PATIENT INTAKE FORM

Patient Information

Name:		Address:	
DOB:		City:	
Gender:		State:	
Home/Cell Phone:		Zip:	

Email:			
Emergency Contact:		Relationship:	Contact Number:
District:		School:	

Medical Insurance

Insurance:	
Insurance Plan:	
Insurance ID:	

Is the patient the primary cardholder? ☐ Yes ☐ No

Is the patient an employee, spouse, or dependent? ☐ Employee ☐ Spouse ☐ Dependent

If the patient is NOT the primary cardholder, please also include:

Insured Member Name:	
Insured Member DOB:	
Relationship to Insured:	

* ☐ **Please check here if uninsured**

If uninsured, please provide your Social Security Number & CA or Mexico ID (if applicable)

Social Security Number:		ID Number & State:	

Primary Healthcare Information

Do you have a current Physician? ☐ Yes ☐ No

Primary Care Provider:		Phone Number:		
Address:		City:	State:	Zip:
Pharmacy:		Phone Number:		
Address:		City:	State:	Zip:

Past/Current Medical Problems

Have you ever been diagnosed or treated for any of the following?

- ☐ Acid Reflux Disease
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Chronic Kidney Disease
- ☐ Cancer: ____________________
- ☐ COPD/Emphysema
- ☐ Depression
- ☐ Diabetes
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Liver Disease
- ☐ Migraines
- ☐ Peripheral Vascular Disease
- ☐ Prediabetes
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ ____________________

Allergies/Medications

Please list all **medications** you currently take including prescription medications, non-prescription over-the-counter medications, and vitamins.

Name of Medication	Dosage	When & how often do you take it?

Please list all items you are **allergic** to and list the reaction - all medications, plants, foods & animals.

Allergy	Reaction

Operations/Hospitalizations/Injuries

Please list any operations, hospitalizations, and injuries (and dates for each).

Operations	Injuries	Hospitalizations (list reason)

Biological Family Medical History

		List any medical problems
Mother:	Deceased? ☐ YES	
Father:	Deceased? ☐ YES	
Paternal Grandmother:	Deceased? ☐ YES	
Paternal Grandfather:	Deceased? ☐ YES	
Maternal Grandmother:	Deceased? ☐ YES	
Maternal Grandfather:	Deceased? ☐ YES	
Paternal Aunt:	Deceased? ☐ YES	
Paternal Uncle:	Deceased? ☐ YES	
Maternal Aunt:	Deceased? ☐ YES	
Maternal Uncle:	Deceased? ☐ YES	
Brothers: # ________	Deceased? ☐ YES	
	Deceased? ☐ YES	
	Deceased? ☐ YES	
Sisters: # ________	Deceased? ☐ YES	
	Deceased? ☐ YES	
	Deceased? ☐ YES	
Sons: # ________	Deceased? ☐ YES	
	Deceased? ☐ YES	
	Deceased? ☐ YES	
Daughters: # ________	Deceased? ☐ YES	
	Deceased? ☐ YES	
	Deceased? ☐ YES	

Biological Family History (continued...)

Please list any **medical problems** that run in your family (uncles, cousins, etc.), including **Diabetes, Cancer and Heart Disease:**

Family Member	Medical Problem

Health Habits

Answer the following questions regarding your **health habits:**

Questions	Answer	Amount per day/When did you quit?
Do you drink alcohol?	☐ YES ☐ NO	
Do you smoke?	☐ YES ☐ NO	
Did you previously smoke?	☐ YES ☐ NO	
Do you consume caffeine?	☐ YES ☐ NO	
Do you use illegal drugs?	☐ YES ☐ NO	
Do you exercise regularly?	☐ YES ☐ NO	
Do you smoke cannabis?	☐ YES ☐ NO	

Menstrual History

Age of first menstrual period:		Number of children:	
Age of menopause:		Number of miscarriages:	
Number of pregnancies:		Number of abortions:	

Travel History

Have you traveled outside of the United States in the last 6 months? ☐ YES ☐ NO

If **YES**, please list countries: ____________________

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate the medical practice properly. We are required by law to protect the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about the Notice, please contact our Privacy Officer.

A. How this Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on the computer. This is your medical record. The medical record is the property of this medical practice, but the information on the medical record belongs to you. The law permits us to use or disclose your information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose information to members of your family or others who can help you when you are sick or injured.
2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates", such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. Although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or healthcare clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, healthcare clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.
4. Appointment Reminders. We may use and disclose medical information to contact you and remind you about appointments and/or other medical services. If you are not home when we call, we may leave this information on your answering machine/voicemail or in message left with person answering the phone. We may also send email or text message reminders for appointments or important notifications.
5. Sign in sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
7. Required by law. As required by law we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceeding, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
8. Public health. We may and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or require informing a personal representative we believe is responsible for the abuse or harm.
9. Health oversight activities. We may, and are sometimes required by law, to disclose your health information to oversight agencies during the course of audits, investigations, inspections, and licenser and other proceedings, subject to limitations imposed by federal and California law.
10. Judicial and administrative proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administration or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administration order.

11. Law enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

12. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

13. Organ or tissue donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

14. Public safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

15. Specialized government functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

16. Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation.

17. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request and will notify you of our decision.

2. Right to Request Special Privacy Protections. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California and federal law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny you request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have the right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 16 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosure for purposes or research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have the right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Practices will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment.

E. Complaints

You will not be penalized for filing a complaint. Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: Department of Health and Human Services, Office of Civil Rights, Hubert H. Humphrey Bldg. 200 Independence Avenue, S. W. Room 509 F HHH Building, Washington, DC 20201

Patient Initials: ____________

RELEASE OF LIABILITY

I ________________________________ am aware that *HealthWise Medical Clinic* **IS NOT** responsible for any additional charges accrued outside of the facility. I understand that these are **MY** responsibilities and not that of my employer nor *HealthWise Medical Clinic*. This includes any referrals, labs or diagnostic studies recommended by *HealthWise Medical Clinic* providers.

☐ *I hereby consent to receive communications via text message or email for the purpose of appointment reminders and other health-related notifications.*

Signature:____ DOB:________________

Print Name:______________________________________ Date:________________