New Patient Information Form

Date of visit: _____

Name (Last, First, MI): _____

Date of Birth: _____ Age: _____ SS#: _____

Street Address: _____

City, State, Zip: _____

Mailing Address (if different): _____

City, State, Zip: _____

Preferred Phone: _____

Email: _____

Emergency Contact Information

Name (Last, First, MI): _____

Preferred Phone: _____

Relationship to Patient: _____

Pharmacy

Preferred Pharmacy: _____

Phone number: _____ Location: _____

Medication Review Policy

In order to provide excellent care to our patients, it is the policy of Century Health Care that all patients establishing care bring in all of their medication bottles from home to be compared to the provided list. This prevents unnecessary medication ordering and lowers the risk of medication interactions. Thank you!

Current Medications

Medication	Dose	Frequency	Date Started

Allergies to Medication

Medication	Reaction

Surgeries

☐ No prior surgical history

☐ Appendectomy	☐ Endometrial Ablation	☐ Masectomy
☐ Breast Lumpectomy	☐ Gall Bladder	☐ Myomectomy
☐ Cardiac Surgery	☐ Heart Surgery	☐ Oophorectomy
☐ Cataract Surgery	☐ Hemorrhoids	☐ Ostomy
☐ Colectomy	☐ Hernia	☐ Prostate Surgery
☐ Subtotal Colectomy	☐ Hysterectomy	☐ Splenectomy
☐ Cone Biopsy	☐ Joint Replacement	☐ Tonsil/Adenoidectomy
☐ D&C	☐ Laparoscopy	☐ Tubal Ligation

Other (Please list): _____

_____

Hospitalizations

☐ No prior hospitalization history

Date	Reason

Personal Medical History

Do you have a history of, or are you currently being treated for any of the following things:

☐ No previous medical history

☐ Alcoholism	☐ Depression	☐ Kidney Disease
☐ Allergies/Hayfever	☐ DM Type 1	☐ Kidney Infections
☐ Anemia	☐ DM Type 2	☐ Kidney Stone
☐ Anxiety	☐ Epilepsy	☐ Migraines
☐ Asthma	☐ Fracture	☐ Multiple Sclerosis
☐ Atrial Fibrillation	☐ Gastric Ulcer	☐ Myocardial Infarction
☐ Blood Transfusions	☐ Gastrointestinal Disease	☐ Neurological Disorder
☐ CAD	☐ GERD	☐ Obesity
☐ Cancer	☐ Gestational Diabetes	☐ Osteoarthritis
☐ Chemotherapy	☐ Glaucoma	☐ Osteoporosis
☐ Cardiac Pacer	☐ Heart Disease	☐ Pneumonia
☐ CHF	☐ Heart Murmur	☐ Prostate Cancer
☐ Chicken Pox	☐ Hepatitis	☐ Pulmonary Disease
☐ Cirrhosis	☐ High Cholesterol	☐ Radiation
☐ Colitis	☐ Hyperlipidemia	☐ Rheumatic Fever
☐ COPD	☐ Hypertension	☐ Rheumatoid Arthritis
☐ Chronic Renal Failure	☐ Hyperthyroidism	☐ Shingles
☐ Crohn's Disease	☐ Hypothyroidism	☐ STD
☐ CVA	☐ Insulin Pump	☐ TIA
☐ DVT	☐ Joint Pain	☐ Tuberculosis

Other (Please list): _____

_____

_____

Family Medical History

Do you have a first degree family members (mother, father, sister, brother, son, daughter) with a history of, or currently being treated for, any of the following things:

☐ No family medical history ☐ Unknown family medical history

☐ Alcoholism	☐ CVA	☐ Kidney Disease
☐ Anemia	☐ Diabetes	☐ Migraines
☐ Anxiety	☐ Depression	☐ Multiple Sclerosis
☐ Asthma	☐ Epilepsy	☐ Myocardial Infarction
☐ Birth Defects	☐ GERD	☐ Neurological Disorder
☐ CAD	☐ Heart Disease	☐ Obesity
☐ Cancer	☐ High Cholesterol	☐ Osteoarthritis
☐ CHF	☐ Hyperlipidemia	☐ Osteoporosis
☐ Congenital Anomaly	☐ Hypertension	☐ Pulmonary Disease
☐ COPD	☐ Hyperthyroidism	☐ Rheumatoid Arthritis
☐ Crohn's Disease	☐ Hypothyroidism	☐ TIA

Social History

Tobacco Use:	☐ Denies ☐ Smoker ☐ Chewing ☐ Former
Alcohol Use:	☐ Denies ☐ Social ☐ Occasional ☐ Frequent ☐ Recovering
Drug Use:	☐ Denies ☐ Marijuana ☐ Other ☐ Recovering
Marital Status:	☐ Single ☐ Married ☐ Divorced ☐ Widowed

Women:

Pregnancies:		Children:	
Miscarriages:		Abortions:	
Last Pap Smear:		Any Abnormal Pap Smears:	
Last Mammogram:		Any Abnormal Mammograms:	
Sexually Active:		Birth Control Method:	

General Consent for Care and Treatment

Disclosure to the Patient: In this clinic, you will be see a Master's Prepared, Board Certified Adult Nurse Practitioner. YOU WILL NOT BE SEEN BY A PHYSICIAN. The state of Arizona recognizes the extensive education and training that a Nurse Practitioner obtains, and therefore grants her or him all authoritative rights (i.e. diagnose, treat, prescribe) that a physician is granted.

Signing this consent form provides the Nurse Practitioner with permission to perform reasonable and necessary medical examinations, perform or order testing, including labs and imaging, and establish a plan of care to treat conditions identified. You, as the patient, have the right to be involved in the development of the plan of care in every step of its development. At any time that additional or specific studies or procedures are considered, you have the right to have them fully explained to you, including risks and benefits, and most importantly, you have the right to decline them. The Nurse Practitioner is available to discuss the specifics of the plan of care anytime that there are questions or concerns. Should any additional test or procedure be deemed reasonable and necessary by both the Nurse Practitioner and the patient, a specific consent form for that individual event will be presented for review and signed with agreement.

_____	_____	_____
Patient Name	Patient Signature	Date

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

Uses and disclosures of health information:
We use and disclose health information about you for treatment, payment, and healthcare operations.
For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information),or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (Such as voicemail messages, postcards, or letters).

Patient Rights:

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

Questions and Complaints
If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us via email to centuryhealthcarenp@gmail.com . You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer.

I acknowledge that I was offered and received, if desired, a copy of notice of privacy practices.

_____	_____	_____
Patient Name	Patient Signature	Date