Patients Name ______________________________ **DOB** ______________

FAMILY HISTORY

Please circle all that apply

MGM - Maternal Grandmother MGF - Maternal Grandfath
PGM - Paternal Grandmother PGF - Paternal Grandfather

Condition								
Alcohol/Substance Abuse	Mother	Father	Brother	Sister	MGM	MGF	PGM	PGF
Allergies (Drug/Pollen)	Mother	Father	Brother	Sister	MGM	MGF	PGM	PGF
Alzheimer's Disease/Dementia	Mother	Father	Brother	Sister	MGM	MGF	PGM	PGF
Anemia	Mother	Father	Brother	Sister	MGM	MGF	PGM	PGF
Anxiety Disorder/Depression	Mother	Father	Brother	Sister	MGM	MGF	PGM	PGF
Asthma	Mother	Father	Brother	Sister	MGM	MGF	PGM	PGF
Bleeding Disorder	Mother	Father	Brother	Sister	MGM	MGF	PGM	PGF
CAD – Coronary Artery Disease	Mother	Father	Brother	Sister	MGM	MGF	PGM	PGF
COPD/Emphysema	Mother	Father	Brother	Sister	MGM	MGF	PGM	PGF
Cancer (Type) __________	Mother	Father	Brother	Sister	MGM	MGF	PGM	PGF
Diabetes	Mother	Father	Brother	Sister	MGM	MGF	PGM	PGF
Endocrine Disorders (Type)	Mother	Father	Brother	Sister	MGM	MGF	PGM	PGF
Epilepsy/Seizures	Mother	Father	Brother	Sister	MGM	MGF	PGM	PGF
Headaches/Migraines	Mother	Father	Brother	Sister	MGM	MGF	PGM	PGF
Heart Attack/Heart Disease/Bypass surgery	Mother	Father	Brother	Sister	MGM	MGF	PGM	PGF
Heart Problems __________	Mother	Father	Brother	Sister	MGM	MGF	PGM	PGF
High Cholesterol	Mother	Father	Brother	Sister	MGM	MGF	PGM	PGF
Hypertension (High Blood Pressure)	Mother	Father	Brother	Sister	MGM	MGF	PGM	PGF
Immune Problems	Mother	Father	Brother	Sister	MGM	MGF	PGM	PGF
Kidney Disease	Mother	Father	Brother	Sister	MGM	MGF	PGM	PGF
Liver Problems	Mother	Father	Brother	Sister	MGM	MGF	PGM	PGF
Mental Illness (Type)	Mother	Father	Brother	Sister	MGM	MGF	PGM	PGF
Obesity	Mother	Father	Brother	Sister	MGM	MGF	PGM	PGF
Osteoporosis	Mother	Father	Brother	Sister	MGM	MGF	PGM	PGF
Other ______________	Mother	Father	Brother	Sister	MGM	MGF	PGM	PGF
Rheumatoid Arthritis	Mother	Father	Brother	Sister	MGM	MGF	PGM	PGF
Sleep Apnea	Mother	Father	Brother	Sister	MGM	MGF	PGM	PGF
Stroke	Mother	Father	Brother	Sister	MGM	MGF	PGM	PGF
Thyroid Problems	Mother	Father	Brother	Sister	MGM	MGF	PGM	PGF
Tuberculosis	Mother	Father	Brother	Sister	MGM	MGF	PGM	PGF

First Name: ______________________ Middle Initial: ______ Last Name: ______________________

Gender: Male ______ Female ______ DOB: ____/____/______ SSN: ______________________

Address: ______________________ City: ______________ State: _____ Zip Code: ________

Home Phone: ______________ Work Phone: ______________ Mobile Phone: ______________

Email Address: ______________________________ Contact Preference: ______________

Race/Ethnicity: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ White ☐ Native Hawaiian or Pacific Islander ☐ Other

Marital Status: S ___ M ___ D ___ W___

Emergency Contact Name: ______________________ Relation: ________ Phone: ______________

Employer Name: __________________ Employer Phone: ____________ Occupation: ___________

Insurance Information
If subscriber is not the patient please provide the following information

_____ Same as above

First Name: ______________________ Middle Initial: ______ Last Name: ______________________

DOB: ____________ SSN: ______________ Driver's License: ______________ State: ________

Address: ______________________ City: ______________ State: _____ Zip Code: ________

Home Phone: ______________ Work Phone: ______________ Mobile Phone: ______________

Primary Insurance: __________________ Policy #: ______________ Group #: ______________

Secondary Insurance: __________________ Policy #: ______________ Group #: ______________

Other Insurance: __________________ Policy #: ______________ Group #: ______________

We will need to obtain copies of all insurance cards, so that we can file your insurance on your behalf.

I authorize release of any information concerning my (or child's) health care and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. I understand that I am responsible for all copays, coinsurances, and deductibles, due at the time services are rendered.

Patient Signature: ______________________________________ Date: ______________

Patient's name: ______________________________ DOB: ______________

Pharmacy: ______________________ Pharmacy Phone #: ______________________

Allergies: ☐ Aspirin ☐ Penicillin ☐ Sulfa ☐ Codeine ☐ Latex ☐ Topical Antibiotics ☐ Other ______________

Past Medical History:

Major Problem: ______________________________ Onset date: ______________

Major Problem: ______________________________ Onset date: ______________

Past Surgical History:

Procedure: ______________________________ Date: ______________

Procedure: ______________________________ Date: ______________

Medications:

Medication:	Dosage:	Frequency	Who prescribed it?	What is medication for?
Example: Benicar	20mg	1 daily	Dr. Wright	Hypertension

If you have any additional medications, please use the back of this form.

Soma, Xanax, Chronic Narcotics Policy

It is the policy of the providers of Total Health Primary Care not to fill Soma, Xanax and other chronic narcotics on a regular basis. If it is determined that long term use of these medications are deemed necessary you will be referred out to a pain management specialist or psychiatrist for your continued care.

Do you understand and agree to the above Soma, Xanax and Chronic Narcotic Policy? YES or NO Initial: ________

Patient's name: ______________________________ DOB: ______________

Patient Signature: ______________________________ Date: ______________

Patient's name: ________________________ DOB: ____________

Chronic Conditions

- ☐ ADD OR ADHD
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bedwetting
- ☐ Bladder or Kidney Problems
- ☐ Blood Diseases
- ☐ COPD
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Congenital Anomalies
- ☐ Constipation
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Developmental or Behavioral Disorders
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Ear or Hearing Problems
- ☐ Eczema, Hives or other skin conditions
- ☐ Fibromyalgia
- ☐ GERD/Reflux
- ☐ Gout
- ☐ Heart Disease
- ☐ Heart Problems
- ☐ High Cholesterol
- ☐ Hospital Admission other than birth
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Muscle, Joint, or Bone Problems
- ☐ Osteoporosis
- ☐ Pulmonary Embolism
- ☐ Seizures/Epilepsy
- ☐ Serious Illness or Injuries
- ☐ Skin Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Vision or Eye Problems

Social History

Occupation: ________________________ Education: ________________________

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner

Exercise Level: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Diet: ☐ Regular ☐ Vegetarian ☐ Vegan ☐ Gluten Free ☐ Specific ☐ Carbohydrate ☐ Cardiac ☐ Diabetic

Smoking Status: ☐ Never Smoker ☐ Former Smoker ☐ Currently every day smoker ☐ Currently some day smoker

Smoking How Much: __________ Smoked since what age: ______

Chewing Tobacco: ☐ None ☐ One/day ☐ 2-4/day ☐ 5+/day

Alcohol Intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Illicit Drugs: Yes No ______________

If female, are you pregnant? ☐ No ☐ Yes

How many months? _______

HIPAA PRIVACY AUTHORIZATION FORM

Release of Information to ANY other person that yourself

I ______________________________, hereby authorize Total Health Primary Care to use and/or
(name of patient)

disclose the protected health information described below to:

____
(Name and Relationship to patient)

____
(Name and Relationship to patient)

I hereby authorize the release of the following information:

- ☐ Appointments
- ☐ Financial
- ☐ Complete Health Records
- ☐ Pathology Results
- ☐ Laboratory Results
- ☐ Other ________________ (Please specify)

This medical information may be used by the person(s) I authorize to receive this information for medical treatment or consultation or other purposes as I may direct. I understand that information use or disclosed pursuant to this authorization may be disclosed by the recipient and is no longer protected by federal or state law.
I understand that I have the right to revoke this authorization, in writing at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has the right to contest a claim.

________ (initial) I authorize the release of sexual health information, including sexual transmitted disease results to another person. If agree, please name the person in which this information can be released to.

____

________ (initial) I understand that this authorization may include information related to HIV, AIDS, Psychiatric care, treatment of alcohol and/or drug abuse or genetic testing.

______________________________ Print Patient Name

______________________________ Date of Birth

______________________________ Signature of Patient

______________________________ Date

Email Authorization Form

Total Health Primary Care may not condition treatment, payment, enrollment or eligibility for benefits based on whether an individual signs the below authorization form. Any written revocation of the below authorization shall be effective expect to the extent that Total Health Primary Care has previously taken action in reliance on the authorization.

I hereby authorize Total Health Primary Care as my Health Care Provider to use the e-mail address listed on the attached patient intake form to contact me concerning products, services, therapies, procedures or treatments and any medical imaging, lab or other medical results. I understand that my e-mail address may be considered individually identifiable health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and that such information could be reasonably used to identify me as a patient of Total Health Primary Care. I hereby release Total Health Primary Care from any liability that may be incurred from the use of my e-mail address to contact me concerning health-related products, services, therapies, procedures or treatments.

This authorization is in addition to other medical release authorization I may have granted in the past or future and does not replace them. This authorization is effective as of the date shown as the date of its signing. This authorization shall terminate on the first to occur of: (1) my death or (2) upon my written revocation actually received by Total Health Primary Care. By signing this authorization, I readily acknowledge that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected by the HIPAA rules. I fully indemnify Total Health Primary Care for all consequences which may occur as a result of their good faith reliance and compliance with this authorization.

Signature of Responsible Party   Date

Financial Policy

In order to better serve you and to avoid any misunderstandings, THPC would like to explain our office policy.

Payment for today's visit is ultimately the patient's responsibility whether or not insurance is involved.

As a courtesy to our patients THPC will file your insurance claim for you, but you the patient need to make sure we have the correct insurance information and you are aware of your benefits.

THPC collects all copays, circumstances, and deductibles dictated by your insurance at the time of you visit.

We accept Cash, Mastercard, Visa, and Discover.

THPC strives to work every patient in that needs to be seen acutely. THPC requires that if you need to cancel or reschedule your appointment to give us 24 hours advanced notice. We give one grace NO SHOW visit and after that if you do not call to cancel or reschedule your appointment within 24 hours there will be a **$60.00** charge posted to your account. If there have been greater than 3 NO SHOW appointments we may ask you to find a new Primary Care Physician that can better address your needs.

I have read and understand THPC financial policy and accept responsibility for payment of all services rendered.

____
Print Name

________________________________ ________________________
Signature Date