First Choice Care

Patient Information		
Last Name	**First Name**	**Social Security Number**
Street Address	**City State Zip**	**Home Phone Number**
Cell Phone Number	**M F Date of Birth Marital Status**	**Spouse's Name (If applicable)**
Occupation (Indicate if Student)	**Employer/School Name**	**Work Phone Number**
Referred By	**Employer Street Address City State Zip**	

Race
□ Caucasian □ Hispanic □ African American □ Asian □ Indian □ Pacific Islander □ Other ________________

Highest Level of Education
□ None □ Elementary School □ High School □ Some College □ College Graduate

Other Information		
Emergency Contact	**Relationship**	**Phone Number**
Primary Care Doctor	**Pharmacy**	**Email Address**
Reason For Being Seen	**Is this an Injury? If so where did it occur Home or Work?**	

Insurance Information		
Primary Insurance Company	**Name of Policy Holder (If not self)**	**Policy Holder's Date of Birth**
Primary Insurance ID#	**Group#**	**Relation to Policy Holder**

Other Insurance Information		
Secondary Insurance Company	**Name of Policy Holder (If not self)**	**Policy Holder's Date of Birth**
Secondary Insurance ID#	**Group #**	**Relation to Policy Holder**

Past Medical History

Name: ____ Date: ____/____ /____

Are you Currently Smoking/Using Tobacco: ☐ No ☐ Yes Type:_______________ How many years: ____
I smoke ____ packs of cigarettes per day, _____ pipes per day, ____ cigars per day.

I presently drink alcohol on a regular basis: ☐ No ☐ Yes
How many per week? ____ glasses of wine, _____ bottles of beer, ______ other drinks

Have you ever used alcohol on a regular basis in the past: ☐ No ☐ Yes
I stopped drinking alcohol on a regular basis on or about: ___ / ____/ ____
I drank/drink per week approximately: ______ glasses of wine, _____ bottles of beer, ____ other drinks

Do you consume caffeine daily: ☐ No ☐ Yes
I consume ___ cups of tea, ___ cups of coffee, ___oz. Soft drinks, ___chocolate drinks /candy per day.

Do you exercise regularly: ☐ No ☐ Yes
How many times per week do you exercise: ______ how many minutes per exercise session: _______

Medications
Are you allergic to any medication(s): ☐ No ☐ Yes

Name of Drug: ___________________________ Describe the effect: _____________________________
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Are you taking any medication(s) (Prescription and /or Over the Counter): ☐ No ☐ Yes

Name of Drug: _________________________ Strength: _______ Dosage (How many per day): ________
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Past Medical History

Past Illness
Have you ever had allergies: (Hay Fever, Asthma, Other) ☐ No ☐ Yes

Type: _______ Date Started: __ /__ /__ Date of most recent episode: __ / __ /__ Still Active: □ No □ Yes
Type: _______ Date Started: __ /__ /__ Date of most recent episode: __ / __ /__ Still Active: □ No □ Yes
Type: _______ Date Started: __ /__ /__ Date of most recent episode: __ / __ /__ Still Active: □ No □ Yes
Type: _______ Date Started: __ /__ /__ Date of most recent episode: __ / __ /__ Still Active: □ No □ Yes

First Choice Care

Any Illness, Conditions, or Injuries: ☐ No ☐ Yes

Describe: ____ Date of Diagnosis: __ / __ / ___
Describe: ____ Date of Diagnosis: __ / __ / ___
Describe: ____ Date of Diagnosis: __ / __ / ___
Describe: ____ Date of Diagnosis: __ / __ / ___

Have you had any Surgery: ☐ No ☐ Yes

Type: ____ Date: __ / __ / ___
Type: ____ Date: __ / __ / ___
Type: ____ Date: __ / __ / ___
Type: ____ Date: __ / __ / ___

Have you been Hospitalized: ☐ No ☐ Yes

Reason: ____ Date: __ / __ / __
Reason: ____ Date: __ / __ / __
Reason: ____ Date: __ / __ / __
Reason: ____ Date: __ / __ / __

Did any immediate family members have any Illness or Conditions: ☐ No ☐ Yes

Relative: ____________________ Illness/Condition: ______________________ Deceased: □ No □ Yes
Relative: ____________________ Illness/Condition: ______________________ Deceased: □ No □ Yes
Relative: ____________________ Illness/Condition: ______________________ Deceased: □ No □ Yes
Relative: ____________________ Illness/Condition: ______________________ Deceased: □ No □ Yes

For Women Only:	
Are you Post-Menopausal: □ No □ Yes	Date of Last Breast Exam; __ / __/ ___
Date of Last Menstrual Period: __ / __ /__	Date of Last Mammogram:__/ __/ __
Are you pregnant: □ No □ Yes	Date of Last Pap Test: __/ __/ __
If yes, expected date of delivery: __ / __ / __	How Many Children do you have?
Are you planning a pregnancy: □ No □ Yes If yes, when: __ /__ / __	
Form of contraceptive:	

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I certify that the information I have provided above is truthful to the best of my knowledge. **I understand that if the insurance information I provided is incorrect or not in effect for the date of service, that I will be responsible for all charges incurred.** I understand that I am responsible for the terms and conditions of my individual insurance policies, I realize that First Choice Care and personnel are not responsible for informing me which tests and procedures are covered. I hereby give consent to medical treatment for the above patient.

___________________________________ ___________________________ ___________________

Patient/Guardian Signature (Must be 18) **Relationship** **Date**

Authorization to Release Medical Information
To Members of Your Family or Other Individuals

In accordance with Federal Government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1966 (HIPPA), in order for your physician or the staff of First Choice Care to discuss your condition with members of your family or other individuals that you designate other than you Primary Care Doctor, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

1. _____ **I authorize** First Choice Care to verbally release any or all information concerning my medical care to the following individuals:

_______________________________ _________________ ____ ______________
Name (Please Print) Relationship Phone Number

_______________________________ _________________ ____ ______________
Name (Please Print) Relationship Phone Number

______ **I do not** authorize First Choice Care to release any information concerning my care to any individual.

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2. ______ **I authorize** First Choice Care to leave a detailed voice mail on any phone number I provide.

______ I **do not** authorize First Choice Care to leave a detailed voice mail.

_____________________________________ _____________________________________
Patient Name/ Guardian (Print) Patient/ Guardian Signature

______________________________________ ___ /___/ ____
Relationship (If not Patient) Date

Patient unable to sign. Verbal consent given. Witness: ______________________________
Reason: ____

First Choice Care

Consent to Treat

I hereby voluntarily consent to outpatient treatment at **First Choice Care**, encompassing routine diagnostic procedures, examinations, and medical treatment including, but not limited to, routine laboratory work (such as blood, urine, and other studies) and administration of medications prescribed by the provider.

I further consent to those diagnostic procedures, examinations, and rendering of medical treatment by the Physician and their assistants, including Nurse Practitioners, Physician Assistants, and Medical Assistants, or their designees as is necessary.

Release of Information: (A) I authorize **First Choice Care** to release medical information to third party insurance carriers for the purpose of filing insurance claims related to my medical care. **(B)** I further authorize the release of medical information about treatment here to my doctor or anyone designated by me.

I understand that this consent form will be valid and remain in effect as long as I receive medical care at **First Choice Care**.

This form has been explained to me and I fully understand this Consent to Treatment and agree to its contents.

I Do/Do Not have an advanced directive or Living Will (circle one). If you have a living will, Please provide a copy to our office.

Patient Consent Form (HIPAA)

Under Health Insurance Portability & Accountability Act of 1996 (HIPAA), you have certain right to privacy, which are outlined in the HIPAA form provided. This information will be used to:

- Plan, Conduct and Direct your Treatment and Follow up among multiple health care providers involved in your treatment.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessment and physician certification.

You have the right to review a **NOTICE OF PRIVACY PRACTICES** prior to signing this consent. This organization has the right to change its Notice of Privacy Practices from time to time and that you may contact this organization at anytime to obtain a copy of the Notice of Privacy Practices.

Patient Name:____

Patient/Guardian Signature:____

Relationship to Patient:____

Date:______________