



(347) 378-8010

Patient Demographic Form # 1

Last Name _____ First Name _____ M.I. _____

Date of Birth: _____ Social Security Number: _____ Sex: **Male/ Female/ Other**

Address _____ City _____ State _____ Zip _____

Phone: Home _____ Mobile _____ Work _____

Email _____

Spouse Information:

Last Name _____ First Name _____ M. I. _____

Spouse Date of Birth _____ Spouse Social Security Number _____

Spouse Employer _____ Phone _____ Address _____

Insurance Information:

Primary Insurance _____ ID # _____ Subscriber _____

Secondary Insurance _____ ID # _____ Subscriber _____

Emergency Contact: _____ 2nd Emergency Contact: _____

Relationship: _____

Relationship: _____

Phone number: _____

Phone number: _____

3rd Emergency Contact: _____

Relationship: _____

Phone Number: _____

Email: _____

I hereby authorize North City Medical, its representatives, physicians, and staff, to share any and all medical and financial information with the above individual(s):

X _____ Date: _____

Signature of patient or patient's representative

New Patient Medical History Form

Patient Name _____ Date _____

Prior Primary Care Provider _____ Last Office Visit _____

Former Specialists Name/Phone _____

Do you have an "Advanced Directive" or "Durable Power of Attorney"? _____ If so, please provide a copy.

Past Medical History: Please check any that apply and note the date if known.

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Depression | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Acid Reflux/Heartburn | <input type="checkbox"/> Blood Clots/Bleeding Disorders | <input type="checkbox"/> Eye Disorders | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> CVA/ Stroke | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Crohns's Disease/Colitis | <input type="checkbox"/> Irritable Bowels | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease/ Attack/Failure | <input type="checkbox"/> Liver Disease | |
| <input type="checkbox"/> Cancer (type) _____ Treatment _____ | | Year _____ | |
| <input type="checkbox"/> Other _____ | | | |

Past Surgical History:

| Procedure | Year | Procedure | Year | Procedure | Year |
|---|------|---|------|---|------|
| <input type="checkbox"/> Angioplasty | | <input type="checkbox"/> Gastric Bypass | | <input type="checkbox"/> Cesarean Section | |
| <input type="checkbox"/> Angioplasty w/ Stent | | <input type="checkbox"/> Hip Replacement | | <input type="checkbox"/> D and C | |
| <input type="checkbox"/> Appendectomy | | <input type="checkbox"/> Knee Replacement | | <input type="checkbox"/> Hysterectomy | |
| <input type="checkbox"/> Arthroscopic Knee | | <input type="checkbox"/> Liver Biopsy | | <input type="checkbox"/> Mastectomy | |
| <input type="checkbox"/> Back Surgery | | <input type="checkbox"/> ORIF/ Hip Fracture | | <input type="checkbox"/> Breast Biopsy | |
| <input type="checkbox"/> CABG/ Bypass | | <input type="checkbox"/> Pacemaker | | <input type="checkbox"/> Prostatectomy | |
| <input type="checkbox"/> Carpal Tunnel | | <input type="checkbox"/> Bowel Resection | | <input type="checkbox"/> Vasectomy | |
| <input type="checkbox"/> Cataract | | <input type="checkbox"/> Thyroidectomy | | <input type="checkbox"/> Other | |
| <input type="checkbox"/> Gall Bladder | | <input type="checkbox"/> Tonsillectomy | | <input type="checkbox"/> Other | |
| <input type="checkbox"/> Colostomy | | <input type="checkbox"/> Tubal Ligation | | <input type="checkbox"/> Other | |

Past Diagnostic History:

| Procedure | Date | Procedure | Date | Procedure | Date |
|---------------------------------------|------|--|------|------------------------------------|------|
| <input type="checkbox"/> Colonoscopy | | <input type="checkbox"/> Cardiac Stress Test | | <input type="checkbox"/> Eye Exam | |
| <input type="checkbox"/> Bone Density | | <input type="checkbox"/> Cardiac Catheterization | | <input type="checkbox"/> Pap Smear | |
| <input type="checkbox"/> Mammogram | | <input type="checkbox"/> Echocardiogram | | <input type="checkbox"/> PSA | |

Medications:

What is your preferred pharmacy? _____ Phone # _____

Do you use a pill organizer? YES/ NO

Check here if you have NO MEDICATION ALLERGIES

Please list all medication ALLERGIES.

| MEDICATION | REACTION | MEDICATION | REACTION |
|------------|----------|------------|----------|
| 1. | | 4. | |
| 2. | | 5. | |
| 3. | | 6. | |

Please list all prescription medications and dosage amount:

| Medications | Dosage and directions |
|-------------|-----------------------|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| 6. | |
| 7. | |
| 8. | |
| 9. | |
| 10. | |

Please list all vitamins, supplements and other over the counter products:

| Vitamins/OTC | Dosage and directions |
|--------------|-----------------------|
| 1. | |
| 2. | |
| 3. | |
| 4. | |

Family History:

Check here if you were adopted

Please check if any family member has ever had any of the following conditions. Include information even if the person is deceased.

| Disease | Mother | Father | Sister | Brother | Grandparents | Other |
|-----------------------------|--------|--------|--------|---------|--------------|-------|
| CAD/ Heart Disease | | | | | | |
| Heart Disease before age 50 | | | | | | |
| Cancer: Type | | | | | | |
| Cancer: Type | | | | | | |
| CVA/ Stroke | | | | | | |
| Diabetes | | | | | | |
| High Cholesterol | | | | | | |
| High Blood Pressure | | | | | | |
| Depression/ Anxiety | | | | | | |
| Osteoporosis | | | | | | |
| Glaucoma | | | | | | |
| Macular Degeneration | | | | | | |

Social History:

Marital Status: Married Single Divorced Widow _____

Number of Children: _____ In/Out of home

Children:

| Name | Age | Health Status | Live Nearby? | Phone # |
|------|-----|---------------|--------------|---------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Employer & Occupation: _____ Current Retired Year: _____

Military Service: Yes No Combat: Yes No

Exercise: What type of exercise? _____ How many days per week? _____

Alcohol Use: Never Rarely Frequent Type of alcohol? _____

How many drinks per day? _____ Per week? _____

Tobacco Use: Never Former Current Type of tobacco used? _____

Age at onset of use? _____ Year Quit _____ Packs per day? _____

Illicit or prescription drug abuse? Never Former Current If yes, type? _____

Date last used? _____

Any history of sexually transmitted disease? Yes No _____

Vaccination History:

| Vaccine | Date | Vaccine | Date |
|--|------|---|------|
| <input type="checkbox"/> Hepatitis A | | <input type="checkbox"/> Influenza | |
| <input type="checkbox"/> Hepatitis B (3 shot series) | | <input type="checkbox"/> Pneumovax 23 | |
| <input type="checkbox"/> Tetanus (Td) | | <input type="checkbox"/> Prevnar 13 | |
| <input type="checkbox"/> Tetanus & Pertussis (Tdap) | | <input type="checkbox"/> Herpes Zoster/Shingles | |

North City Medical Multiple Consent Form

Patient Name: _____ Date of Birth: _____ MRN#: _____

Notice of Health Information Practices:

I acknowledge that I have been given a copy of the "Notice of Health Information Practices". I have read and understand the information contained on the document. I also understand that if I have any questions I may call my physician's office manager for clarification.

X

Signature of Patient or Patient's Representa...

Consent to Leave Messages:

I hereby authorize North City Medical, its representatives, physicians, and staff to leave messages related to my healthcare on a recorder at the following phone number(s):

Home: _____ Cell: _____ Work: _____

I also authorize North City Medical, its representatives, physicians and staff, to share any and all medical and financial information with the following individual(s):

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

X

Signature of Patient or Patient's Representa...

Photo Consent:

This consent is for the purpose of capturing your photograph to be attached to your chart.

I understand that I may revoke this authorization at any time, by notifying North City Medical in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by North City Medical before receiving my revocation. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment and enrollment in a health plan or eligibility for benefits. I hereby authorize North City Medical and their staff to capture my photograph to be attached to my chart.

X

Signature of Patient or Patients Representat...

Relationship to Patient _____

North City Medical Authorization for Release of Health Information

Patient Name _____ DOB _____

Social Security Number _____ MRN# _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following physician or organization is authorized to make the disclosure:
- 3.

Name: _____

Address: _____ Phone _____ Fax _____

4. This information may be released to and used by the following organization:

Name: _____

Address: _____

5. The type and amount of information to be released:

- | | | |
|--|--|--|
| <input type="radio"/> Complete Medical Record | <input type="radio"/> Immunization Record | <input type="radio"/> Problem List |
| <input type="radio"/> Physician Progress Notes | <input type="radio"/> Lab Reports | <input type="radio"/> Hospital Records |
| <input type="radio"/> List of Allergies | <input type="radio"/> Medication List | <input type="radio"/> Diagnostic Testing Reports |
| <input type="radio"/> X-ray Reports | <input type="radio"/> EKG | <input type="radio"/> Most Recent 5 year History |
| <input type="radio"/> Problem List | <input type="radio"/> Consultation Reports | <input type="radio"/> Discharge Summary |
| <input type="radio"/> Other _____ | | |

6. Unless otherwise provided by law, records and information concerning the following types of diagnoses, care and treatment will be released only if I indicate my specific consent by checking the appropriate box:

Drug/ Alcohol Abuse Mental Health Notes HIV/ AIDS Genetic Testing

7. I understand that I have a right to cancel this authorization at any time. I understand that if I wish to withdraw this authorization I must do so in writing. I must present my written cancellation to the health information management department. I understand that the authorization withdrawal will not apply to information that has already been released due to this authorization. I understand that the cancellation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise cancelled, this authorization will expire on the following date _____. If I fail to specify an expiration date or event, this authorization will expire in six months.
8. I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I don't have to sign this form to receive treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the possibility for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact my physician's office manager. I understand that there may be a charge for costs associated with copying my health information.

X

Signature of Patient/ Legal Representative (Specify Relationship to Patient)

Date



Notice of Health Information 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.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone’s health or safety

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers’ compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers’ compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- **We are required by law to maintain the privacy and security of your protected health information.**
- **We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.**
- **We must follow the duties and privacy practices described in this notice and give you a copy of it.**
- **We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.**

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

North City Medical

New Patient Survey

How did you hear about us?

We are very happy that you are here with us today! Thank you for sharing with us how you learned about North City Medical.

Name: _____

I learned about North City Medical from (check as many as may apply):

A friend or family member: _____ Name of referring patient: _____

Insurance plan or broker: _____ Name of plan: _____

An North City Medical employee: _____ Name of employee: _____

A referral from another physician: _____ Name of physician: _____

Online: _____ Name of website: _____

An advertisement:

KMOX radio _____

KPTS radio _____

Direct Mail _____

Post-Dispatch paper _____

Post-Dispatch website _____

Seminar _____

Other _____

Any other source not listed: _____



FACILITY CONTACT AUTHORIZATION

Patient Name: _____

Birth Date: _____

I authorize the North City Medical team to access my medical records and communicate with physicians and staff at any healthcare facility, including mental health facilities, for the purpose of managing my care while I am admitted.

X _____

Signature of patient or patient's representative

Date: _____