ANDERSON
FAMILY CARE

Patient Request for Health Information

Patient Information

First Name _____ Middle Name _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Phone _____

_____ **I request that the following organization provide my health information to Anderson Family Care:**

Name _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

Release records from the following dates: _____ to _____

_____ **I request that Anderson Family Care provide my health information to:**

Name _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

Release records from the following dates: _____ to _____

Release the following records:

_____ Entire Record/All _____ Labs _____ Immunizations _____ Images _____ Office Notes

_____ Other (specify): _____

Signature of Patient: _____ Date: _____

Signature of Representative: _____ Relationship to Patient: _____

A processing fee may be applied.

ADULT NEW PATIENT FORM

Please fill out completely.

Last Name _____ First Name _____ Middle Name _____

Date of Birth _____ Gender _____ SSN ____-____-____

Preferred Contact ☐Home Phone ☐Work Phone ☐Cell Phone ☐Email ☐Postal Mail

Marital Status _____ Spouse Name _____

Street Address _____ City _____ State _____ Zip _____

Primary Language _____ Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race ☐Black or African American ☐White ☐Asian ☐Other _____

Home Phone (____) _____ Cell Phone (____) _____

Work Phone (____) _____ Email Address _____

Emergency Contact _____ Phone (____) _____ Relationship _____

Pharmacy: _____ Pharmacy City: _____

Responsible Party (if other than patient)

Name _____ Phone (____) _____

Date of Birth _____ Gender _____ SSN ____-____-____

Street Address _____ City _____ State _____ Zip _____

Primary Insurance

Company _____ ID/Policy # _____ Group # _____

Insurance Phone (____) _____ Is this policy through your employer? Y / N Spouse's employer? Y / N

Employer _____ Phone (____) _____

Secondary Insurance

Company _____ ID/Policy # _____ Group # _____

Insurance Phone (____) _____ Is this policy through your employer? Y / N Spouse's employer? Y / N

Employer _____ Phone (____) _____

Patient's Signature _____ Date _____

Insured's Signature _____ Date _____

ANDERSON FAMILY CARE
Health History ADULT

Name: _____ DOB _____

Phone: _____

How did you find out about our office? _____

PERSONAL HISTORY

Birthplace: _____

Marital Status: *Single Married Separated Divorced Widowed*

Children/Ages: _____

Occupation: _____

Religion: _____

CURRENT SPECIALTY PHYSICIANS NONE

Specialty	Physician Name
Cardiology	
Endocrine	
Gastroenterology (GI)	
Nephrology (Kidney)	
Surgery	
Urology	
Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization

SURGERIES

Year	Surgery	Reason for Surgery

DATE OF LAST:

Menstrual Period: _____

PAP Smear: _____

Mammogram: _____

Colonoscopy: _____

DEXA Scan: _____

Tetanus Vaccine: _____

Pneumonia Vaccine: _____

Flu Vaccine: _____

Shingles Vaccine: _____

COVID Vaccine: _____

HEALTH HABITS / SOCIAL HISTORY

	Currently		How Much?	Quit Date
Caffeine:	YES	NO	_____	_____
Tobacco:	YES	NO	_____	_____
Alcohol:	YES	NO	_____	_____
Any Drugs:	YES	NO	_____	_____

Have you ever felt you should cut down on your drinking? YES NO

Are you sexually active? YES NO

PERSONAL & FAMILY HEALTH HISTORY

Check (√) if you or your blood relatives have ever had any of the following. Include details on the right.

You	Disease	Family	Details If you, what year? If family, what relation?
	ADD/ADHD		
	Alcohol/Drug dependency		
	Anemia		
	Anxiety or depression		
	Arthritis or Lupus		
	Asthma/ Lung Disease		
	Blood Clots		
	Blood Transfusions		
	Breast Disease or Cancer		
	Cancer (list type)		
	Dementia		
	Diabetes		
	Genetic disease or Birth defects		
	Heart problems		
	Hepatitis		
	High Blood Pressure		
	HIV		
	Kidney disease		
	Liver disease		
	Migraines		
	Neurological disease		
	Pap smear ever abnormal		
	Sexual infections (Gonorrhea, Chlamydia, Herpes, Syphilis)		
	Seizures		
	Stomach problems		
	Stroke		
	Thyroid disease		
	Tuberculosis		
Other Medical Problems			

ADVANCE DIRECTIVE / LIVING WILL

_____ I have executed an Advanced Healthcare Directive, Living Will, or Durable Power of Attorney.
_____ I would like to fill out an Advanced Directive.
_____ I would like to talk about my options.
_____ I do not wish to fill out an Advanced Directive at this time.

ANDERSON
FAMILY CARE

MEDICATION LIST

Please list ALL medications, dosage, and instructions. This includes over the counter medications.

Name:	Date of Birth:
Allergies/ Reaction:	

Medication	Dosage	Directions	Prescribed By:
Example: **Metformin**	**500mg**	**Twice a day**	**Dr. Anderson**

ANDERSON
FAMILY CARE

PATIENT CONTACT RECORD

Patient Name: _____

The HIPAA Privacy Rule gives individuals the right to restrict release of their Private Health Information (PHI). A copy of Anderson Family Care, LLC's Notice of Privacy Practices is included in this packet.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT OF FORM

I, _____, have received a copy of Anderson Family Care, LLC's Notice of Privacy Practices.

Signature _____ Date _____

AUTHORIZATION TO RELEASE MEDICAL HISTORY TO ANOTHER INDIVIDUAL

Please list the individual(s) you will allow Anderson Family Care, LLC to release or discuss your PHI with.
Do not list other physicians.

Name	Relationship	Phone Number

AUTHORIZATION TO OBTAIN MEDICATION HISTORY

I, _____, hereby authorize Anderson Family Care, LLC to obtain/download my medication history from Pharmacies and/or Pharmacy Benefit Managers. This authorization will allow my physician to check drug-to-drug interactions for any new prescriptions he/she may prescribe and to facilitate electronic pharmacy prescriptions. I understand this authorization will remain in effect until revoked by me in writing.

AUTHORIZATION TO LEAVE RECORDED MESSAGES

I give Anderson Family Care permission to leave protected health information on an answering machine or voicemail.

(Circle Yes or No) YES NO

AUTHORIZATION OF ELECTRONIC CORRESPONDENCE

I give Anderson Family Care permission to communicate protected health information with me via email, text message and other electronic mechanisms. I understand the potential risks associated with electronic correspondence.

(Circle Yes or No) YES NO

Signature _____ Date _____

ANDERSON
FAMILY CARE

ASSIGNMENT OF BENEFITS

Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered.

I request that payment of authorized insurance benefits, including Medicare if I am a Medicare beneficiary, be made on my behalf to Anderson Family Care, LLC for any equipment or services provided to me by its physicians or clinical staff.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to Anderson Family Care, LLC, my insurance carrier, or other medical entity. A copy of this authorization will be sent to my insurance company or other entity if requested. The original authorization will be kept on file by Anderson Family Care, LLC.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for services rendered.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I have read and I understand the information above. I agree to be financially responsible for all charges as discussed above.

Patient Signature _____

Date_____