FAMILY HEALTH CARE ASSOCIATES
PATIENT INFORMATION SHEET

NAME: ______________________ **DOB:**______________

SSN:_________________ **PHONE:**__________________

ADDRESS:_________________________ **City:**________ **State:**____ **Zip:**_____

ANY KNOWN DRUG ALLERGIES:_____________

Employer ____________ **Address:** ________________ **Occupation** ________________

Marital Status: Single_____ **Married** _____ **Widowed** ____ **Divorced** ____ **Separated** _____

EMERGENCY CONTACT: ______________________ **PHONE:** _____________

RELATIONSHIP TO YOU: _______________ **ALTERNATE PHONE:** _____________

Insurance Cards Required Please Have Available Upon Check In
Insurance Info: (Check One) **Medicaid** ____ **Medicare** _____ **Tricare** _____ PRIVATE____ **Self pay** _____

INSURANCE:____

ID#____________________ **GROUP#** _____________

Do you have Living Will or Advance Directive? Yes____ **No**_____ **Do you want information**
Yes ____ **No**____ **Literature on Living Will/Advance Directive given to patient.**

I have received a copy of the "Notice of Privacy Policies & Practices" Of Family Health Care Associates And / Or have been offered a copy of the health insurance portability & Privacy Act "HIPPA" Along with Privacy Regulations, Information & Assignment of Benefits. Pursuant to the Health Insurance Portability and Accountability Act (HIPPA) Privacy Regulations, 45 CFR sec. 164.508
INITIAL ______

I authorize the release of any medical information necessary to process this claim. I further permit a copy of this authorization to be used in place of the original.
INITIAL ______

I hereby authorize Family Health Care Associates to apply for benefits on my behalf for covered services rendered by him/her, or by his/her order. I request that payment from my insurance company be made directly to Family Health Care Associates to the party who accepts assignments. I certify that the information I have submitted is correct this authorization may be revoked by my or my insurance company at any in any time writing.
INITIAL ______

I authorize release of any and all medical information including the diagnosis, records, & X-Rays of treatment and/or any examination including psychological and/or HIV related treatments rendered to me or child during the period of health care to third party health practitioners or providers and/or third party payers. I understand my health insurance carrier may pay less than services are billed and I agree to be responsible for full payment of all services rendered on behalf of myself or dependents. Failure to pay my account in full may lead to termination of services along with collection and services & fees.

SIGNATURE: ______________________________ **DATE:** _______________

NAME: ______________________ **DOB:** ______________

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems (with dates).

- ___ Heart disease: Rheumatic Fever — *specify type* ____________
- ___ Asthma/Lung disease/ TB
- ___ Skin Disorder: Eczema/ Measles/ Rubella
- ___ Arthritis
- ___ Seizure Stroke
- ___ High blood pressure
- ___ Diabetes
- ___ Other: (specify): ____________
- ___ Liver: Hepatitis
- ___ Ulcer/ GERD/Chrons
- ___ High cholesterol
- ___ Thyroid problem
- ___ Kidney disease
- ___ Cancer: (specify): ____________
- ___ Mental Disorders: Depression / Anxiety

SURGICAL HISTORY: Please list all prior operations (with dates):

____

FAMILY HISTORY: Please indicate the current status of your immediate family members:

Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism ____________ High cholesterol ____________

Cancer, specify type ____________ High blood pressure ____________

Heart disease ____________ Stroke ____________

Depression/suicide ____________ Bleeding or clotting disorder ____________

Genetic disorders ____________ Asthma/COPD ____________

Diabetes ____________ Other: ____________

SOCIAL HISTORY

Tobacco Use

Cigarettes ☐ Never ☐ Quit Date ____________

☐ Current Smoker: packs/day ______ # of yrs ______

Other Tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Are you interested in quitting? ☐ No ☐ Yes

Alcohol Use

Do you drink alcohol? ☐ No ☐ Yes # drinks/week ______

Is your alcohol use a concern for you or others? ☐ No ☐ Yes

Drug Use

Do you use any recreational drugs? ☐ No ☐ Yes

Have you ever used needles to inject drugs? ☐ No ☐ Yes

Sexual Activity

Sexually active: ☐ Yes ☐ No ☐ Not currently

Current sex partner(s) is/are: ☐ male ☐ female

Birth control method: ____________ ☐ None needed

Have you ever had any sexually transmitted diseases (STDs)?
☐ No ☐ Yes

Are you interested in being screened for sexually transmitted diseases? ☐ No ☐ Yes

☐ AIDS ☐ HIV ☐ Herpes ☐ Hepatitis

OTHER CONCERNS

Caffeine Intake: ☐ None ☐ Coffee/tea/soda ______ cups/day

Weight: Are you satisfied with your weight? ☐ No ☐ Yes

Diet: How do you rate your diet? ☐ Good ☐ Fair ☐ Poor

Do you eat or drink four servings of dairy or soy daily or take calcium supplements? ☐ No ☐ Yes

Exercise: Do you exercise regularly? ☐ No ☐ Yes

What kind of exercise? ____________

How long (minutes) ______ How often? ______

If you do not exercise, why? ____________

Safety: Do you use a bike helmet? ☐ No ☐ Yes ☐ NA

Do you use seatbelts consistently? ☐ No ☐ Yes

Is violence at home a concern for you? ☐ Yes ☐ No

Have you ever been abused? ☐ Yes ☐ No

Do you have a gun in your home? ☐ Yes ☐ No

Have you completed a living will or or durable power of attorney for health care? ☐ Yes ☐ No

SOCIOECONOMICS Occupation: ____________ Employer: ____________

Years of education/highest degree: ______ Marital Status: Single Partner/Married Divorced Widowed Other: ______

Spouse/partner's name: ____________ Number of children/ages: ____________

Who lives at home with you? ____________

WOMEN'S HEALTH HISTORY # pregnancies ______ # deliveries ______ # abortions ______ # miscarriages ______

Age at start of periods: ______ Age at end of periods: ______

CONTROLLED MEDICATION PRESCRIBING AGREEMENT

Family Health Care Associates is a multi-provider facility serving the rural, indigent, underserved communities within Southeastern Kentucky. The purpose of this Agreement is to prevent misunderstanding about certain medications that you may be taking for pain management, anxiety, weight management and/or sleep disorders. This is to help both you and the health care provider to comply with the law regarding controlled pharmaceuticals.

A written Agreement must be made between a licensed provider and the patient who is requesting the controlled medication. The Agreement must be witnessed.

The Agreement must include the following:
That you understand that this Agreement is essential to the trust and confidence necessary in a healthcare provider/patient relationship and that the health care provider undertakes to treat the patient based on the Agreement. You must understand that if you break this Agreement the healthcare provider may stop prescribing controlled medications.

If you break this agreement, the health care provider may choose to taper you off the medication over a period of several days or weeks, as necessary to avoid withdrawal symptoms, depending upon the reason for the discontinuation of the medication. It is at the providers' discretion as to whether controlled medication will be continued or discontinued. Also, a drug- dependence treatment program may be recommended by the health care provider depending on the severity of the issue and the providers' professional judgment.

In Relation to Pain Control:
Your compliance while taking prescribed controlled medications shall be monitored by the provider in accordance to standard of care practice, laws of the state, as well as the statutes enforced by the medical and nursing licensing boards.

You must agree to communicate fully with the healthcare provider about the character and intensity of the patient's pain, the effect of the pain on your daily life, and how well the medication is helping relieve your pain.

You must agree not to use any illegal controlled substances, including cocaine, meth, heroin, etc. Any exception is noted specifically in this Agreement.

You must agree not to share, sell, or trade medications with anyone.

You must agree not to attempt to obtain any controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medications from any other healthcare provider. It is your responsibility to notify the provider immediately if you require additional controlled medication due to dental work, auto accident, etc. You must agree to safeguard pain medications from loss or theft. Lost or stolen medications will not be replaced.

You must agree that refills for prescriptions for controlled medication will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or weekends.

You must agree to give authorization to your healthcare provider and to your pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of your controlled medication. You agree your healthcare provider has your authorization to provide a copy of this Agreement to your pharmacy. You agree to waive any applicable privilege or right to privacy or confidentiality with respect to these authorizations.

You must agree that you will submit to a blood or urine test or submit to a pill count, if requested by the healthcare provider to determine your compliance with your program of controlled medication.

In Relation to Marijuana:
Should you test positive for marijuana, your reason for using marijuana, the pathology/diagnosis, reason for you being prescribed the controlled medication will be taken into consideration. The health care provider may choose to discontinue the controlled medication at that time, counsel you to deter from future use of marijuana, warn you of risk of future positive drug tests for marijuana, or refuse to continue treating you and request another provider in the group to take over your health care.

You must agree that you will use your medication at a rate no greater than the prescribed rate and that use of your medication at a greater rate will result in you being without medication for a period of time. You must agree to follow the guidelines that have been fully explained to you. All of your questions and concerns regarding treatment should be adequately answered.

I AGREE TO USE ____________________ **PHARMACY, PHONE:** ________________________ **LOCATED AT** ____________________________.

THIS AGREEMENT IS ENTERED INTO ON THIS DAY ________________________

PATIENT SIGNATURE: ____

PROVIDER SIGNATURE: ________________________________

WITNESSED BY: ____