

NORTH COUNTRY FAMILY PRACTICE, P.A. v11/3/11

Date: _____ [] NEW PATIENT - How do you hear about us: [] Friend [] Insurance Company [] _____
[] UPDATE - List other patients this update effects _____

PATIENT INFORMATION:

Name: _____ Date of Birth: _____ Sex: Male Female

Address: _____ City: _____ State _____ Zip: _____

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

Circle Order of Preference 1 2 3 1 2 3 1 2 3

Email Address: _____ Patient's SS#: _____ Marital Status: _____

Preferred Language: [] English [] Spanish [] Other: _____ **Ethnicity:** [] Hispanic/Latino [] Not Hispanic/Latino [] Decline to answer

Race: [] White [] Black/African American [] Asian [] Native Hawaiian [] Other Pacific Islander [] American Indian/Alaska Native
[] More than 1 race [] Decline to Answer

Emergency contact name: _____ Phone #: _____ Relationship: _____

PRIMARY INSURANCE COMPANY: _____

Primary Insurance Policy Holder's Information [] Same as Patient

Complete below if different than patient

Relationship to Patient: _____

Name: _____ Date of Birth: _____ Sex: Male Female

Address: _____ City: _____ State _____ Zip: _____

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

Circle Order of Preference 1 2 3 1 2 3 1 2 3

Email Address: _____ Patient's SS#: _____ Marital Status: _____

Employer: _____

SECONDARY INSURANCE COMPANY: _____

Secondary Insurance Policy Holders Information [] Same as Patient [] Same as Primary

Complete if different than patient or primary policy holder

Relationship to Patient: _____

Name: _____ Date of Birth: _____ Sex: Male Female

Address: _____ City: _____ State _____ Zip: _____

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

Circle Order of Preference 1 2 3 1 2 3 1 2 3

Email Address: _____ Patient's SS#: _____ Marital Status: _____

Employer: _____

PLEASE COMPLETE REVERSE SIDE

North Country Family Practice
Yearly Personal and Family History Form

10/26/10

Name: _____ Date of birth: _____ Date: _____

Current or Past Medical Problems: (please circle all that apply)

Anemia	Diabetes – Juvenile	Elevated Cholesterol	Urinary Incontinence
Arthritis	Diabetes – Gestational	Hypertension	UTI
Asthma	Chronic Ear Infections	Hyperthyroidism	Varicose Veins
Cancer: _____	Endometriosis	Hypothyroidism	Other: _____
Cataracts	Gastro-Esophageal Reflux	Kidney Stones	
Stroke	Glaucoma	Meningitis	
Cirrhosis	Gout	Muscular Dystrophy	
Colitis	Headaches	Multiple Sclerosis	
Congestive Heart Failure	Heart Disease	Osteoporosis	
Constipation	Heart Attack	Peptic Ulcer Disease	
Chronic Lung Disease	Hemorrhoids	Pneumonia	
Depression	HIV	Sexually Transmitted Disease	
Diabetes – Adult onset	ADD	Ulcers	

Drug or food allergies and reaction: _____

Medication List

Please include prescription medication name, your dosage, and prescribing doctor. Include all over-the-counter medications, herbs, and vitamins.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____

Immunization History: (Write in date of most recent)

Tetanus: _____	Hepatitis B: _____	Hepatitis A: _____
MMR: _____	Pneumovax: _____	Chicken Pox: _____
Shingles: _____		

Name: _____ Date of birth: _____ Date: _____

Parents History: Both Healthy? Yes No

Father	Illnesses	Cause of Death	Age at Death
Mother	Illnesses	Cause of Death	Age at Death

Siblings History: Number: _____ All Healthy? Yes No

1	Brother / Sister / Half	Illnesses	Cause of Death	Age at Death
2	Brother / Sister / Half	Illnesses	Cause of Death	Age at Death
3	Brother / Sister / Half	Illnesses	Cause of Death	Age at Death
4	Brother / Sister / Half	Illnesses	Cause of Death	Age at Death
5	Brother / Sister / Half	Illnesses	Cause of Death	Age at Death
6	Brother / Sister / Half	Illnesses	Cause of Death	Age at Death
7	Brother / Sister / Half	Illnesses	Cause of Death	Age at Death
8	Brother / Sister / Half	Illnesses	Cause of Death	Age at Death

Children(s) History: Number: _____ All Healthy? Yes No

1	Son / Daughter	Illnesses	Cause of Death	Age at Death
2	Son / Daughter	Illnesses	Cause of Death	Age at Death
3	Son / Daughter	Illnesses	Cause of Death	Age at Death
4	Son / Daughter	Illnesses	Cause of Death	Age at Death
5	Son / Daughter	Illnesses	Cause of Death	Age at Death
6	Son / Daughter	Illnesses	Cause of Death	Age at Death

Name: _____ Date of birth: _____ Date: _____

Social History:

Illicit Drug Use: NO YES Type: _____ Year Quit: _____

Alcohol Use: None Minimal Moderate Large Recovering Alcoholic
TYPE: Beer Wine Hard Liquor

Tobacco Use: Did you ever use tobacco products? YES NO
Cigarettes Pipe Cigar Smokeless Tobacco
Max Amt _____ Total years smoking _____ Year Quit _____

Caffeine Use: None Minimal Moderate Large

Exercise: NO YES Type: _____ Frequency: _____

Occupation: _____ **Currently Working** Yes No

Birth Control Method: _____

Women Only: Number of Pregnancies: _____ # of Deliveries _____
Hysterectomy: Age _____ Method: Vaginal or Abdominal
Ovaries removed: YES NO
Last Pap Smear: _____ Last Mammogram: _____ Last DEXA Scan: _____

Surgical History: (please circle all that apply)

Appendix	Carpel Tunnel Release	Hip Replacement	Thyroid Surgery
Back Surgery	Cataract Surgery	Hysterectomy	Tubal Ligation
Breast Augmentation	Gallbladder	Knee Arthroscopy	Vasectomy
Breast Biopsy	Colectomy	Knee Replacement	Wisdom Teeth
Breast Reduction	D&C of Uterus	Mastectomy R or L	Prostate Biopsy
C-Section	LEEP	Kidney Surgery	Prostatectomy-Total
Coronary Bypass Surgery	Hemorrhoid Surgery	Spleen Removal	PTCA
Carotid Surgery	Hernia Repair	Tonsil and Adenoids	Other:

Date of last: Colonoscopy _____ EGD _____ Stress test _____

Pharmacy Information:

Name of Local Pharmacy _____ Phone number _____

Name of Mail order Pharmacy _____ Phone number _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I _____, hereby authorize

INFO OF OFFICE THAT WILL BE RELEASING YOUR RECORDS

Name: _____
Address: _____
City, St., Zip: _____
Office Telephone: _____ Fax: _____

To disclose the following specific medical information by ___mail or ___fax TO:

NORTH COUNTRY FAMILY PRACTICE
1050 E. Hwy 114, Suite 100, Southlake, Texas 76092 * fax 817/329-1285

From the Health Records of:

PATIENT'S INFORMATION

Name: _____
Address: _____
City, St., Zip: _____

For the purpose of: _____

My authorization extends only to those data elements/documents initialed below:

- | | |
|--|---|
| <input type="checkbox"/> Statements of charges or payments | <input type="checkbox"/> Records of visits (all visits) |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Photographs, videotapes, digital or other images |
| <input type="checkbox"/> Discharge summary | <input type="checkbox"/> History and Physical Examination |
| <input type="checkbox"/> Consultation Reports | |
| <input type="checkbox"/> Record of visit for specific date or dates specific dates include or are limited to: _____ | |
| <input type="checkbox"/> Copies of records or reports provided to the above named (i.e.hospital, lab, clinic, etc) | |
| <input type="checkbox"/> All of the above | |
| <input type="checkbox"/> Other (Must be specific) _____ Mental Health and/or alcohol and drug abuse treatment <input type="checkbox"/> Hepatitis information | |

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available from the receptionist.
4. North Country Family Practice, P.A., its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this Authorization.
6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____ Patient's Name Printed	_____ Date
_____ Patient's signature (or guardian, if a minor)	_____ Expiration date (if other than one year from date above)
_____ Social Security Number (for identification purposes only)	_____ Date of Birth
_____ Patient's Personal Representative	_____ Date

Patient's Personal Representative's Authorization to Act

Witness

North Country Family Practice, P.A.

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, North Country Family Practice, P.A. creates and maintains health records and other information describing, among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations, be restricted. I also understand that the Practice and I must agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

Patient's name printed	Date
Patient's signature (or guardian, if a minor)	Social Security Number (for identification purposes)
Witness (optional)	Date

NORTH COUNTRY FAMILY PRACTICE, P.A.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protecting your privacy

Protecting your privacy and your medical information is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper or the Internet. At North Country Family Practice, P.A. (**hereinafter referred to as “the Practice”**), privacy is one of our highest priorities.

Keeping your information

Keeping the medical and health information we have about you secure is one of our most important responsibilities. We value your trust and will handle your information with care. Our employees access information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims and otherwise meet your needs. We may also access information about you when considering a request from you or when exercising our rights under the law or any agreement with you.

We safeguard information during all business practices according to established security standards and procedures, and we continually assess new technology for protecting information. Our employees are trained to understand and comply with these information principles.

Working to meet your needs through information

In the course of doing business, we collect and use various types of information, like name and address and claims information. We use this information to provide service to you, to process your claims and to bring you health information that might be of interest to you.

Keeping information accurate

Keeping your health information accurate and up-to-date is very important. If you believe the health information we have about you is incomplete, inaccurate or not current, please call or write us at the telephone numbers or addresses listed below. We take appropriate action to correct any erroneous information as quickly as possible through a standard set of practices and procedures.

How – and why – information is shared

We limit who receives information and what type of information is shared.

Revised: June 10, 2002

- *Sharing information within **the Practice**.* We share information within our company to deliver you the health care services and the related information and education programs specified in your plan.

- *Sharing information with companies that work for us.* To help us offer you our services, we may share information with companies that work for us, such as claim processing and mailing companies and companies that deliver health education and information directly to you. These companies act on our behalf and are obligated contractually to keep the information that we provide them confidential.
- *Other.* Patient-specific personally identifiable data is released only when required to provide a service for you and only to those with a need to know, or with your consent. Data is released with the condition that the person receiving the data will not release it further, unless you give permission.

If we received a subpoena or similar legal process demanding release of any information about you, we will attempt to notify you (unless we are prohibited from doing so). Except as required by law or as described above, we do not share information with other parties, including government agencies.

The Practice does not share any customer information with third-party marketers who offer their products and services to our patients.

Count on our commitment to your privacy

You can count on us to keep you informed about how we protect your privacy and limit the sharing of information you provide to us – whether it's at our office, over the phone or through the Internet.

North Country Family Practice

1050 E. Hwy 114, Suite 100
Southlake, Texas 76092

(817) 329-8364