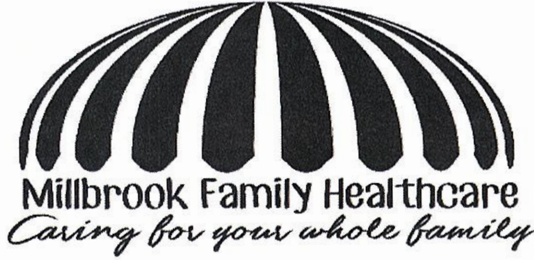
Patient ID#_______________
Pharmacy __________________________ Copay$________



IS TODAY'S VISIT WORK RELATED? IF YES – PLEASE LET THE FRONT DESK KNOW

Patient Last Name: ________________________ **First Name:** ________________________ **MI:** ______

Date of Birth: ____/____/____ **Social Security Number:** ______-______-______ **Gender: M / F**

Language: ____________ **Race:** ______________ **Marital Status: (circle one) M S D W**

Mailing Address: ____

City: ______________________ **State:** ________ **Zip Code:** ____________

Email: ______________________________ **Cell Phone** ______________

Primary or Previous Doctor: ________________ **Reason for Visit:** ________________

Best Way to Reach You: Patient Portal Physical Mail E-mail Cell Home Work (circle one)

Emergency Contact:

Name: ____________________ **Phone Number:** _____-_____-_______ **Relationship** __________

Primary Insurance Policy Holder / Party Responsible for Payment if DIFFERENT from information above:

Name: ______________________________ **Relationship to Patient:** ______________

Date of Birth: ____/____/____ **Gender: M / F Social Security Number:** ______-______-______

Responsible Party Address, Phone, and Email if DIFFERENT from above

Mailing Address: ____

City: ______________________ **State:** ________ **Zip Code:** ____________

Phone: ____________________ **Email:** ____________________________

I authorize Millbrook Family Healthcare to release my Private Health Information to the individuals below (please list):

Name: ______________________________ **Relationship** __________ **Exp. Date** ________

Name: ______________________________ **Relationship** __________ **Exp. Date** ________

How Did You Hear About Us (Circle One)?

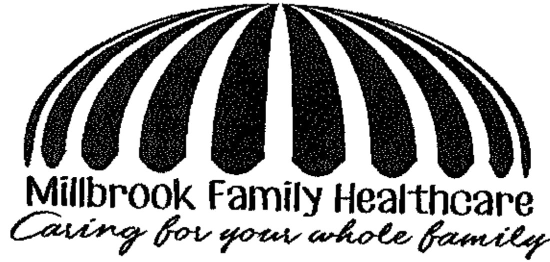
Drive By/Saw Sign Event Facebook Friend/Family Internet Search Mail Radio Other ____________

Privacy, Billing, and Other Important Information

I authorize Millbrook Family Healthcare to contact me: (1) at the number(s) listed above and leave a voicemail if I am unavailab e; (2) send text messages to phone number(s) listed above; (3) send email messages to email(s) listed above. I have read and reviewed Millbrook Family Healthcare's Billing Policies and Privacy Policy. We will file a claim with your insurance company for the services provided, in the event of non-payment you will be responsible the charges incurred today. I authorize release of any information concerning my (or my child's) health care and treatment for the purpose of evaluating and administering claims of insurance benefit. I authorize Millbrook Family Healthcare to charge my credit card for charges allowed, but not paid for, by my insurance company (patient responsibility). I hereby authorize payment of insurance benefits, otherwise payable directly to me, to the Provider who has assigned those to Millbrook Family Healthcare. I consent to care and treatment of myself (or my child) by the attending provider and his/her associates and assistants.

X____ Date: ______________

(Signature of patient or parent/guardian of minor)



HIPAA PATIENT CONSENT FORM

HIPAA PATIENT CONSENT FORM Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The patient understands that: Protected health information may be disclosed or used for treatment, payment, or health care operations. The Practice has Notice of Privacy Practices and that the patient has the opportunity to review this Notice. The practice reserves the right to change the Notice of Privacy Practices. The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions. The patient may revoke this Consent in writing at any time and all future disclosures will then cease. The Practice may condition receipt of treatment upon the execution of this Consent.

This consent was signed by:
Printed Name-Patient or Responsible Party ______________________________

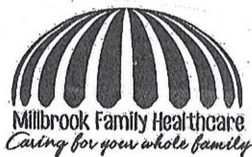
Patient Signature or Responsible Party ______________________________

Relationship to patient (if other than patient) ______________________________

Witness Signature:______________________________

Printed Name-Practice Representative ____________________

Date _______/_____/__________



______________________ Name ____________ Date

Adult Health History Form

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you cannot remember specific details, please provide your best guess. **Thank You.**

Date of Birth: ____________ How would you rate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Main reason for today's visit: ______________________________

Other concerns: ______________________________

REVIEW OF SYMPTOMS: Please check any current symptoms you have.

Constitutional
____ Unexplained weight loss/gain
____ Recent fevers/sweats
____ Unexplained fatigue/weakness
____ Recent chills/cold sweats

Cardiology
____ Chest pains/discomfort
____ Palpitations
____ Decreased exercise tolerance

Dermatology
____ Rash
____ New or change in mole

Endocrinology
____ Cold/heat intolerance
____ Increase thirst/appetite

ENT
____ Change in hearing
____ Congestion
____ Sinus pain
____ Sore throat

Hematology/Lymph
____ Unexplained lumps
____ Easy bruising/bleeding

Genitourinary
____ Painful/bloody urination
____ Leaking urine
____ Nighttime urination
____ Discharge: penis or vagina
____ Concern with sexual functions

Gastroenterology
____ Heartburn/reflux
____ Bloody stools
____ Change in bowel movement
____ Nausea/vomiting/diarrhea
____ Pain in abdomen

Musculoskeletal
____ Muscle/joint pain
____ Recent back pain
____ Weakness
____ Swollen joints

Neurology
____ Memory loss
____ Headaches
____ Fainting
____ Numbness/tingling in hands/feet
____ Loss of balance

Opthalmology
____ Change in vision
____ Eye pain

Psychology
____ Anxiety/stress
____ Sleep problems

Respiratory
____ Cough/wheeze
____ Coughing blood
____ Short of breath with exertion
____ Pain with breathing

Women
____ No periods
____ Heavy periods
____ Painful periods
____ Irregular periods
____ Unusual vaginal bleeding

Date of last period: ____________
Menopause at age: ____________

In the past month, have you had little interest or pleasure in doing things, or felt down, depressed or hopeless? ☐ Yes ☐ No

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

Medication/Vitamin/Supplement	Dose/Strength (e.g., mg/pill)	How many times per day

ALLERGIES: Do you have allergies or reactions to:

Medications	Reaction	**Foods**	Reaction

IMMUNIZATIONS: Date of most recent record.

Hepatitis A ______ Hepatitis B ______ Influenza (flu shot) ______ MMR ______ Pneumovax (pneumonia) ______
Meningitis ______ Tetanus (Td) ______ Varicella (chicken pox) shot or illness ______ Tdap (tetanus & pertussis) ______

HEALTH MAINTENANCE: Date of most recent record.

Cholesterol ______ Abnormal? □ Yes □ No
Colonscopy ______ Abnormal? □ Yes □ No
Bone Density Scan ______ Abnormal? □ Yes □ No
Women: Mammogram ______ Abnormal? □ Yes □ No Pap Smear ______ Abnormal? □ Yes □ No
Men: PSA (prostate) ______ Abnormal? □ Yes □ No

MEDICAL HISTORY:

Major Illnesses: (i.e. high blood pressure, high cholesterol, depression, etc.)	Year of Diagnosis	Currently Treated?
1		
2		
3		
4		
5		
6		
7		
8		

SURGICAL HISTORY:

Surgeries:	Year of Surgery	Reason for Surgery
1		
2		
3		
4		
5		
6		
7		
8		

FAMILY HISTORY: Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism ______
Cancer, specify type ______
Heart disease ______
Depression/suicide ______
Genetic disorders ______
Diabetes ______
Kidney disease ______
High cholesterol ______
High blood pressure ______
Stroke ______
Bleeding/clotting disorder ______
Asthma/COPD ______
Anxiety ______
Other: ______

SOCIAL HISTORY:

Tobacco Use

Cigarettes □ Never □ Quit Date ______
□ Current Smoker: packs/day ______ # of yrs ______
Other Tobacco: □ Pipe □ Cigar □ Snuff □ Chew
Are you interested in quitting? □ Yes □ No

Alcohol Use

Do you drink alcohol? □ Yes □ No # drinks/week ______
Is your alcohol use a concern for you or others? □ Yes □ No

Drug Use

Do you use any recreational drugs? □ Yes □ No
Have you ever used needles to inject drugs? □ Yes □ No

Sexual Activity

Sexually active: □ Yes □ No □ Not currently
Current sex partner(s) is/are: □ male □ female
Birth control method: ______ □ None needed
Have you ever had any sexually transmitted diseases (STDs)?
□ Yes □ No
Are you interested in being screened for sexually transmitted diseases? □ Yes □ No

Caffeine Intake: □ None □ Coffee/tea/soda ______cups/day
Weight: Are you satisfied with your weight? □ Yes □ No
Diet: How do you rate your diet? □ Good □ Fair □ Poor
Do you eat or drink four servings of dairy or soy daily or take calcium supplements? □ Yes □ No
Exercise: Do you exercise regularly? □ Yes □ No
What kind of exercise? ______
How long (minutes) ______ How often? ______
If you do not exercise, why? ______

SOCIOECONOMICS:

Occupation: ______
Employer: ______
Martial Status: □ Single □ Partner/Married □ Divorced
□ Widowed □ Other: ______
Number of children/ages: ______

WOMENS HEALTH HISTORY

Preganicies: ______
Deliveries: ______
Abortions: ______
Miscarriages: ______
Age at start of periods: ______ Age at end of periods: ______

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: ______________________ **Date of Birth:** ______________________

Phone: H) ______________________ **Phone: W)** ______________________

Address: ______________________ **City/State/Zip:** ______________________

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: ______________________ **Facility Phone:** ______________________

Facility Address: ______________________ **Facility Fax:** ______________________

City, ST, Zip: ______________________

Dates and Type of information to disclose:

☐ 2 years prior from last date seen
☐ Dates Other: ______________________
☐ Specific Information Requested:
____

The purpose of disclosure is:

☐ Change of Insurance or Physician
☐ Continuation of Care (e.g., VA Med Ctr)
☐ Referral
☐ Other______________________

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: Millbrook Family Healthcare

Address: 2588 Main Street

City, State, Zip: Millbrook, AL 36054 ☐ **Please mail records.**

Fax: 334-285-5705 **Phone:** 334-285-5703 ☒ **Please fax records.**

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation 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 revoked, this authorization will expire on the following date, event, or condition: ______________. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X______________________ ______________________

Signature of Patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.)

Date

______________________ ______________________

Printed name of Authorized Representative

Relationship / Capacity to patient

____

Address and telephone number of authorized representative