Patient Information

(10/18/2012)

Personal / Work

Cell Phone: _____

Patient Name: _____ Hm. Phone: _____

Address: _____ City: _____ State: ___ Zip: ___

Sex: _ Age: _ Birth Date: _____ Social Security #: _____

Email: _____ Married: ☐ Spouse: _____

Employer: _____ Job: _____ Wk. Phone: _____

Emp. Address: _____ City: _____ State: ___ Zip: ___

Initial Visit / Responsible Party

Reason for visit: _____

Due to injury: ☐ On the Job: ☐ Auto accident: ☐ Injury date: _____

Referred by: _____ Family doctor: _____

Rel/Friend: _____ Relationship: _____ Phone: _____

Responsible party if patient is minor -
Guardian:_____ Relationship: _____ Phone: _____

Address: _____ City: _____ State: ___ Zip: ___

Insurance / Assignment

Please give insurance card to Office Manager to copy

I received a copy of the Privacy Practice. Signature _____ Date: _____

I hereby assign all medical and surgical benefits to include major medical benefits to which I am entitled, including private insurance, and any other health plans to Hamlet Newsom, M.D. I transfer my title of reimbursement from my insurance company to Hamlet Newsom, M.D. I hereby agree to pay any and all charges that exceed or that are not covered by insurance. I authorize said assignee to release information necessary to secure payment. I authorize the release of my medical records or insurance claims to be sent via Fax. This assignment will remain in effect until revoked revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Signature _____ Date: _____

Witness _____

Health Information

(10/18/2012)

Patient Name: _____ Weight: ___

Height: _____

Medical History

CARDIAC (x all that apply)

High blood pressure: ☐ Chest pain: ☐ Dizziness: ☐ Fainting: ☐ High cholesterol: ☐ Pacemaker: ☐
Murmurs: _ Valve disorder: _ Abnormal heart rhythm: ☐ Rhythm type: _____
Other: _____

PULMONARY (x all that apply)

Spitting up blood: ☐ Asthma: ☐ Shortness of breath: ☐ Upper respiratory infection ☐ Wheezing: ☐
Sleep apnea: ☐ Pneumonia: ☐ COPD/Emphysema: ☐ Other: _____

NEURO-MUSC-ORTHO (x all that apply)

Cramps: ☐ Numbness: ☐ Joint pain/swelling: ☐ Tingling: ☐ Spasms: ☐ Muscle weakness: ☐
Stiffness: ☐ Seizures: ☐ Stroke/TIA: ☐ Rheumatoid arthritis: ☐ Other: _____

GI (x all that apply)

Diarrhea: ☐ Ulcer: ☐ Reflux: ☐ Nausea: ☐ Vomiting: ☐ Hemorrhoids: ☐ Constipation: ☐
Blood in stool: ☐ Other: _____

GU (x all that apply)

Frequency: ☐ Incontinence: ☐ Discharge: ☐ Urgency: ☐ Discomfort: ☐ Blood in urine: ☐ Stones: ☐
Dribbling: ☐ Recent UTI: ☐ Abnormal vaginal bleeding: ☐ Kidney stone: ☐
Other:_____

SKIN (x all that apply)

Rashes: ☐ Lesions: ☐ Bruising ☐ Delayed healing ☐ Non healing ☐ Psoriasis ☐ Mole change: ☐
Other:_____

ENDOCRINE (x all that apply)

Diabetes: ☐ Diabetes type: ___ Frequency of checks: _____ Blood glucose: ___
Hyperthyroid: ☐ Hypothyroid: ☐ Other: _____

HEMATOLOGY/IMMUNE (x all that apply)

Steroid use: ☐ Cancer: ☐ Cancer type: _____ If breast cancer - L/R/B: _ Anemia: ☐
Sickle cell: ☐ Bleeding disorder: ☐ Gout: ☐ Autoimmune: ☐ HIV/AIDS: ☐ Hepatitis: ☐
Organ transplant: ☐ Other: _____

MENTAL (x all that apply)

Depression: ☐ Eating disorder (Anorexia/Bulima): ☐ Post traumatic stress: ☐ Anxiety disorder: ☐
Other: _____

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SURGICAL

List previous operations and dates: _____

_____

Any problems with surgery/anesthesia? _____

Any blood transfusion? _

MEDICATIONS

Current medications: _____

(including aspirin, birth control, and herbal)

ALLERGIES

List any adverse reactions to medications, drugs, or anesthesia: _____

Have you taken aspirin containing drugs in the past two weeks?

Ever had a reaction to Latex, Betadine, or surgical tape? _____

SOCIAL

Do you smoke ☐ packs/day: _

Do drink alcohol - Never: ☐ Occasionally ☐ Regularly: ☐ Amount/day: _____

List any recreational drugs, such as marijuana, or cocaine: _____

Date of last menstrual period: _____

FAMILY

Anesthesia problems: ☐ Diabetes: ☐ High blood pressure: ☐ Stroke: ☐

Heart: ☐ Seizures: ☐ Cancer: ☐ Cancer type: _____

Kidney problems: ☐ Bleeding: ☐ Arthritis: ☐ Crohn's: ☐ TB: ☐

Anemia: ☐ Allergies: ☐ Depression: ☐

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Patient Consent Form

Patient consent for use of credit or debit cards, and for financial disclosure of protected health information

It may become necessary to release your protected health information to financial entities such as credit or debit card companies, banks, or financial institutions when requested to facilitate payment.

Services that are paid for with a credit card, debit card, or by third-party financing are not eligible for payment challenges after services have been rendered. By signing this form I am irrevocably consenting to allow Dr. Hamlet Newsom to use and disclose my protected health information to any credit card company, bank, or financing organization, when and if they request such information to process an account and otherwise assist with payment.

_____ I will not challenge credit or debit cards, or any other arranged financing, once the services have been provided. This practice encourages complete post-op care and follow-up to address any issues that might arise. These and other items are further discussed in our Revision Policy.

_____ I agree that this non credit card challenge agreement is irrevocable.

_____

Signature of patient or legal guardian Date

_____

Print patient's name Date

_____

Witness Signature Date

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