PATIENT MEDICAL HISTORY

NAME: _____ DATE: _____

DATE OF BIRTH: _____ PAST PCP: _____

REFERRING PHYSICIAN: _____ OTHER TREATING PHYSICIANS: _____

CHIEF COMPLAINT

WHY ARE YOU SEEING THE DOCTOR TODAY? _____

VACCINATIONS

DO YOU TAKE A YEARLY FLU SHOT? ☐ YES ☐ NO LAST FLU SHOT? _____

LAST TETANUS SHOT? _____ LAST PNEUMONIA SHOT? _____

OTHER VACCINATIONS YOU CURRENTLY TAKE: _____

SCREENINGS

COLON CANCER SCREENING (BEGINS AT 45 UNLESS RISK FACTORS/FAMILY HISTORY INDICATES OTHERWISE)

HAVE YOU HAD ANY BLOOD IN THE STOOL OR TARRY BLACK STOOLS? ☐ YES ☐ NO

ANY CHANGES IN STOOL PATTERN OR SIZE? ☐ YES ☐ NO IF YES, DESCRIBE: _____

HAVE YOU HAD A COLONOSCOPY OR COLOGUARD BEFORE? ☐ YES ☐ NO

IF SO, WHEN? _____ PERFORMING PHYSICIAN: _____

MALE SCREENING (PROSTATE CANCER)

DO YOU SEE A UROLOGIST FOR PROSTATE CANCER SCREENING? ☐ YES ☐ NO

IF YES, WHAT IS THE NAME OF YOUR PHYSICIAN? _____

IN THE PAST YEAR, HAVE YOU HAD A BLOOD PSA (PROSTATE ANTIGEN)? ☐ YES ☐ NO

DO YOU HAVE A FAMILY HISTORY OF PROSTATE CANCER? ☐ YES ☐ NO

IF YES, WHAT IS THEIR NAME AND RELATION TO YOU? _____

FEMALE SCREENING

GYNOCOLOGIST: _____ LAST PELVIC EXAM/PAP SMEAR: _____

LAST MAMMOGRAM: _____ LAST BONE DENSITY SCAN: _____

DO YOU HAVE A FAMILY HISTORY OF BREAST CANCER? ☐ YES ☐ NO

IF YES, WHAT IS THEIR NAME AND RELATION TO YOU? _____

PAST MEDICAL HISTORY PLEASE CHECK ANY/ALL OF THE FOLLOWING THAT APPLY

- ☐ ANEMIA
- ☐ ARTHRITIS TYPE:
- ☐ ASTHMA
- ☐ BLEEDING DISORDER
- ☐ BYPASS/STENTS/MI
- ☐ CANCER: BREAST
- ☐ CANCER: COLON
- ☐ CANCER: LUNG
- ☐ CANCER: PROSTATE
- ☐ CANCER: OTHER
- ☐ COPD/EMPHYSEMA
- ☐ DEPRESSION/ANXIETY
- ☐ DIABETES
- ☐ DVT/BLOOD CLOTS
- ☐ EPILEPSY
- ☐ GOUT
- ☐ HEART DISEASE
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ IRRITABLE BOWEL SYNDROME
- ☐ KIDNEY ISSUES
- ☐ LIVER DISEASE
- ☐ MIGRAINES/HEADACHES
- ☐ OSTEOPOROSIS
- ☐ PERIPHERAL VASCULAR DISEASE
- ☐ PULMONARY EMBOLISM
- ☐ STROKE/TIA
- ☐ THYROID PROBLEM
- ☐ ULCERS/ACID REFLUX
- ☐ OTHER: _____

MEDICATION HISTORY LIST ALL MEDICATIONS OR SUPPLEMENTS YOU TAKE **WITH OR WITHOUT** A PRESCRIPTION

PHARMACY NAME: _____ **ADDRESS:** _____

NAME OF MEDICATION/DOSAGE	NAME OF MEDICATION/DOSAGE

ALLERGIES PLEASE DESCRIBE ANY CURRENT OR PAST ALLERGIC REACTIONS

DRUG ALLERGY

PAST SURGICAL HISTORY

PROCEDURE/YEAR

☐ I HAVE NOT HAD SURGERY OR BEEN HOSPITALIZED

SOCIAL HISTORY

DO YOU SMOKE/VAPE? ☐ YES ☐ NO HAVE YOU SMOKED/VAPED IN THE PAST? ☐ YES ☐ NO

HOW LONG? _____ # PACKS A DAY: _____

DO YOU USE CHEWING TOBACCO? ☐ YES ☐ NO HAVE YOU CHEWED TOBACCO IN THE PAST? ☐ YES ☐ NO

DO YOU USE A PIPE OR CIGARS? ☐ YES ☐ NO HAVE YOU USED A PIPE/CIGARS IN THE PAST? ☐ YES ☐ NO

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO HOW MANY DRINKS A MONTH? _____

DO YOU HAVE A HISTORY OF DRUG/ALCOHOL ABUSE? ☐ YES ☐ NO

FAMILY HISTORY CHECK BOX IF A BLOOD RELATIVE HAS BEEN DIAGNOSED WITH THE FOLLOWING

	MOTHER	FATHER	SIBLING	(M) GRANDMOTHER	(M) GRANDFATHER	(F) GRANDMOTHER	(F) GRANDFATHER
ALZHEIMER'S	☐	☐	☐	☐	☐	☐	☐
BLOOD CLOTS/DVT	☐	☐	☐	☐	☐	☐	☐
BREAST CANCER	☐	☐	☐	☐	☐	☐	☐
COLON CANCER	☐	☐	☐	☐	☐	☐	☐
DIABETES	☐	☐	☐	☐	☐	☐	☐
HEART DISEASE	☐	☐	☐	☐	☐	☐	☐
HYPERTENSION	☐	☐	☐	☐	☐	☐	☐
KIDNEY DISEASE	☐	☐	☐	☐	☐	☐	☐
STROKE	☐	☐	☐	☐	☐	☐	☐
SUDDEN DEATH	☐	☐	☐	☐	☐	☐	☐
OTHER	☐	☐	☐	☐	☐	☐	☐

PATIENT INFORMATION

NAME: _____ HOME PHONE: _____

SS NUMBER: _____ CELL PHONE: _____

ADDRESS: _____ GENDER: _____

EMAIL ADDRESS: _____ DATE OF BIRTH: _____

EMERGENCY CONTACT: _____ PHONE: _____

RELATIONSHIP TO PATIENT: _____

FOR MEDICARE PATIENTS ONLY: DO YOU LIVE IN A SKILLED NURSING FACILITY? ☐ YES ☐ NO

IF YES, WHAT IS THE NAME OF THE FACILITY? _____

EMPLOYMENT/STUDENT STATUS

☐ EMPLOYED FULL TIME ☐ STUDENT FULL TIME

☐ EMPLOYED PART TIME ☐ STUDENT PART TIME

☐ UNEMPLOYED

☐ RETIRED

EMPLOYER NAME AND ADDRESS: _____

OCCUPATION: _____

ETHNICITY OF PATIENT:

☐ HISPANIC ORIGIN

☐ NON-HISPANIC ORIGIN

☐ UNKNOWN

☐ DECLINED TO ANSWER

RACE OF PATIENT:

☐ AMERICAN INDIAN/ ALASKAN NATIVE

☐ ASIAN

☐ BLACK/ AFRICAN AMERICAN

☐ NATIVE HAWAIIAN/ OTHER PACIFIC ISLANDER

☐ WHITE

☐ UNKNOWN

☐ DECLINED TO ANSWER

PREFERRED LANGUAGE:

☐ ENGLISH ☐ SPANISH

☐ OTHER: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ OTHER: _____

TO DEMONSTRATE MEANINGFUL USE, WE ARE REQUIRED TO CAPTURE DEMOGRAPHIC DATA, INCLUDING YOUR PREFERRED LANGUAGE, RACE, AND ETHNICITY, IN COMPLIANCE WITH THE AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009 (ARRA).

FINANCIALLY RESPONSIBLE PERSON (IF DIFFERENT FROM ABOVE)

NAME: _____ HOME PHONE: _____

SS NUMBER: _____ CELL PHONE: _____

ADDRESS: _____ DATE OF BIRTH: _____

EMPLOYER NAME: _____

RELATIONSHIP TO PATIENT: _____

INSURANCE COMPANY INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

SECONDARY INSURANCE COMPANY NAME: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

☐ PLEASE CHECK THIS BOX IF YOU WILL NOT BE USING AN INSURANCE COMPANY FOR TREATMENT.

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I CERTIFY THAT THE INFORMATION I REPORTED ABOUT MY INSURANCE COVERAGE IS CORRECT. I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO AVALA FOR ANESTHESIA AND ORTHOPEDIC SURGICAL SERVICES PROVIDED TO ME. I FULLY UNDERSTAND THAT PAYMENT FOR SERVICES IS NOT CONTINGENT UPON RECOVERY, AND THIS DOES NOT RELIEVE ME OF MY PRIMARY OBLIGATION TO PAY.

SIGNATURE: _____ DATE: _____

MEDICARE PATIENTS

IF YOU ARE COVERED BY MEDICARE, PLEASE READ AND SIGN THE FOLLOWING:
IN MEDICARE CASES, AVALA AGREES TO ACCEPT THE CHARGE DETERMINATION OF MEDICARE AS THE FULL CHARGE, AND THE PATIENT IS RESPONSIBLE ONLY FOR DEDUCTIBLE, CO-INSURANCE, AND NON-COVERED SERVICES. COINSURANCE AND DEDUCTIBLES ARE BASED UPON THE CHARGE DETERMINATION OF MEDICARE.

SIGNATURE: _____ DATE: _____

E-PRESCRIBING

E-PRESCRIBING IS A FEDERALLY MANDATED INITIATIVE THAT REQUIRES ALL PHYSICIANS PRESCRIBE IN THIS MANNER BY 2011.

E-PRESCRIBING SOFTWARE SENDS PRESCRIPTIONS OVER THE INTERNET TO YOUR PHARMACY IN A SAFE, SECURE WAY THROUGH THE SAME TECHNOLOGY USED BY CREDIT CARD COMPANIES. THIS HELPS PROTECT THE PRIVACY OF YOUR PERSONAL INFORMATION.

EPRESCRIBING SOFTWARE ALSO LETS YOUR DOCTOR SEE IMPORTANT INFORMATION - LIKE DRUG INTERACTIONS AND YOUR PRESCRIPTION HISTORY.

PATIENT CONSENT

I AGREE THAT AVALA MAY REQUEST AND USE MY PRESCRIPTION MEDICATION HISTORY FROM OTHER HEALTHCARE PROVIDERS OR THIRD-PARTY PHARMACY BENEFIT PAYORS FOR TREATMENT PURPOSES.

_____ _____
PATIENT SIGNATURE DATE

DESIGNATION OF INDIVIDUAL INVOLVED IN MY CARE

UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA"), YOU HAVE THE RIGHT TO AUTHORIZE THE RELEASE OF YOUR PROTECTED HEALTH INFORMATION, INCLUDING MEDICAL AND BILLING RECORDS, TO AN INDIVIDUAL(S) YOU DESIGNATE. PLEASE COMPLETE THIS FORM IN ITS ENTIRETY, DESIGNATING THE INDIVIDUAL(S) WITH WHOM YOU WOULD LIKE AVALA TO SHARE YOUR INFORMATION.

PATIENT NAME: _____ DATE OF BIRTH: _____

DESIGNATION OF INDIVIDUAL(S) INVOLVED IN MY CARE:

AT MY REQUEST, I HEREBY IDENTIFY THE FOLLOWING INDIVIDUAL(S):

_____

_____

_____

(COLLECTIVELY, THE "DESIGNATED INDIVIDUAL") AS AN INDIVIDUAL(S) INVOLVED IN MY CARE, I HEREBY AUTHORIZE AVALA TO RELEASE ANY AND ALL PROTECTED HEALTH INFORMATION ABOUT ME, INCLUDING BILLING AND MEDICAL RECORDS, TO THE DESIGNATED INDIVIDUAL. THIS AUTHORIZATION PERMITS THE DISCLOSURE OF PAPER RECORDS, ELECTRONIC RECORDS, AND VERBAL COMMUNICATIONS. ADDITIONALLY, TO THE EXTENT MY MEDICAL OR BILLING RECORDS CONTAIN INFORMATION RELATED TO DRUG AND/OR ALCOHOL ABUSE, PSYCHIATRIC CARE, SEXUALLY TRANSMITTED DISEASE, HEPATITIS B OR C TESTING, HIV/AIDS, AND/OR OTHER SENSITIVE INFORMATION, I HEREBY AGREE TO ITS RELEASE

TERMINATION/REVOCATION OF DESIGNATION: UNLESS TERMINATED SOONER IN WRITING BY ME, THIS AUTHORIZATION WILL TERMINATE THREE (3) YEARS AFTER MY LAST DATE OF TREATMENT BY AVALA. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AND CANCEL THIS DESIGNATION BY SENDING A WRITTEN REVOCATION OF DESIGNATION FORM TO AVALA. I UNDERSTAND AND ACKNOWLEDGE THAT THE REVOCATION OR CANCELLATION OF THIS DESIGNATION SHALL NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASED BEFORE THE REVOCATION/CANCELLATION DATE.

RE-DISCLOSURE: I UNDERSTAND THAT THE INFORMATION DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY HIPAA.

NO OBLIGATION TO SIGN: I UNDERSTAND I DO NOT HAVE TO SIGN THIS AUTHORIZATION, AND TREATMENT WILL NOT BE DENIED IF I DO NOT SIGN THIS FORM. I HEREBY RELEASE AND DISCHARGE AVALA, ITS EMPLOYEES, AGENTS, AND OWNERS OF ANY LIABILITY AND WILL HOLD THEM HARMLESS OR COMPLYING WITH THIS AUTHORIZATION.

ACKNOWLEDGEMENT

_____ _____

PATIENT SIGNATURE DATE

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES OF **AVALA.**

_____ **INITIAL**

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

SECTION A: REQUIRED FOR ALL AUTHORIZATION FOR RELEASE OF PHI OR RIGHT OF ACCESS

PATIENT NAME: _____ DATE OF BIRTH: _____

PATIENTS ADDRESS: _____ SS NUMBER:(OPTIONAL) _____

PHI RECIPIENT NAME: AVALA CARE FAX NUMBER: 985-338-2621

PHI SENDER NAME: _____ FAX NUMBER: _____

THIS AUTHORIZATION WILL EXPIRE ON THE FOLLOWING: (FILL IN THE DATE OR EVENT, BUT NOT BOTH)

DATES: _____ EVENT: _____

PLEASE CHECK WHICH OF THE FOLLOWING YOU WOULD LIKE TO BE REQUESTED:

☐ ALL PHI IN RECORD	☐ PHYSICIAN ORDERS	☐ DEMOGRAPHICS
☐ HISTORY AND PHYSICAL	☐ LABORATORY	☐ REHABILITATION SERVICES
☐ CONSULT REPORT	☐ IMAGING/RADIOLOGY	☐ SPECIAL TEST/THERAPY
☐ OPERATIVE REPORT	☐ NURSING NOTES	☐ ITEMIZED BILL/CLAIMS
☐ PROGRESS NOTE	☐ MEDICATION RECORD	☐ OTHER

I ACKNOWLEDGE AND HEREBY CONSENT TO SUCH THAT THE RELEASE INFORMATION MAY CONTAIN ALCOHOL, DRUG ABUSE, OR PSYCHIATRIC. HIV TESTING, HIV RESULTS, OR AIDS INFORMATION.

_____ **INITIAL** ☐ IF NOT APPLICABLE, CHECK HERE

I UNDERSTAND THAT:

> I MAY REFUSE TO SIGN THIS AUTHORIZATION, AND MY TREATMENT WILL NOT BE CONDITIONED UPON THE SIGNATURE OF THIS AUTHORIZATION (EXCEPT FOR NON-HEALTH-RELATED SERVICES SUCH AS PRE-EMPLOYMENT TESTING, LIFE INSURANCE EXAMS, OR DRUG SCREENINGS).

> I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING, BUT IF I DO, IT WILL NOT HAVE ANY EFFECT ON ANY ACTIONS TAKEN BEFORE RECEIVING THE REVOCATION. FURTHER DETAILS MAY BE FOUND IN THE NOTICE OF PRIVACY PRACTICES.

> IF THE REQUESTOR OR RECEIVER IS NOT A HEALTH PLAN OR HEALTH CARE PROVIDER, THE RELEASED INFORMATION MAY NO LONGER BE PROTECTED BY FEDERAL REGULATIONS AND MAY BE RE-DISCLOSED.

> I UNDERSTAND THAT I MAY SEE AND OBTAIN A COPY OF THE INFORMATION DESCRIBED ON THIS FORM FOR A REASONABLE COPY FEE IF I ASK FOR IT.

> I WILL RECEIVE A COPY OF THIS FORM AFTER I SIGN IT.

SECTION C: SIGNATURES

I HAVE READ THE ABOVE AND AUTHORIZE THE DISCLOSURE OF THE PROTECTED HEALTH INFORMATION.

_____ _____

PATIENT/GUARDIAN/PATIENT REPRESENTATIVE SIGNATURE DATE

_____ _____

PRINT NAME OF PATIENT'S REPRESENTATIVE: RELATIONSHIP TO THE PATIENT

PLEASE MAIL MEDICAL RECORDS TO AVALA CARE AT
7039 HIGHWAY 190 E. SERVICE ROAD, COVINGTON, LA, 70433, OR FAX RECORDS TO 985-338-2621.