Wellstone HEALTH PARTNERS

PATIENT INFORMATION

Patient's Last Name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Ethnicity: ❑ Declined ❑ Hispanic or Latino ❑ Non-Hispanic or Latino ❑ Unknown	Race (optional): ❑ Declined ❑ American Indian / Alaska Native ❑ Asian ❑ White ❑ Other ❑ Black or African American ❑ Native Hawaiian/Pacific Islander ❑ Unknown	Social Security #	Birth date: / /	Age:	Sex: ❑ M ❑ F

Primary Language Spoken: _____	Secondary Language: _____

Street Address:	Home Phone # ( )	Cell # ( )

City:	State:	Zip Code:	Email address:

Occupation:	Employer:	Work Phone # ( )

Referred to clinic by: (please check one box)	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:

Preferred Pharmacy (Please include name & address)

❑ Local Pharmacy: _____

❑ Mail Order: _____

INSURANCE INFORMATION

Primary Insurance Carrier:	*Who is the insured?*	*Relationship to the Insured:*
Member ID #	*Group Number:*	*Birth Date:*
Secondary Insurance Carrier:	*Who is the insured?*	*Relationship to the Insured:*
Member ID #	*Group Number:*	*Birth Date:*

GUARANTOR / RESPONSIBLE PARTY

Name and address:	DOB: SS#:	Home Phone: Work Phone:

IN CASE OF EMERGENCY

Name of friend or relative:	Relationship to patient:	Home Phone: Work Phone:

This information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize ***Wellstone Health Partners*** *or my insurance company to release any information required to process my claims*

Patient/Guardian Signature Date:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

NAME *(Last, First, M.I.):* ☐ M ☐ F		**DOB:**
MARITAL STATUS: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
PREVIOUS OR REFERRING DOCTOR:		**DATE OF LAST PHYSICAL EXAM:**

PERSONAL HEALTH HISTORY

CHILDHOOD ILLNESS: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

LIST ANY MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED

SURGERIES

Year	Reason	Hospital

OTHER HOSPITALIZATIONS

Year	Reason	Hospital

HAVE YOU EVER HAD A BLOOD TRANSFUSION? IF ***YES***, WHEN? : How many?:	☐ Yes	☐ No

LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS AND INHALERS		
Name the Drug	Strength	Frequency Taken
ALLERGIES TO MEDICATIONS		
Name the Drug	Reaction You Had	

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				

Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No
Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
FATHER			Children	☐ M ☐ F	
MOTHER				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**GRANDMOTHER** *Maternal*		
	☐ M ☐ F		**GRANDFATHER** *Maternal*		
	☐ M ☐ F		**GRANDMOTHER** *Paternal*		
	☐ M ☐ F		**GRANDFATHER** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Patient Name:_____

Address: _____

Date of Birth:_____ Social Security Number: _____

Authorizes ***Wellstone Health Partners***, to release the following medical information to:

Name of Person (family member, caregiver, etc.) _____

Address: _____

City/State/Zip_____ Phone Number: _____

□ Confer orally with person(s) listed below about my medical conditions: (family member, caregiver, etc.)

Name of Person: _____

May we contact you at work and/or leave a message? □ Yes □ No

May we contact you at home and/or leave a message regarding appointments? □ Yes □ No

This authorization shall be valid from the date of signature. The patient can revoke this authorization in writing at any time.

The patient agrees that a photocopy of this authorization may be considered valid. □ Yes □ No

_____ _____

Signature of Patient or Representative Relationship to Patient

_____ _____

Date Signed Witness Signature

Office Policies

Patient Name: _____ **Date of birth:** _____

As a patient of Wellstone Health Partners I understand that the following policies are currently in effect:

- A $30.00 fee will be assessed on all returned checks. Returned checks will have to be paid in cash within 10 days of notification. I also understand if outstanding check is not resolved within the 10 day limit I may be dismissed from the practice.
- A $25.00 may be applied to my account for any missed appointments I do not cancel more than 24 hours in advance. I also understand this fee, if assessed, must be paid prior to my next visit with Wellstone Health Partners.
- I understand payment is due at time services are rendered, unless prior payment arrangements are made with the office. This includes any deductible, copayment or co-insurance amounts. Any balances not paid by my insurance carrier are my responsibility to resolve. I further understand that balances due must be paid in a timely manner to avoid further collection action. I understand if my account is forwarded to a collection agency I may be dismissed from the practice, my outstanding balance may be reported to the credit bureau and my balance may be charged an 18% interest rate per year until balance is resolved.
- **I am to present proof of my insurance coverage at *every* office visit**.
- **I understand if I am more than 15 minutes late for my scheduled appointment I *may* be asked to reschedule for another day.**
- **Finally, I understand that I am to allow at least 48 hours for my prescription refills**.

My signature confirms I have read & understood the above office policies and have had an opportunity to ask questions regarding any concerns I may have about these policies.

_____ _____

Patient Signature **Date**

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Wellstone Health Partners to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of Wellstone Health Partners

I have also been informed of and given the right to review and secure a copy of the clinic's *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that Wellstone Health Partners reserves the right to change the terms of this notice from time to time and that I may contact them at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that Wellstone Health Partners is not required to agree to these requested restrictions. However, if they do agree, they are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoked this consent is not affected.

_____ _____

Signature of Patient or Representative Date

_____

Printed Name

_____

Relationship to Patient

Wellstone
HEALTH PARTNERS

PERMISSION TO RELEASE MEDICAL RECORDS	
Name:	
Date of Birth:	Social Security #:
FROM:	**TO: Wellstone Health Partners**
	Dr. _____
	Address_____
	City/State_____
	Phone #_____
	Fax #_____

Release records for the following dates of service: _____

The following information is requested and may be released:		
□ **All Records**	□ Operative Reports	□ Medication Information
□ Medical Summary	□ EKG Reports	□ X-Ray Reports
□ Progress Notes	□ Lab Reports	□ Other

I □ ***do*** □ ***do not*** **consent to transmission of my medical records via fax machine.**

I recognize the information disclosed may contain mental health information that is protected by state and federal laws**.**
I □ ***do*** □ ***do not*** **consent to the disclosure of this information.**

Signature:_____**Date:**_____

I recognize the information disclosed may contain drug/alcohol information that is protected by state and federal laws**.**
I □ ***do*** □ ***do not*** **consent to the disclosure of this information.**

Signature:_____**Date:**_____

I recognize the information disclosed may contain information regarding sexually transmitted diseases or HIV/Aids testing**.**
I □ ***do*** □ ***do not*** **consent to the disclosure of this information.**

Signature:_____**Date:**_____

PERMISSION IS HEREBY GRANTED FOR RELEASE OF INFORMATION	
Signature of Patient or Representative:	
Relationship to Patient:	Date: