theGROVE
Primary Care Clinic

Patient Information (please print)

Last Name _____ **First Name**_____MI _____

Title •Mr •Mrs •Ms •Dr •Rev •Other, _____ Suffix •Jr. •Sr. •II •III •Other, _____

Date of Birth _____ **Social Security Number** _____

Gender ☐ Male ☐Female **Ethnicity** ☐Not Hispanic ☐Hispanic/Latino

Race ☐Black/African American ☐White/Caucasian ☐Hispanic/Latino ☐Other _____

Language Preference ☐English ☐Spanish ☐Refused ☐Other_____

Marital Status ☐Married ☐Single ☐Separated ☐Divorced ☐Widowed

Student Status ☐Full-Time ☐Part-Time Institution _____

Email Address: _____

Mailing Address _____

Apartment # _____ City_____St _____ Zip Code_____- _____

Physical Address (if different from mailing address):_____

City_____St _____ Zip Code_____- _____

Home Phone (___)____-_____ Work Phone (___)____-____ Cell Phone (___)____-_____

Employer_____Job Title _____

Employer's Address (with city, ST, zip) _____

Primary Emergency Contact NAME_____Relationship_____

Home Phone (___)____-_____ Work Phone (___)____-____ Cell Phone (___)____-_____

Other Emergency Contacts you wish us to have on file

NAME_____Relationship_____

Home Phone (___)____-_____ Work Phone (___)____-____ Cell Phone (___)____-_____

NAME_____Relationship_____

Home Phone (___)____-_____ Work Phone (___)____-____ Cell Phone (___)____-_____

If you are the responsible party, mark "self"; otherwise, please complete the following:

Patient's relationship to the responsible party (Insurance Subscriber) ☐Self ☐Spouse☐Dependent

Guarantor's First Name_____MI____Last Name_____

Date of Birth_____SSN#_____

Mailing Address _____

City_____State_____Zip _____

Home Phone (___)____-_____Work Phone (___)____-_____Cell Phone (__)__-_____

INSURANCE INFORMATION (please provide your card{s} or copies of the front and back)

Primary Insurance_____Telephone Number (____)_____-_____

Group or Policy Number_____Subscriber or ID Number _____

Subscriber Name_____Effective Date_____Co-Pay $_____Deductible $_____

Secondary Insurance_____Telephone Number (____)_____-_____

Group or Policy Number_____Subscriber or ID Number _____

Subscriber Name_____Effective Date•Co-Pay $_____•Deductible $____

By your signature below, you understand and acknowledge that you will be responsible for the charges of any services provided that are denied, non-covered, or not paid by your insurance.

Referred By:_____**Signature:** _____

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General Consent for Treatment

1. _____ consents to examination, care and treatment from the physicians and other healthcare professionals of The Grove Primary Care Clinic, LLC, including but not limited to tests deemed necessary, medical treatment and surgical procedures.

2. I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that no guarantees have been made to me by the staff at The Grove Primary Care Clinic, LLC as to the results of diagnosis, examinations or treatments by the staff or facilities and healthcare providers they refer to me to.

3. I understand that medical information and records may be released to other institutions, agencies, healthcare organizations of healthcare providers, who accept me for medical or institutional care. I further understand that my medical information may be released to my insurer(s), managed care organization(s), governmental entities responsible for paying for my care, and/or pharmaceutical manufacturers, and their respective agents, for purposes including, but not limited to, payment, Utilization Review and Quality Assurance Review, and to support applications for patient assistance programs.

4. I hereby authorize The Grove Primary Care Clinic, LLC to contact me via phone, mail, and my given e-mail address with clinic results and with generalized clinic messages they deem reasonable to send me for management of my health and in answer to queries generated by me.

5. I hereby agree that a photocopied, digital or faxed copy or transmission of this authorization is as valid as the original.

6. I hereby assign all medical and/or surgical benefits, to which I am entitled, including Medicare, private insurance and any other health plans to The Grove Primary Care Clinic, LLC. This assignment is for services rendered to me by the medical providers and staff at The Grove Primary Care Clinic. This assignment will remain in effect until revoked by me in writing or revoked by a medical provider in writing. A photocopy/email of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize The Grove Primary Care Clinic, LLC to release all information necessary to secure this payment. I understand that failure to notify The Grove Primary Care Clinic, LLC of any changes or insurance coverage may result in the financial obligation to rest fully on me regardless of any contract between the insurance company and the medical providers and The Grove Primary Care Clinic, LLC.

_____

Signature of patient/Authorized Representative Date

_____

Signature of staff member Date

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Advance Directives

Advanced Directives:

Do you have a living will or durable power of attorney? _____ No _____ Yes

If you do have a durable power of attorney, please identify: _____

Would you like us to give you a packet of information regarding advance directives?

_____ No _____ Yes (Packet distributed)

_____ _____

Patient (or Guardian Signature) (Date)

_____ _____

Witness (Office staff is considered your witness) (Date)

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Release of Information

I,_____, give the office of The Grove Primary Care Clinic permission to release health information to (include the name and their relation to you):
*Please list a family member or friend; someone that is ok to release medical information to, in case of emergency.

_____

_____.

Other:_____

Employee Signature processing form:_____

Office of The Grove Primary Care Clinic use only:

(Employee note: explanation required here if other is marked above.)

_____

_____

Acknowledgment of Receipt of Notice of Privacy Practices

By signing this document, I acknowledge that a copy of the Medical Office of The Grove Primary Care Clinic Notice of Privacy Practices has been made available to me.

_____
Please print patient's name on above line

_____ _____/_____, 20___
Patient Signature (if other than patient, your relation to the patient) Date

• Patient unable to sign/no family member available

• Patient refused to sign

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Release of Information TO another facility

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION FROM ANOTHER FACILITY

Patient Name:	Date of Birth:	SSN:
	Other Names Known By:	

Person/Organization Authorized to Disclose Protected Health Information:

Release Records to:	Address:	Fax:	City & State:
The Grove Primary Care Clinic	Telephone:		Zip:
Attention:			
CONFIDENTIAL			

Purpose of Disclosure: ☐ Medical Care ☐ Insurance ☐ At the Request of the Patient
☐ Media, Public Relations, Marketing, Advertising, Posting, or Radio Broadcasting
☐ Other, Please Explain:

Description of Information to be Used or Disclosed:

Dates of Treatment: Place of Treatment:

Choose From the Following:

☐ All Dictated Reports	☐ Lab (may include AIDS/HIV information)		☐ History & Physical
☐ Radiology Reports	☐ Pertinent Summary	☐ Discharge Summary	☐ Pathology Reports
☐ ER Record	☐ Consultation	☐ Anesthesia Record	☐ Billing Record
☐ Operative/Procedure Report	☐ Entire Chart	☐ Photographs/Images	☐ Other (specify):

I understand that:

1. I may revoke this authorization in writing at any time by notifying in writing the person/organization providing or disclosing the information. However, if I revoke this authorization, it will not have any effect on any actions taken by the person/organization providing, disclosing, or receiving the information prior to receiving the revocation, nor shall it be valid to the extent that the disclosing person/organization or receiving organization has taken action in reliance on this authorization.
2. This authorization allows **The Grove Primary Care Clinic** to obtain any and all documents in my medical record including those copies from other health care facilities and providers. I understand that the information that is released or provided may be re-disclosed and no longer protected by federal privacy regulations.
3. Any disclosure of records concerning diagnosis and/or treatment of alcohol and/or drug abuse is covered by Title 42 CFR, and if there is any such information; I hereby authorize the release of information. This authorization also includes any information related to diagnosis and/or treatment of any psychiatric or mental illness or any state of infection with the HIV (AIDS) virus.
4. The Office of **The Grove Primary Care Clinic** is hereby released from any liability and the undersigned will hold **The Grove Primary Care Clinic** harmless for requesting or seeking my protected health information.
5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal will affect my ability to obtain treatment, receive payment, or eligibility for benefits.
6. The authorization will expire in ninety (90) days unless I provide an alternate date or event. This authorization will not apply to any dates of service that occur after the date this authorization is signed.
7. A facsimile of this authorization or a copy of this authorization shall be valid and binding with the same force as an original signature, and the person/organization releasing the information shall be entitled to rely on the same.

I have read and understood this authorization. I hereby authorize the release of the above-requested medical information about me to **The Grove Primary Care Clinic** from the facility named above.

Signature of Patient	Signature of Patient's Authorized Representative
_,20___	
Telephone Number Date	Description of Representative's Authority to Act for Patient

Original Date:

Dates Revised:

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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name
(Last, First, M.I.): ☐ M ☐ F **DOB:**

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Previous or referring doctor: **Date of last physical exam:**

Occupation: **Spouse's Occupation:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and dates:

☐ Tetanus	☐ Zostavax	☐ Pneumonia
☐ Hepatitis	☐ Gardasil	☐ Chickenpox
☐ Influenza	☐ Meningicoccal	☐ MMR *Measles, Mumps, Rubella*

Recent and recurring medical problems:

Most recent cholesterol/lipid test results:
Most recent PSA results (men only):
Date of last colonoscopy, location, and physician's name:
Date of last mammogram, location, and physician's name:

Other medical problems, including those diagnosed by another physician:

Surgeries

Year	Reason	Year	Reason

Other hospitalizations

Year	Reason	Year	Reason

Have you ever had a blood transfusion? ☐ Yes ☐ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications: Please circle: Yes or No If yes, please list:

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	☐ # of years	□ Or year quit	Are you exposed to secondhand smoke?		☐ Yes	☐ No
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No

Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every_____days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies_____Number of live births _		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

(Women skip to the last section on this page)

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS

(MEN AND WOMEN)

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	