HEALTHfast MEDICAL

PATIENT INFORMATION

Name: **Date of Birth:** **Social Security #** **Sex:**

_____ _____/_____/_____ _____ M / F

First Middle Initial Last

Address: _____

Street or PO Box City State Zip

Cell Phone: _____ **Home Phone:** _____ **Email:** _____

Primary Care Doctor: _____ **Phone #:** _____ **Location:** _____

_____ _____ _____ _____

Emergency Contact **DOB** **Phone #** **Relationship**

Race: Asian African American American Indian Caucasian Other: _____

Ethnicity: Hispanic / Latino Not Hispanic / Latino **Preferred Language:** _____

Today's Visit

Reason For Visit _____

Preferred Pharmacy: _____ **Location:** _____ **Phone #:** _____

Is your visit related to (please circle one): Auto Accident Work-Related N/A

INSURANCE / PAYMENT INFORMATION

Self-Pay Patients: PAYMENT IS DUE AT THE TIME OF SERVICE

PLAN TYPE: **PPO** **HMO**

Insurance Plan: _____ **Subscriber Name:** _____

Member ID: _____ **Subscriber DOB:** _____

Group Number: _____ **Subscriber SSN:** _____

How did you hear about us? Social Media ____ Word of Mouth ____

Other _____

TREATMENT CONSENT AND AUTHORIZATION

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history symptoms, examination and test results, diagnosis, treatment and any plans for the future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment and is a means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying for applying my diagnosis and surgical information to my bill and a means by which a third-party payer can verify by services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I hereby authorize HealthFast Medical to furnish to any designated attorney or insurance company all information necessary to file a health insurance claim form, to obtain reimbursement. *I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance, and any other health plans to HealthFast Medical.* I understand that I am financially responsible for all charges whether paid or not paid by my insurance company. Also, I hereby authorize the disclosure of health information in any data format regarding my treatment during hospitalization and/or outpatient care to HealthFast Medical. I understand that this facility will maintain medical records in accordance with state requirements. By my signature below, you are fully authorized to disclose such information when requested by HealthFast Medical. The foregoing information is true and correct to the best of my knowledge. I authorize HealthFast Medical to provide medical treatment to me in the office.

Signature of Patient/Guardian _____ Date _____

RELEASE OF INFORMATION TO OTHERS (HIPAA)

I authorize HealthFast Medical and its staff to use and disclose the protected health information described below, to the individuals named. These individuals may also pick up prescriptions, medical records and other health related items on my behalf.

What level of information can we release?

☐ All information including specific medications and dosages, lab results and information related to sensitive issues such as sexually transmitted diseases (including but not limited to AIDS and Hepatitis C).

☐ **No information whatsoever.**

To whom can we release information (please list names):

Name _____ Phone # _____ Relation to patient _____

Name _____ Phone # _____ Relation to patient _____

☐ **No one except the patient can obtain information.**

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing that the revocation will not apply to any information already release in response to the authorization.

Signature of Patient/Guardian _____ Date _____

Minor / Guardian Information (Fill only if under 18)

If patient is under the age of 18, please list the name and relation of the individual presenting the patient today:

Name: _____ **Relation to Patient:** _____

Are you a legal guardian to this patient? ☐ **Yes** ☐ **No**

IF NO, is the legal guardian aware that the minor is here to be seen? ☐ **Yes** ☐ **No**

Are you able to provide a complete medical history for the minor? ☐ **Yes** ☐ **No**

Name of Legal Guardian _____ **Phone Number** _____

We will require in most cases written permission by the legal guardian to see a minor, if this is not available please speak to the front desk before continuing paperwork.

INITALS_____ **DATE**_____

MEDICATION ALLERGIES

☐ **No Known Drug Allergies**

Medication Allergies	Response/Symptoms

CURRENT MEDICATIONS

Please list all PRESCRIBED medications. MUST HAVE the Name and Dosage of Medication.

☐ **Not Currently Taking Medication**

MEDICATION	DOSE	TIMES PER DAY	REASON PRESCRIBED

SOCIAL HISTORY

Smoking Status: Former Current Never **Vaping Status:** Former Current Never

Last Menstrual Period: _____

Alcohol Intake: Never Socially Daily **Caffeine Intake:** Never Occasionally Daily

INITALS_____ **DATE**_____

CURRENT / PAST MEDICAL HISTORY

Do you currently, or have you ever had, any of the following?:

	PAST	NOW		PAST	NOW		PAST	NOW
Alcoholism	□	□	Depression	□	□	Kidney Infections	□	□
Allergies	□	□	Diabetes Type 1	□	□	Kidney Stones	□	□
Anemia	□	□	Diabetes Type 2	□	□	Migraines	□	□
Anxiety	□	□	Diabetes - Gestational	□	□	Multiple Sclerosis	□	□
Asthma	□	□	Epilepsy	□	□	Myocardial Infarction	□	□
Atrial Fibrillation	□	□	Fractures	□	□	Obesity	□	□
Blood Transfusions	□	□	Gastric Ulcer	□	□	Osteoarthritis	□	□
CAD	□	□	Gastrointestinal Disease	□	□	Osteoporosis	□	□
Cancer	□	□	GERD	□	□	Pneumonia	□	□
Cardiac Pacer	□	□	Glaucoma	□	□	Neuro Disorder	□	□
Cardiovascular Disease	□	□	Heart Murmur	□	□	Pulmonary Disease	□	□
Congestive Heart Failure	□	□	Hepatitis	□	□	Rheumatic Fever	□	□
Chicken Pox	□	□	High Cholesterol	□	□	Rheumatoid Arthritis	□	□
Cirrhosis	□	□	Hyperlipidemia	□	□	Shingles	□	□
Colitis	□	□	Hypertension	□	□	STD	□	□
COPD	□	□	Hyperthyroidism	□	□	Terminal Illness	□	□
Renal Failure	□	□	Hypothyroidism	□	□	Thyroid Disease	□	□
Crohn's Disease	□	□	Insulin pump	□	□	Transient Ischemic Attack	□	□
Cerebrovascular Accident	□	□	Joint Pain	□	□	Tuberculosis	□	□
Deep Vein Thrombosis	□	□	Kidney Disease	□	□	Valvular Problems	□	□

☐ Other**:** _____ ☐ **NONE OF THESE APPLY TO ME**

Please list any surgeries _____

GENERAL FAMILY HISTORY

CHECK ALL THAT APPLY

- ☐ Alcoholism
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Birth Defects
- ☐ CAD
- ☐ Cardiovascular Disease
- ☐ CHF
- ☐ Cancer:
  TYPE: _____
- ☐ Congenital Anomaly
- ☐ COPD
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ GERD
- ☐ Hypercholesterolemia
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Hypothyroidism
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Multiple Births
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pulmonary Disease
- ☐ Stroke

☐ **NONE OF THESE APPLY TO MY FAMILY** ☐ **UNKNOWN FAMILY HISTORY**

Urinalysis Waiver

Due to insurance benefit changes, your urinalysis screening may not be covered by your health insurance plan. Coverage will vary depending on your benefit plan. The urinalysis fee is $10.00 and if it is not covered under your health plan you will be responsible for the remaining balance.

By signing this consent form, you are acknowledging that you are responsible for the balance from the urinalysis if insurance denies the service.

X_____
Patient Name (printed)

X_____
Patient Signature

X_____
Legal Guardian (if under 18)

X_____
Date

INITALS_____ **DATE**_____