Holy Cross Medical Group

PATIENT INFORMATION RECORD

Allergies:_____ **Age:**_____

Patient's Legal Name: _____ Today's Date: _____
First M.I. Last

Address: _____
Street City State Zip

Phone #'s – Daytime:_____ Evening:_____ Emergency: _____ Cell:_____

Where do you prefer to receive calls?: ❑ Home Number ❑ Work Number ❑ Cell Number ❑ In Writing
❑ OK leave message with detailed info ❑ Leave message with call-back number only

Patient's Date of **Birth:**_____ **Sex:** ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Partner Religion: _____ Primary Language: _____

Ethnicity: _____ Race: _____

Social Security No.:_____ – _____ – _____ Referred By: _____

Responsible Party: _____ Telephone: (___)- _____
First M.I. Last

Address: _____
Street City State Zip

Responsible Party Social Security No.:_____ – _____ – _____ Date of Birth: _____

Employer:_____ Telephone: (___)- _____

Address: _____
Street City State Zip

Next of Kin: _____ Relationship:_____ Telephone: Res:(___)-_____ Work:(___)- _____

I. INSURANCE INFORMATION:

Is Your Insurance a: ❑ PPO ❑ HMO ❑ Medicare ❑ Medicaid ❑ Other:_____

II. IS PATIENT'S CONDITION RELATED TO:

Employment (Current or Previous): ❑ Yes ❑ No Auto Accident: ❑ Yes ❑ No Other Accident: ❑ Yes ❑ No

*** * * * FOR OFFICE USE ONLY * * * ***

Identification Presented: ❑ Passport ❑ Driver's License ❑ State I.D. ❑ Insurance Card

Holy Cross Medical Group

MEDICARE AND MEDICAID SIGNATURE AUTHORIZATION

Medicare and Medicaid patient certification - patient certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVIII and/or TITLE XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services. I request that this authorization apply to all claims, present and future. I understand that I am responsible for my health insurance deductible and coinsurance.

Date: _____

Print Patient's/Beneficiary's Name: _____

Patient's/Beneficiary's Signature: _____

****

COMMERCIAL INSURANCE, MANAGED CARE MEMBERS AND SECONDARY PAYOR AUTHORIZATION

I authorize the release of any medical information necessary to process my insurance claim(s). I request that the payment authorized be made on my behalf. I assign the benefits payable for physician services to the HOLY CROSS MEDICAL GROUP / HOLY CROSS HOSPITAL. I request that this authorization apply to all insurance claims, present and future. I understand that I am responsible for payment of any balance not paid by my insurance company.

Date: _____

Print Patient's/Insured's Name (Parent's Signature if child): _____

Signature of Insured: _____

Patient's/Insured's Signature: _____

Holy Cross Medical Group

Patient Name_____ DOB _____

Holy Cross Hospital is now collecting information from patients during their office visit as part of the Meaningful Use healthcare initiatives put in place by the Federal Government. Listed below is the information that we are gathering to comply with the new program. If you would please take a moment to answer the following questions then hand this paper back to the front desk.

We thank you in advance for your time.

Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity

This classification provides a minimum standard for maintaining, collecting, and presenting data on race and ethnicity for all Federal reporting purposes. The categories in this classification are social-political constructs and should not be interpreted as being scientific or anthropological in nature. They are not to be used as determinants of eligibility for participation in any Federal program. The standards have been developed to provide a common language for uniformity and comparability in the collection and use of data on race and ethnicity by Federal agencies. (http://www.whitehouse.gov/omb/inforeg_statpolicy/#dr).

1. Which of the following do you consider yourself?

_____ Hispanic or Latino _____ Not Hispanic or Non-Latino

_____ Declined _____ Unknown _____Other

2. Which category best describes your race?

_____Black, African American _____Asian _____White

_____ Chinese _____ Filipino _____Hispanic _____Japanese

_____American Indian, Alaska Native

_____ Native Hawaiian, Other Pacific Islander _____ Pacific Islander

_____Other _____ Declined _____Unknown

3. Which language do you prefer to use to communicate?

_____ English _____ French _____ Creole
_____ Spanish _____ Portuguese_____ Russian _____ Other

4. What communication method would you prefer the office to use when conveying medical information?

_____ Postal Service (Mailing) _____ Cell Phone _____-_____-_____

_____Home Phone _____-_____-_____ _____ Work Phone _____-_____-_____

_____ PO Box

Holy Cross Hospital

PATIENT HISTORY FORM

Date: _____

Patient's Name: _____ **Birthdate:** _____

Reason for Visit: _____

It is helpful to gather information about your medical history for the physician to use in your examination. Please complete this form completely for the physician's review.

CONSTITUTIONAL SYMPTOMS

Good general health lately	❑ No	❑ Yes
Recent weight change	❑ No	❑ Yes
Fever	❑ No	❑ Yes
Fatigue	❑ No	❑ Yes
Exercise regularly	❑ No	❑ Yes
Eat a balanced diet	❑ No	❑ Yes

EYES

Eye disease or injury	❑ No	❑ Yes
Wear glasses/contact lenses	❑ No	❑ Yes
Blurred or double vision	❑ No	❑ Yes
Glaucoma	❑ No	❑ Yes

EARS/NOSE/THROAT

Hearing loss or ringing	❑ No	❑ Yes
Earaches or drainage	❑ No	❑ Yes
Chronic sinus problem or rhinitis	❑ No	❑ Yes
Nose bleeds	❑ No	❑ Yes
Mouth sores	❑ No	❑ Yes
Bleeding gums	❑ No	❑ Yes
Sore throat or voice change	❑ No	❑ Yes

CARDIOVASCULAR

Heart trouble	❑ No	❑ Yes
Chest pain or angina pectoris	❑ No	❑ Yes
Palpitation	❑ No	❑ Yes
Shortness of breath with walking	❑ No	❑ Yes
Swelling of feet, ankles or hands	❑ No	❑ Yes
Murmur	❑ No	❑ Yes
Mitral valve prolapse	❑ No	❑ Yes

RESPIRATORY

Chronic or frequent coughs	❑ No	❑ Yes
Spitting up blood	❑ No	❑ Yes
Shortness of breath	❑ No	❑ Yes
Asthma or wheezing	❑ No	❑ Yes

GASTROINTESTINAL

Loss of appetite	❑ No	❑ Yes
Change in bowel movements	❑ No	❑ Yes
Nausea or vomiting	❑ No	❑ Yes
Frequent diarrhea	❑ No	❑ Yes
Constipation	❑ No	❑ Yes
Rectal bleeding or blood in stool	❑ No	❑ Yes
Abdominal pain	❑ No	❑ Yes
Peptic ulcer (stomach or duodenal)	❑ No	❑ Yes
Reflux	❑ No	❑ Yes

MUSCULOSKELETAL

Joint pain	❑ No	❑ Yes
Joint stiffness or swelling	❑ No	❑ Yes
Weakness of muscles or joints	❑ No	❑ Yes
Muscle pain or cramps	❑ No	❑ Yes
Back pain	❑ No	❑ Yes
Cold extremities	❑ No	❑ Yes
Difficulty in walking	❑ No	❑ Yes
Sports injury	❑ No	❑ Yes

INTEGUMENTARY (SKIN, BREAST)

Rash or itching	❑ No	❑ Yes
Change in skin color	❑ No	❑ Yes
Change in hair or nails	❑ No	❑ Yes
Varicose veins	❑ No	❑ Yes
Breast pain	❑ No	❑ Yes
Breast lump	❑ No	❑ Yes
Breast discharge	❑ No	❑ Yes
Changing mole	❑ No	❑ Yes

NEUROLOGICAL

Frequent or recurring headaches	❑ No	❑ Yes
Light headed or dizzy	❑ No	❑ Yes
Convulsions or seizures	❑ No	❑ Yes
Numbness or tingling sensations	❑ No	❑ Yes
Tremors	❑ No	❑ Yes
Paralysis	❑ No	❑ Yes
Stroke	❑ No	❑ Yes
Head injury	❑ No	❑ Yes

PSYCHIATRIC

Memory loss or confusion	❑ No	❑ Yes
Nervousness	❑ No	❑ Yes
Depression	❑ No	❑ Yes
Insomnia	❑ No	❑ Yes

ENDOCRINE

Glandular or hormone problem	❑ No	❑ Yes
Thyroid disease	❑ No	❑ Yes
Diabetes	❑ No	❑ Yes
(Insulin or non insulin – circle one)		
Excessive thirst or urination	❑ No	❑ Yes
Heat or cold intolerance	❑ No	❑ Yes
Skin becoming dryer	❑ No	❑ Yes
Change in hat or glove size	❑ No	❑ Yes

GENITOURINARY

Frequent urination ..... ❑ No ❑ Yes
Burning or painful urination ..... ❑ No ❑ Yes
Blood in urine ..... ❑ No ❑ Yes
Incontinence or dribbling ..... ❑ No ❑ Yes
Kidney stones ..... ❑ No ❑ Yes
Sexual difficulty ..... ❑ No ❑ Yes
Pain with periods ..... ❑ No ❑ Yes
Use douche ..... ❑ No ❑ Yes
Irregular periods ..... ❑ No ❑ Yes
Vaginal discharge ..... ❑ No ❑ Yes
Age at the onset of menstruation: _____
Number of days menstruation lasts: _____
Date of last PAP smear: _____
Date of last menstrual period: _____
Date before that: _____
Age at first intercourse: _____
Date of last mammogram: _____

History of vaginal/pelvic infection ..... ❑ No ❑ Yes
Number of pads or tampons per day: _____

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts ..... ❑ No ❑ Yes
Bleeding or bruising tendency ..... ❑ No ❑ Yes
Anemia ..... ❑ No ❑ Yes
Phlebitis ..... ❑ No ❑ Yes
Past transfusion ..... ❑ No ❑ Yes
Enlarged glands ..... ❑ No ❑ Yes

ALLERGIC/IMMUNOLOGIC

Allergic to medications ..... ❑ No ❑ Yes
(If yes, please list)

_____
_____
_____
_____

FORM OF BIRTH CONTROL: _____

List all pregnancies with dates, weights and problems (Please include miscarriages, terminations and pre-term:

_____
_____
_____
_____

PAST MEDICAL HISTORY

Previous hospitalizations/surgeries/serious injuries: _____
_____
_____
_____

Medications: _____
_____
_____

PATIENT SOCIAL HISTORY

Marital status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed
Use of alcohol: ❑ Never Number per week: _____
Use of tobacco: ❑ Never ❑ Previously quit – Date quit: _____ ❑ Current packs per day: _____
Use of drugs: ❑ Never ❑ Type/frequency: _____
History of: ❑ Sexual assault: _____ ❑ Domestic violence: _____

FAMILY MEDICAL HISTORY

	Age	Diseases	If deceased, cause of death
Father:			
Mother:			
Siblings:			
Children:			
Other blood relatives:			

Do you wish to have an assistant present during your exam?: ..... ❑ No ❑ Yes

Patient Signature: _____

Physician reviewed: _____ **Date:** _____

Holy Cross Hospital

PATIENT ACKNOWLEDGEMENT

I have been given a copy of the Holy Cross Hospital, Inc. Notice of Privacy Practices, version effective July 15, 2004.

Signature of Patient or Representative: _____ Date: _____

Print Name of Patient or Representative: _____

Relationship of Representative to Patient: _____

Test Results may be left on my answering machine: ❑ YES ❑ NO

When calling my phone, results can also be left with – Name: _____

IN EMERGENCY SITUATIONS ONLY:

PLEASE CHECK ONE BOX:

❑ DO NOT RELEASE ANY OF MY MEDICAL INFORMATION TO A FAMILY MEMBER OR FRIEND

❑ PLEASE RELEASE MY MEDICAL INFORMATION IF NEEDED TO:

_____

Relationship: _____ Phone: _____

* *

FOR HOLY CROSS HOSPITAL, INC. USE ONLY

If acknowledgement of receipt of the Notice of Privacy Practices is not obtained from the Patient or the Patient's Representative, please explain your efforts to obtain their acknowledgement and the reason you could not obtain it: _____

_____

_____

Holy Cross Medical Group

ADVANCE MEDICAL DIRECTIVE

Many people have become aware that medicine today has the ability to keep people alive for extended periods of time, even in hopeless situations. For many, this is a great concern and question, how can you be sure this does not happen to you? If you are at least 18 years of age and of sound mind, there is something you can do to make your wishes known. You have the right to execute an Advance Directive/Living Will. An Advance Directive is a witnessed statement, usually written and made in advance of a future event, that states a person's wishes about what life-sustaining treatments would be wanted if he/she became incapacitated and unable to express his/her wishes. There is no legal requirement to complete an Advance Directive. However, if you have not made an Advance Directive or Designated Healthcare Surrogate, healthcare decisions may be made for you by a court appointed guardian, your spouse, adult child, your parent, your adult sibling, an adult relative or a close friend, in that order. This person would be called a proxy.

DO YOU HAVE A LIVING WILL?

* ❑ YES ❑ NO

WOULD YOU LIKE TO HAVE A LIVING WILL?

* ❑ YES ❑ NO

Patient's Name: _____

Patient's Signature: _____

Date: _____

*** If you have a Living Will or Advance Directive, or plan to have one in the future, it is your responsibility to provide this office with a copy so that we may abide by your directives.**