

PATIENT MEDICAL HISTORY

NAME: _____ DATE: _____

DATE OF BIRTH: _____ COMPLETED BY: SELF OTHER: _____

CHIEF COMPLAINT

WHY ARE YOU SEEING THE DOCTOR TODAY? _____

VACCINATIONS

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

BIRTH HISTORY

HOSPITAL: _____ LENGTH: _____ WEIGHT: _____

BORN FULL TERM? YES NO

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

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> ACID REFLUX | <input type="checkbox"/> CANCER | <input type="checkbox"/> JAUNDICE | <input type="checkbox"/> SEIZURE |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> DIABETES | <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> THYROID PROBLEMS |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> LUNG DISEASE | <input type="checkbox"/> ULCERS |
| <input type="checkbox"/> BLEEDING TENDENCY | <input type="checkbox"/> HIGH CHOLESTEROL | <input type="checkbox"/> RENAL DISEASE | <input type="checkbox"/> OTHER: _____ |

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

PHARMACY NAME: _____ ADDRESS: _____

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

SCHOOL: _____ GRADE LEVEL: _____

GPA: _____ ACADEMIC PROBLEMS? _____

BEHAVIOR PROBLEMS AT SCHOOL? YES NO IF YES, DESCRIBE: _____

PARENTS' MARITAL STATUS: MARRIED DIVORCED SINGLE WIDOWED RE-MARRIED

WHO LIVES IN THE HOME WITH THE CHILD? _____

PETS AT HOME? YES NO IF YES, TYPE: _____

DOES SOMEONE SMOKE IN THE HOME? YES NO

HOBBIES/EXTRACURRICULARS: (PLEASE LIST)

DEVELOPMENTAL MILESTONES PLEASE IDENTIFY ANY PAST PROBLEMS OR CONCERNS

GROSS MOTOR SKILLS (ROLLING OVER, WALKING, CLIMBING) GOOD CONCERN

FINE MOTOR SKILLS (SCRIBBLES, USES FINGERS, WRITES WELL) GOOD CONCERN

SOCIAL SKILLS (PLAYS PAT-A-CAKE, IMITATES ACTIONS, PLAYS WELL) GOOD CONCERN

LANGUAGE SKILLS (LAUGHS, SAYS MAMA/DADA, KNOWS ABC'S, CLEAR SPEECH) GOOD CONCERN

VISION (REGARDS FACE, LOOKS AROUND, NO CROSSING OF EYES) GOOD CONCERN

HEARING (RESPONDS TO VOICE, MULTIPLE EAR INFECTIONS, SPEECH GOOD) GOOD CONCERN

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BLOOD CLOTS/DVT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BREAST CANCER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COLON CANCER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HYPERTENSION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
KIDNEY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STROKE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SUDDEN DEATH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PATIENT INFORMATION

NAME: _____ HOME PHONE: _____
 SS NUMBER: _____ CELL PHONE: _____
 ADDRESS: _____ GENDER: _____
 EMAIL ADDRESS: _____ DATE OF BIRTH: _____
 EMERGENCY CONTACT: _____ PHONE: _____
 RELATIONSHIP TO PATIENT: _____

ETHNICITY OF PATIENT:

- HISPANIC ORIGIN
- NON-HISPANIC ORIGIN
- UNKNOWN
- DECLINED TO ANSWER

PREFERRED LANGUAGE:

- ENGLISH SPANISH
- OTHER: _____

RACE OF PATIENT:

- AMERICAN INDIAN/ ALASKAN NATIVE
- ASIAN
- BLACK/ AFRICAN AMERICAN
- NATIVE HAWAIIAN/ OTHER PACIFIC ISLANDER
- WHITE
- UNKNOWN
- DECLINED TO ANSWER

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

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: _____

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.

THE BENEFIT TO YOU:

- > LESS CONFUSION OVER HANDWRITTEN PRESCRIPTIONS OR UNCLEAR PHONE CALLS
- > REDUCED POSSIBILITY OF MEDICAL ERRORS
- > LESS CHANCE OF ADVERSE DRUG REACTIONS
- > FEWER TRIPS TO DROP OFF AT THE PHARMACY
- > A SAFER, FASTER, EASIER WAY TO GET YOUR PRESCRIPTION FILLED

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/REVOCAION 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:

- | | | |
|---|--|--|
| <input type="checkbox"/> ALL PHI IN RECORD | <input type="checkbox"/> PHYSICIAN ORDERS | <input type="checkbox"/> DEMOGRAPHICS |
| <input type="checkbox"/> HISTORY AND PHYSICAL | <input type="checkbox"/> LABORATORY | <input type="checkbox"/> REHABILITATION SERVICES |
| <input type="checkbox"/> CONSULT REPORT | <input type="checkbox"/> IMAGING/RADIOLOGY | <input type="checkbox"/> SPECIAL TEST/THERAPY |
| <input type="checkbox"/> OPERATIVE REPORT | <input type="checkbox"/> NURSING NOTES | <input type="checkbox"/> ITEMIZED BILL/CLAIMS |
| <input type="checkbox"/> PROGRESS NOTE | <input type="checkbox"/> MEDICATION RECORD | <input type="checkbox"/> 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.**