Catoctin Family Practice

Medical History Form

Name:_____ **DOB**_____

Language_____ race_____ ethnic group_____

Occupation_____

Habits: Cigarettes: Do you smoke_____ PPD x_____ years

Are you a former smoker_____ When did you quit_____

Other tobacco Products?_____

Alcohol _____ how many drinks per day/week_____

ALLERGIES to Medications, X-Ray Dyes or Other Substances: Please list all

_____

_____

Past **Medical History**: Please check if you or a blood relative have ever had any of the listed conditions:

Conditions	**You**	**Relative**	**Condition**	**You**	**Relative**
Diabetes:			Anemia		
High Blood Pressure			Leukemia		
Stroke			Sickle Cell		
Heart Attack			Bleeding Problems		
Asthma			Stomach Problems		
Migraines			Gallstones		
Cancer			Seizures		
Emphysema			TB		
Kidney Problems			Alcoholism		
Arthritis			Depression		
Eye Problems			Suicide		
Skin Problems			Mental Illness		

Please list all:

Operations_____

Hospitalizations other than surgery:

MEDICATIONS: Please list all medications and dosages:

FOR WOMEN ONLY:

Age of first menstrual period_____Date of last period_____

Date of last Pap smear_____Breast exam_____Mammogram_____

If periods have stopped, have you had any bleeding since:_____

Number of Pregnancies_____Births_____Miscarriages/Abortions_____

Method of Birth Control_____

Patient Information Form

Last Name:_____First:_____MI:_____

Street Address_____Apt#_____

City:_____State_____Zip_____

Home Phone_____Cell:_____

Work Phone_____Which number do you prefer we use?_____

DOB:_____SS_____

Gender: male _____ female_____

Marital Status: Married _____Single _____ _____Divorced _____ ___ Widowed_____

Employer Name_____

Employer Address_____

EMERGENCY CONTACT

Name_____Relation_____

Home Phone_____Cell_____Work_____

INSURANCE:

Guarantor Name_____DOB_____

Primary Insurance Name:_____

Subscriber Number _____Group_____

Secondary Insurance Name:_____

Subscriber Number _____Group_____

PREFERRED PHARMACY:

Local:

Name_____Address_____

Mail Order:

Name_____Address_____

NOTICE OF PRIVACY PRACTICES CONSENT FORM

Catoctin Family Practice, P.C.
211 South King Street
Leesburg, VA 20175
703.777.6655
Fax: 703.777.6835

I understand that, under the Health Insurance Portability & Accountability Act of 1966 (HIPPA), I have certain rights to privacy regarding my health information. I understand that this information can and will be used to:

- Conduct, plan and direct treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as the business aspects of running the practice on a daily basis.

I have been given access to your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this practice has the right to change its Notice of Privacy Practices from time to time and that I may contact this practice at any time to obtain a current copy of this notice.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by the restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

CATOCTIN FAMILY PRACTICE

CONSENT FOR MEDICATION HISTORY

I give my permission for **Catoctin Family Practice** to request, **electronically**, my prescription medication history from other healthcare providers, my pharmacy, and/or health plan benefit payors for treatment purposes.

Patient name – please print | Date of birth

Signature | Date

Relationship to patient

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name of Patient: _____

(Please print)

Date of Birth: _____

I request that all communications to me (by telephone, mail or otherwise) by Catoctin Family practice and/or its staff be handled in the following manner:

- For written communications: Address to: _____

  _____

  _____

  _____

  _____

- For oral communications: Call: _____

  (Telephone number)

  May we leave a message? □ Yes □ No

- I give my permission to leave any medical information with the following people:
  - _____
  - _____

If the address provided above is not your home address or is not a street address, please provide us with a street address for the purpose of ensuring payment:

_____

_____

_____

_____

_____ _____

Patient Signature Date

For Practice Use Only:

Practice: □ Accepts □ Denies

Privacy Officer Signature: _____ Date: _____