92 N. High Street, Suite 260
Dublin, OH 43017
Phone: 614.442.7610
Fax: 614.326.4663

Patient Information

Patient Name: _____ Preferred Language: _____

Address: _____ City: _____ State: ____ Zip: _____

Cell Phone: _____ Home Phone: _____

Date of Birth: _____ Ethnicity: _____ Gender: _____

Email Address: _____

Employer: _____ Address: _____

Occupation: _____ Work Phone: _____

Preferred Pharmacy/Street: _____ Pharmacy Phone: _____

Emergency Contact

Name: _____ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Insurance Information

Do you have insurance coverage? ☐ Yes ☐ No If yes, please answer the following insurance questions.

Primary Insurance: _____ Policy Number: _____

Subscriber's Name: _____ Group Number: _____

Subscriber's Date of Birth: _____ Subscriber's Relationship to Patient: _____

Assignment and Release

I, _____, have insurance coverage and assign all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Insured/Guardian of Insured Date

Section I: Allergies and Sensitivities

Are you allergic to any medications or local anesthesia? ☐ No ☐ Yes, please list:

_____

_____

Section II: Medications

Are you taking any medications, vitamins, or herbal supplements? ☐ No ☐ Yes, please list:

	Medication	Dose	How long have you been taking?
1.			
2.			
3.			
4.			
5.			

Section III: Specific Medical History

Are you pregnant? ☐ No ☐ Yes Height: _____ Weight: _____

Have you had or do you still have:	No	Yes	Description
Asthma	☐	☐	
Emphysema	☐	☐	
High Blood Pressure	☐	☐	
Heart Disease	☐	☐	
Hepatitis or Liver Disease	☐	☐	
Kidney Disease	☐	☐	
Diabetes	☐	☐	
Epilepsy or Seizures	☐	☐	
Stroke	☐	☐	
Sleep Apnea	☐	☐	If yes, CPAP Setting: _____
Mental Illness	☐	☐	
Skin Infection	☐	☐	
MRSA	☐	☐	
Problem Scarring	☐	☐	
Issues with Bleeding/Bruising	☐	☐	
Blood Clots	☐	☐	
Have you been advised to or had psychiatric care?	☐	☐	

Other(s) not listed: _____

Section VI: Family History

Have any blood relatives had any of the following?	No	Yes	Description
Cancer	☐	☐	
Bleeding Problems or Blood Clots	☐	☐	
Heart Disease	☐	☐	
High Blood Pressure	☐	☐	
Repeated Infections	☐	☐	
Chronic Lung Disease	☐	☐	
Asthma	☐	☐	
Severe Allergies	☐	☐	
Kidney Disease	☐	☐	
Mental Illness	☐	☐	
Seizures	☐	☐	
Migraine Headaches	☐	☐	
Diabetes	☐	☐	
Thyroid Problems	☐	☐	
Obesity	☐	☐	

Do you have any blood relative(s) who had anesthesia complications of any kind? ☐ No ☐ Yes, please describe:

_____

_____

Section III: Social History

1. Do you smoke? ☐ No ☐ Yes, how often? _____
2. Do you drink? ☐ No ☐ Yes, how often? _____
3. Do you use illicit drugs? ☐ No ☐ Yes, what type? _____
4. Do you have children? ☐ No ☐ Yes, how many? _____

Section IV: Surgery History

Have you ever had surgery: ☐ No ☐ Yes, please list (include dates if possible):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Section V: Systems Review

In the past month, have you experienced any of the following?

Symptom	No	Yes		Symptom	No	Yes
Weight Gain	☐	☐		Skin Infections	☐	☐
Weight Loss	☐	☐		Hair Loss	☐	☐
Fatigue	☐	☐		Painful Urination	☐	☐
Fevers	☐	☐		Depression	☐	☐
Joint Pain	☐	☐		Anxiety	☐	☐
Joint Swelling	☐	☐		Appetite Changes	☐	☐
Muscle Pain	☐	☐		Hoarseness	☐	☐
Weakness	☐	☐		Sore Throat	☐	☐
Numbness	☐	☐		Nausea/Vomiting	☐	☐
Rashes	☐	☐		Stomach Pain	☐	☐
Skin Infections	☐	☐		Diarrhea	☐	☐
Dry Eyes	☐	☐		Constipation	☐	☐
Vision Changes	☐	☐		Chest Pain	☐	☐
Ringing in Ears	☐	☐		Cough	☐	☐
Changes in Hearing	☐	☐		Difficulty Breathing	☐	☐
Skin Rashes	☐	☐		Fainting	☐	☐

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

_____ _____

Signature of Patient/Legal Guardian Date

Consent to Communicate

Name: _____

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Method	Best Time to Call
☐ Call Cell Phone	☐ Yes ☐ No	☐ Yes ☐ No	☐	
☐ Call Home Phone	☐ Yes ☐ No	☐ Yes ☐ No	☐	
☐ Call Work Phone	☐ Yes ☐ No	☐ Yes ☐ No	☐	
☐ Send Text Message ☐ Text Appointment Reminders ☐ Text Office Specials			☐	
☐ Send Email ☐ Email Appointment Reminders ☐ Email Medical Information ☐ Email Office Specials			☐	
☐ Send Regular Mail ☐ Send to Home Address ☐ Send to Other Address (please list): _____				

If it is okay to leave a message with another person, please list him/her:

Name	DOB	Relationship	Ok to Release Medical Results	Comments
			☐ Yes ☐ No	
			☐ Yes ☐ No	

_____ _____

Signature of Patient/Legal Guardian Date

HIPAA Information and Consent Form

Name: _____

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

_____ _____

Signature of Patient Date