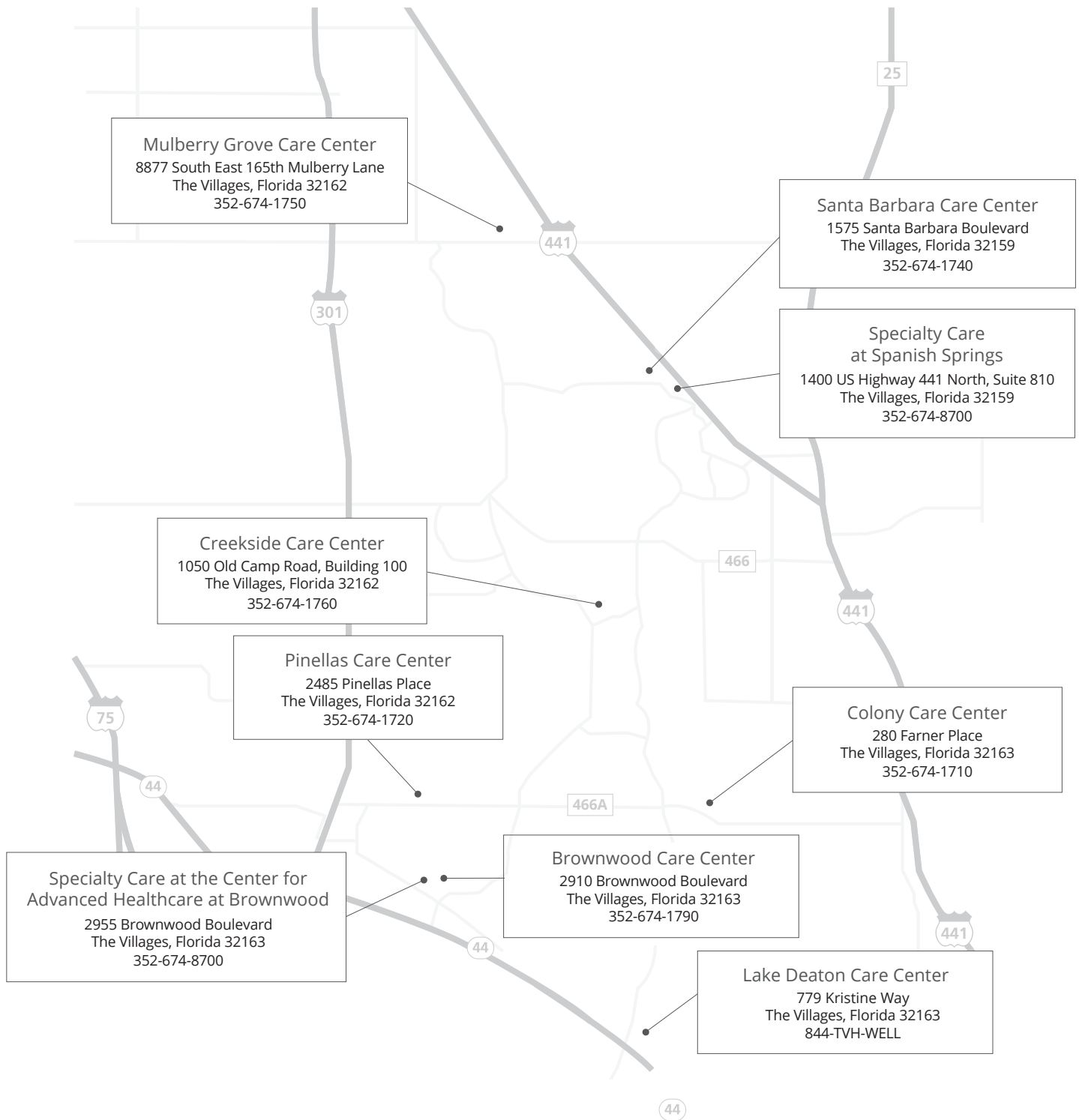
DATE OF HOSPITALIZATION	REASON FOR HOSPITALIZATION	COMPLICATIONS
____/____/____	_____	_____
____/____/____	_____	_____
____/____/____	_____	_____
____/____/____	_____	_____

Person completing this medical history is Patient Other _____

Relationship to Patient _____

PRINT NAME

9 CONVENIENT LOCATIONS



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