Richmond Primary Care Specialist, P.C.

Patient Profile

Doctor: _____

Patient Information

First, MI, Last Name: _____ **Employer:** _____ **[ ] Employed [ ] Retired [ ] Other**

Adress: _____ **Occupation:** _____ **Phone:** _____

_____ **Patient DOB:** _____ **Sex: [ ] M [ ] F**

Social Security Number

City, State, Zip: _____ **Marital Status: [ ] Married [ ] Divorced [ ] Widowed**

Phone: _____ **[ ] H [ ] W [ ] Other** **Referred By:** _____

Phone: _____ **[ ] H [ ] W [ ] Other** **Email Address:** _____

EMERGENCY CONTACTS

Name: _____ **Phone:** _____

Name: _____ **Phone:** _____

GUARANTOR [ ] Same as Patient

First, MI, Last Name: _____ **DOB:** _____ **Relation:** _____

Address: _____ **SSN:** _____-_____-_____ **Sex: [ ] M [ ] F**

City, State, Zip: _____ **Phone:** _____ **[ ] H [ ] W [ ] Other**

PRIMARY INSURANCE

Insurance Company: _____ **Insured ID #:** _____ **Group#** _____

Name of Insured: **Insured DOB:** **Sex: [ ] M [ ] F**

Name: _____ **Date of Birth:** ___/___/____

Drug Allergy: _____ _____

_____ _____

Hospitalizations (include surgery and childbirth):

Year	Reason

Medical History

[ ] Abdominal Pain (chronic)	[ ] Gallbladder	[ ] Pneumonia	[ ] Chicken pox	[ ] Polio	[ ] Mumps
[ ] Allergies/Hay fever	[ ] Gout	[ ] Prostate Disease	[ ] Measles,	[ ] Rubella	[ ] Rheumatic Fever
[ ] Anemia/ bleed easily	[ ] hair loss	[ ] psoriasis/eczema	[ ] Scarlet Fever,	[ ] TB.	[ ] Herpes
[ ] ankles swollen	[ ] headaches	[ ] rashes/ hives	[ ] Other _____		
[ ] appetite (loss of)	[ ] heart murmur	[ ] menstrual problems	[ ] Other		

[redacted]

[ ] Asthma/ wheezing	[ ] Hernia	[ ] Stool bloody/ tar	**FEMALES PLEASE COMPLETE:**
[ ] Back pain recurrent	[ ] ^ blood pressure	[ ] Stroke	Pregnant [ ] YES [ ] NO
[ ] Bones broken	[ ] Heart burn	[ ] trouble swallowing	Planning Pregnancy [ ] YES [ ] NO
[ ] Changing bowel habits	[ ] Infections	[ ] Tetanus	**MENSTRUAL CYCLE**
[ ] Bronchitis/ chronic cough	[ ] Jaundice	[ ] Hepatitis	[ ] regular [ ] irregular [ ] severe pain/cramps
[ ] Cancer	[ ] Kidney disease	[ ] Thyroid disease	# of pregnancies ____ [ ] Cycle Length ____
[ ] Chest Pain	[ ] Lactose Intolerant	[ ] Tremor/ hand shakes	# of miscarriages/abortions ____
[ ] Convulsions/ Seizures	[ ] leg pain Walking?	[ ] Ulcers	Birth Control Method: _____
[ ] Diabetes	[ ] Memory Loss	[ ] Urethral Discharge	Menopausal Symptoms [ ] YES [ ] NO
[ ] Diarrhea [ ] Constipation	[ ] Mental Illness	[ ] Urinate Frequently	_____
[ ] Chon's Disease/ colitis	[ ] Moodiness	[ ] Urination Painful	_____
[ ] Diverticulitis	[ ] muscle weakness	[ ] Urination Control	_____
[ ] Dizziness/ Fainting	[ ] Nausea/ Vomit	[ ] blood in Urine	_____
[ ] Depression	[ ] Nervousness	[ ] Varicose veins	_____

[redacted]

Richmond Primary Care Specialist, P.C.

AUTHORIZATION FOR RELEASE OF INFORMATION

Section A: Must be completed for all authorizations

[redacted]

Patient Name: _____
ID Number: _____

Please identify those persons/organizations authorized to use or disclose your information:

disclosure to a third party such as physical examinations for school, camp, and employment purposes).

INITIALS: _____

b. I understand that I may revoke this authorization at any time by notifying Richmond Primary Care Specialists, P.C. in writing, however such revocation does no affect any actions taken by Richmond Primary Care Specialist, P. C. before Richmond Primary Care

[redacted]

INITIALS: _____

c. I understand that I may revoke this authorization at any time by notifying Richmond Primary Care Specialists, P.C. in writing however such revocations does not affect any

[redacted]

Richmond Primary Care Specialist, P.C.

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding your Health Record/Information each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a: basis for planning your care and treatment means of communication among the many health professionals who contribute to your care; a legal document describing the care you received; means by which you or a third party payer can verify that services billed were actually provided; a tooling educating health professionals; a source of data for medical research; a source of information for public health officials charged with improving the health of the nation; a source of data for facility planning and marketing and a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy;

[redacted]

better understand who, what, when, where and why others may access your health information; make

[redacted]

informed decisions when authorizing disclosure to others.

Your Health Information Rights:

Richmond Primary Care Specialist, P.C.

For more information or to report a problem or if you have questions and would like additional information, you [redacted]

rights have been violated, you can file a complaint with the Director of Health Information Management or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint; Examples of Disclosure for Treatment, Payment and Health Operations.

We use your health information for treatment. For example: Information obtained by a nurse physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. You physician will document in your record his expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent healthcare provider with copies of various reports that

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacement.

Workers Compensation: We may disclose health information to the extent and in the manner