## **NEW PATIENT INFORMATION**

Today's Date:	Date: Home Phone Numb							
Patient Name: (Last, First, M.I.)				Cell Ph	one Number:			
Street Address	èss				City, State, Zip Code			
Social Security Number	Date of Bir	th Se	ex	Mar	ital Status			
/ /	1 1	M	F	S M	1 D W			
Current Employer	Address			Work Ph	one Number:			
Spouse's Name	Spouse's D	eate of Birth		Spouse's	Work Phone:			
Local Contact (not living with you)	Street Add	lress	City, St	ate, Zip C	ode			
Relationship to you World	k#( )		Hon	ne# (	)			
Referred By:								
RESPONSIBLE PARTY	7 FOR PAN	YMENT IF	OTHER	THAN P	ATIENT			
RESPONSIBLE PARTY FOR PAYMENT IF OTHER THAN PATIENT Name (Last, First, M.I.) Home Phone Number:								
Street Address: City, State, Zip Code								
Social Security Number	Date of /	of Birth Sex / M F						
Current Employer	Address	W	ork Phon	e Numbei	•			
D) 1'./	I	<u> </u>			·			
Please list current and former d Doctor Special		Doctor		Spe	cialty			
					**************************************			
I hereby assign to Medical Specialists Associated any money payable to me under hospitalization or other insurance coverage, and/or other arrangements with third parties, for payment of such services. I also authorize Medical Specialists to furnish my insurance company the medical information requested. I also agree to be responsible for any testing or treatment that may not be considered by my insurance company, to be medically necessary.								

In signing this HIPAA Patient Acknowledgment form, you acknowledge and authorize, that you hold harmless this Healthcare Facility, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring from this authorization. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until this Healthcare Facility is in actual receipt of a signed revocation or until the records retention period required under federal and state law has expired and the records have been destroyed; that I have the right to revoke this authorization at any time, provided I do so in writing; that I have been given the opportunity to ask question; that I have received a copy of the signed authorization; that I may inspect a copy of my PHI to be used or disclosed under this authorization; that this Healthcare Facility has not conditioned provision of services to or treatment of me upon receipt of this signed authorization; and that I may refuse to sign this authorization. A copy of this signed, dated Authorization shall be as effective as the original.

## Consent to release Protected Health Information (PHI)

I understand that in order to disclose my PHI, Medical Specialist Associated, must have my consent, therefore, I authorize Medical Specialist Associated to disclose my PHI as described in the above forms, to the recipients listed below. Description of the information to be disclosed (check all that apply) ☐ All Procedures ☐ Test Results ☐ Appointments ☐ Other ☐ Surgeries ☐ Billing/Account Information Name(s) of the person(s) authorized to obtain the above mentioned information. (e.g. Physician other than referring doctor, family members and other specified person/persons) Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Name: \_\_\_\_\_\_ Relationship: \_\_\_\_\_\_ Phone: \_\_\_\_\_ Name: \_\_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_ Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Contact Information: I authorize Medical Specialists Associated, to contact me at the following with results or questions: Home: \_\_\_\_\_\_ Cell: \_\_\_\_\_\_ Work: \_\_\_\_\_ Email: May we leave a detailed message on your answering machine or voicemail? Yes □ No □ Failure to check one of these boxes may delay results By Patient: (Print Name) DOB: Or Patient's Representative (Print Name, sign and describe authority)

Date: \_\_\_\_\_

## MEDICAL SPECIALISTS ASSOCIATED

## PATIENT HISTORY FORM

Note: This is a confidential record amd will be kept in your doctor's office, information obtained here will not be released to anyone withou your authorization to do so.

Today's Date:// Last Name: Social Security No. : Occupation: Pharmacy Name :			Date of Last Physical Exam//				
			First Name: Date of Birth/				
			Pharmacy Phone No:				
			Current prescription	medications: □ None			rescription medication
1	Mg Dose # tablets	# times per day		Mg Dose # tab			
		***************************************		ALEXANDER MANAGEMENT TO THE TAXABLE MANAGEMENT OF TAXABLE			
List any personal p Surgeries and whe Illness or Surgery	n they occurred.  Date	culosis, bre	east cancer, heart diess  Mammogram PSA or Prostate Exyou on a special die	sease, etc)  Re Las  kam  t? □Yes □No	t PAP(If yes, please explain)		
<u>, , , , , , , , , , , , , , , , , , , </u>	- And Andrews	expla	in)	edicine allergies:			
Substance Abuse?□	Yes <b>□N</b> o Advar	nced Directive/	Living Will: aYes a		s: aYes aNo		
Do you smoke? □Ye	s □No Do	you Drink? □Ye	es ⊡No	Do you exercise re	egularly?		
If yes, how much?	lf y	es, how much?	V	If yes, how much?	?		
Immunizations:Flu _	/ Pr	neu/	/ Tetanus	_//Ot	her/		
Physician use only: (	Comments/Notes)						
Physician/Provider	Signature:			Date:			