PATIENT HISTORY – PLEASE PRINT   Date: ____________

Patient Name: ____________   Birth Date: ____________   Social Security No: ____________

Height: ________ Weight: ________ Marital Stat: S M D W   Referred By: ____________

Chief Complaint(s): ____________

Please list all major symptoms: ____________

DRUG ALLERGIES: ____________

LIST ALL MEDICATIONS YOU TAKE NOW: ____________

____

Previous Surgeries and Approximate Year: ____________

Hospitalizations, Diagnosis and Approximate Year: ____________

REVIEW OF SYSTEMS (Please circle all answers). IN THE PAST FEW MONTHS, HAVE YOU HAD:

H & N

Eye disease or eye pain	No	Yes
Dry Eyes	No	Yes
Ear disease, impaired hearing	No	Yes
Trouble with nose, sinuses, mouth, throat	No	Yes
Trouble swallowing	No	Yes
Glaucoma	No	Yes

CVR

Chronic/frequent cough	No	Yes
Chest pain or angina	No	Yes
Spitting-up of blood	No	Yes
Nightsweats, chills, fever	No	Yes
Shortness of breath	No	Yes
Palpitation or fluttering of heart	No	Yes
Heart Murmur	No	Yes
Swelling of hands, feet or ankle	No	Yes
Rheumatic Fever	No	Yes
High Blood Pressure	No	Yes
Low Blood Pressure	No	Yes
Heart attack	No	Yes
Emphysema	No	Yes

GI

Stomach trouble, ulcer or pain	No	Yes
Indigestion, vomiting, nausea	No	Yes
Liver or gallbladder disease	No	Yes
Hemorrhoids or rectal bleeding	No	Yes
Any black bowel movements	No	Yes
Constipation or diarrhea	No	Yes
Recent change in bowel action	No	Yes
Cirrhosis of liver	No	Yes
Jaundice (yellow jaundice)	No	Yes

GU

Kidney disease or stone	No	Yes
Bladder disease	No	Yes
Albumin, sugar, pus or blood in urine	No	Yes
Difficulty in controlling urine	No	Yes
Difficulty or pain on urination	No	Yes
Urinate more often than usual	No	Yes
Venereal disease	No	Yes

ENDO

Abnormal thirst	No	Yes
Thyroid disease	No	Yes
Any diabetes in family?	No	Yes

List: ____________

Have you ever taken insulin or tablets for diabetes? No Yes

ENDO

Have you ever taken hormone shots or tablets? No Yes

Please specify: ____________

B & J No Yes

Arthritis or rheumatism	No	Yes
Broken Bones Specify:	No	Yes

HEMO No Yes

Anemia (low blood)	No	Yes
Do you bleed or bruise easily?	No	Yes
Any family member a free bleeder?	No	Yes
IV drug abuse	No	Yes
Exposure to AIDS	No	Yes
AIDS	No	Yes

NEURO

Fainting spells	No	Yes
Loss of consciousness	No	Yes
Convulsions/Epilepsy	No	Yes
Dizziness	No	Yes
Paralysis attacks	No	Yes
Migraine headaches	No	Yes
Nervous breakdown	No	Yes
Depression	No	Yes

INTEG

Moles that have changed	No	Yes
Fever blisters	No	Yes
Non-healing sore	No	Yes

BREAST No Yes

Pain in breast	No	Yes
Drainage from nipples	No	Yes
Change in breast skin	No	Yes
Fibrocystic disease	No	Yes
Biopsies	No	Yes
How many?______		
Cancer of breast	No	Yes
Family member(s) with breast cancer?______	No	Yes

ALLERGIES

Hay fever	No	Yes
Hives or eczema	No	Yes
Food allergies	No	Yes

Please list all medication allergies: ____________

____

PREGNANCIES

Total Number: ______

How many children born alive? ______

Are you pregnant now? No Yes

Could you be pregnant now? No Yes

Date of last menstrual cycle: ______

TOBACCO

Do you smoke cigarettes? No Yes

Packs per day: ______

Cigar, pipe or chewing tobacco? No Yes

FAMILY HISTORY

Father: Alive? Yes/No Age: ____

General Health: ____________

Cause of Death: ____________

Mother: Alive? Yes/No Age: ____

General Health: ____________

Cause of Death: ____________

Siblings: How many? ____

Alive? Yes/No Ages: ____

General Health: ____________

Cause of Death: ____________

Spouse: Alive? Yes/No Age: ____

General Health: ____________

Cause of Death: ____________

Children: How many? ____

Alive? Yes/No Ages: ____

General Health: ____________

Cause of Death: ____________

PATIENT INFORMATION – PLEASE PRINT

Date: ______________________

Patient's Name: ______________________________ Sex: ____
Last First Middle

Home Address: ______________________________
City State Zip

Driver's License Number: ____________________

Birth Date: __________ Social Security No: __________ Home Phone: ( ) __________

Email Address: ______________________________

Occupation: __________ Employer: __________ Emp. Phone: ( ) __________
Cell Phone: ( ) __________

Spouse Name: __________ Spouse Employer: __________ Phone: ( ) __________

Occupation: __________ __________ Cell Ph: ( ) __________

Nearest Relative Not Living With You: ______________________________

Relationship To Patient: __________ Phone: ( ) __________

Family Physician: __________ Phone: ( ) __________

MEDICAL INSURANCE INFORMATION – Must Be Completed

Primary Insurance Co: __________ Contract No: __________

Insured's Full Name: __________ Birth Date: __________

Effective Date: __________ Group No: __________

Secondary Insurance Co: __________ Contract No: __________

Insured's Full Name: __________ Birth Date: __________

Effective Date: __________ Group No: __________

Person Responsible for Bill IF OTHER THAN PATIENT: __________

Relationship to Patient: __________ Home Phone: ( ) __________

Employer: __________ Phone: ( ) __________

MEDICAL COST AGREEMENT

The Patient and Responsible Party listed above hereby agree to any and all amounts and charges submitted by The Duquette Center for services rendered during the course of treatment for the Patient, including hospitalization, unless The Duquette Center is otherwise obligated to accept payment solely from a third-party. The Patient and the Responsible Party hereby acknowledge, understand and agree that they are financially responsible to The Duquette Center, even though there may be insurance or other third-party coverage, and agree that failure to make payment when requested is the basis for legal action, and agree to pay any and all cost of collection, including a reasonable attorney fee. The Patient and Responsible Party hereby acknowledge their understanding that the payment is due in full upon receipt of invoice statement, and agree to pay 1.5% per month late charge on all accounts over thirty (30) days past due. The Patient and the Responsible Party recognize and agree that their obligations to make payment are joint and severable and that The Duquette Center may pursue either or both parties for payment, and that they, and not any insurance company, are solely responsible for the entire bill, even though the cost of this medical care may exceed the amount reimbursed by third-party insurers or payors.

____
Patient

____
Date

____
Responsible Party

____
Date

Notice of Privacy Policy Consent Form

As required by the Health Insurance Portability and Accountability Act (HIPAA)

Our Notice of Privacy Policy provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy from our Front Office Assistant or Office Manager. 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 are bound by our agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

- ❑ I request the following restrictions to the use or disclosure of my health information: ______________________________
____
____

- ❑ I request and received a copy of the Notice of Privacy Policy in its entirety for The Duquette Center.

____
Signature

____
Witness

____
Date

NPP Effective April 14, 2003