ROCK RIDGE FAMILY MEDICINE

PATIENT INFORMATION:

Name: _____Birthday _____

Address: _____ City: _____ Zip: _____

Phone: (Home)_____ (Cell) _____ (Work) _____

Social Security Number: _____ Employer_____

Gender (circle one): Male Female

Ethnicity (circle one): Hispanic Non-Hispanic

Race (circle one): Asian American Indian Black/African American Hispanic/Latino
White Pacific Islander Hawaiian Other

EMERGENCY CONTACT INFORMATION:

Name: _____ Phone number: _____

Relationship to Patient: _____

INSURANCE INFORMATION:

Primary Insurance: _____Subscriber's name: _____

Subscriber's SS#_____ Birthdate_____

Secondary Insurance: _____Subscriber's name: _____

Subscriber's SS#_____Birthdate_____

_____I hereby assign payment directly to RRFM for the surgical and/or medical benefits, if any, otherwise payable to me for services as described, but not to exceed indebtedness to RRFM for those services.

_____ I hereby authorize RRFM to release any information acquired in the course of my examination or treatment to my referring doctor and/or my insurance company or employer.

_____ I understand that RRFM providers have the right to refuse to see a patient and will refer you to seek other medical care if there is a patient balance of $300 or greater and/or payments have not been made in 3 months.

Signature_____Date_____

HEALTH HISTORY FORM

PHARMACY: _____

CURRENT MEDICATIONS: (name of medication, dosage and how often it is taken)

_____

_____

_____

_____

Allergies or intolerance to medications (include type of reaction):

_____

_____

HEALTH MAINTENANCE SCREENING TESTS:

Routine Physical Exam	Date_____			
Sigmoidoscopy or colonoscopy (circle one)	Date _____	Polyp?	○ Yes	○ No
Endoscopy (EGD)	Date _____	Abnormal?	○ Yes	○ No

***Men only*:**

Prostate or PSA	Date _____	Abnormal?	○ Yes	○ No
Routine Physical Exam	Date_____			

***Women only*:**

Mammogram	Date _____	Abnormal?	○ Yes	○ No
Pap Smear	Date _____	Abnormal?	○ Yes	○ No
Bone Density Test	Date _____	Abnormal?	○ Yes	○ No

WOMEN'S HEALTH HISTORY:

Total number o f pregnancies: _____ Number of births: _____

Age at beginning of periods (menstruation): _____ Age at end of periods (menopause): _____

MEDICAL HISTORY: Do you have now (current) or have you had (past) any of the following? Do you have a family member that has had any of the following? Please note on family whether it is your mother (M), father (F), brother (B), sister (S), maternal grandmother (MGM), maternal grandfather (MGF), paternal grandmother (PGM) or paternal grandfather (PGF).

Condition	**You** (Current)	**You** (Past)	**Family** (please mark who as described above)	**Comments**
Alcohol/Drug Abuse				
Allergy (hay fever)				
Anemia				
Anxiety				
Arthritis (rheumatoid or osteoarthritis)				
Asthma				
Bladder/Kidney Problems				
Blood Clot (leg or lung)				
Blood Transfusion				
Breast Lump (benign)				
Cancer Breast				
Cancer Colon				
Cancer Ovarian				
Cancer Prostate				
Cancer Skin				
Cancer Other				
Cataracts				
Chicken Pox				
Colon Polyp				
Coronary Artery Disease				
Depression				
Diabetes (adult onset)				
Diabetes (childhood onset)				
Diverticulitis/ Diverticulosis				
Emphysema				
Fractures (broken bones)				Where?
Gallbladder Disease				
GERD/Heartburn				
Glaucoma				
Gout				
GYN condition (endometriosis)				
GYN condition (fibroids)				
GYN condition (other)				
Heart Attack				
Hepatitis-Type A				
Hepatitis-Type B				
Hepatitis- Type C				
Hepatitis- Other				
High Blood Pressure				
High Cholesterol				
Irritable Bowel Syndrome				
Kidney Disease/Failure				

Kidney Stones				
Liver Disease				
Migraine Headaches				
Osteoporosis				
Pneumonia				
Prostate (enlargement)				
Prostate (nodules)				
Seizure/Epilepsy				
Skin Condition (eczema)				
Skin Condition (psoriasis)				
Skin Condition (abnormal moles)				
Sleep Apnea				
Stomach Ulcer				
Stroke				
Thyroid (nodule)				
Thyroid (hyperthyroid)				
Thyroid (hypothyroid)				
Other				
Other				

SURGICAL HISTORY: Please mark any procedures or surgeries, list any abnormal findings or complications.

Surgical Procedure	**Yes**	**Year**	**Comments**
Abdominal Surgery			
Appendix removal			
Back Surgery (thoracic or lumbar)			
Biopsy (location)			
Breast Surgery			Circle: Right Left Both
Carpal Tunnel Release			
Cesarean Section			
Colon/Gastric Surgery			
Coronary Bypass			
Coronary Sent			
Cataract			
Gallbladder Removal			Laparoscopic?
Heart Surgery (other than bypass)			
Hip Surgery			Circle: Right Left Both
Hysterectomy (total, includes ovaries)			Circle: Laparoscopic Vaginal Abdominal
Hysterectomy (partial, ovaries left)			Circle: Laparoscopic Vaginal Abdominal
Knee Surgery			Circle: Right Left Both
LEEP (Cervix surgery)			
Neck Surgery			
Ovary Ligation (“Tubal”)			
Ovary Removal			Circle: Right Left Both
Vasectomy			
Shoulder Surgery			
Sinus Surgery			
Tonsillectomy			
Other			

OTHER HEALTH ISSUES:

Tobacco Use:

Smoke cigarettes: ○ Never ○ No ○ Yes

Quit date: _____ How many years did you smoke? _____

Approximately how many packs per day did you smoke? _____
Current smoker: Packs/day: _____ # of years: _____

Alcohol use:
Do you drink alcohol? ○ No ○ Yes
# of drinks/week: _____ ○ Beer ○ Wine ○ Liquor

Drug use:
Do you use recreational drugs? ○ No ○ Yes
Have you ever used needles to inject drugs? ○ No ○ Yes

Sexual Activity:
Sexually involved currently: ○ No ○ Yes
Sexual partners is/are/have been: ○ Male ○ Female
Birth control Method (circle all that apply): condom, pill, diaphragm, vasectomy, none, other _____

Exercise:
Do you exercise regularly? ○ No ○Yes
What kind of exercise? _____
How long (minutes)? _____ How often? _____

Have you completed (circle all that apply: an Advance Directive for Health Care, Living Will or Physician Orders for Life Sustaining Therapy? If not, would you like to? ○No ○Yes

SOCIAL HISTORY:
Are you currently (circle one): employed for wages, unemployed, disabled, retired, on leave of absence
Occupation (or prior occupation): _____
Employer: _____
Years of education or highest degree: _____

Marital status (circle one): single, partner, married, divorced, widowed
Spouse/partner's name: _____ # of children: _____
Who lives at home with you? _____

Leisure activities, group involvement, religion, volunteer work, recent travel:
_____
_____
_____

Rock Ridge Family Medicine

Regular attendance is an important aspect of successful treatment. Below is Rock Ridge Family Medicine's policy of "**missed appointments** "and a description of how this will be applied.

The definition of a missed appointment is when a client fails to keep an appointment with less than 24 hours cancellation notice. We **require** 24 hours notice when rescheduling any appointment. Cancellations and no shows are subjected to a fee of **$25.00**. **Insurance will NOT be billed for No Show.** The missed appointment fee will need to be paid prior to the appointment being rescheduled. A total of 3 missed/cancelled appointments will result in automatic termination from Rock Ridge Family Medicine. It is important that you are on time to each appointment to ensure that every patient can be seen in a timely manner. When you are late, you are making everyone else wait. Please be courteous and prompt. We appreciate your business.

Signature: _____ Date:_____

Notice of Privacy Practices for Protected Health Information

Only as otherwise required by law or with your written authorization, you may revoke the authorization as previously provided in this Notice under "Your Health Information Rights".

Patient Record of Disclosure

In general, the HIPAA privacy law, give individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means; Such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Home Telephone: ___Ok to leave message with detailed information
___Leave a message with call back number only
Written Communications____ Ok to mail my home address
_____Ok to mail to my work/office address
_____Ok to fax to this number

My insurance information may be discussed with. The following individuals:

Name and Relationship:_____Name and Relationship: _____

My protected health information may be discussed with the following individuals:

Name and Relationship:_____Name and Relationship:_____

Signature: _____ Date:_____

ROCK RIDGE
FAMILY MEDICINE

Authorization for Disclosure of Health of Information

Patient Name:_____ Date of Birth:_____

1. I authorize the use of disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:
   (PREVIOUS DOCTOR)

   Name:_____

   Address:_____

   City:_____ State:_____ Zip:_____

3. The type and amount of information to be used or disclosed is as follows (include dates where appropriate).

   ____Last Year Health Records

   ____Other _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
5. This information may be disclosed to and used by the following individual or organization.
   (Individual who wants records)

   Name:_____

   Address:_____

   City: _____State: _____Zip:_____

6. I understand that I have the right to revoke this release at anytime with written notification.
7. If I fail to specify an expiration date, event or condition, this authorization will expire in 1 year. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. (I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.) If I have question about disclosure of my information, I can contact Rock Ridge Family Medicine.

Patient Signature:_____Date_____

Controlled and Opioid Medication Agreement
2016

The long term use of opioid therapy is somewhat controversial because of uncertainty regarding the extent to which this treatment actually improves the quality of lives of those receiving it. There is the potential risk of development of an addictive disorder or of relapse occurring in a person with a prior addictive disorder. The extent of this risk is not certain. These medications have potential for abuse or diversion and, accordingly, rather strict accountability is necessary when use is prolonged.

The purpose of this agreement is to prevent misunderstandings about certain medicines you will be taking for pain management, as well as other conditions requiring use of controlled substances. This is to help both you and your doctor to comply with laws regarding controlled pharmaceuticals.

Please initial the following after reading:

____I understand that if I break this agreement, my doctor will stop prescribing these medications. In this case, my doctor will taper me off of the medication over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug- dependence treatment program may be recommended.

____I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life and how well the medicine is helping to relieve the pain.

____I will not use any illegal controlled substances, including methamphetamine, cocaine, etc. I also agree to not use alcohol while on controlled medicines due to the potential adverse effects that the combination can cause.

____I will not share, sell or trade my medications with anyone including my family and friends.

____I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctor. If controlled medications are given to me through an ER or minor emergency center, a surgeon or other specialist, it is my responsibility to notify Dr. Wolff's office within 24 hours of receiving these medications.

____I will safeguard my controlled medicines from loss of theft. Medications will not be replaced if they are lost, fall in the toilet, are eaten by pets, left on an airplane, or for any other reason. I understand that stolen medications will need a police report filed. I agree to notify the doctor within 24 hours of my medication being lost or stolen.

____I agree that refills of my prescriptions for controlled medicines will be done only at the time of an office visit or during regular office hours. No refills will be available during evenings or weekends. I understand that I will need to be seen every 30 days for refills and that no exceptions will be made to the rule.

____I authorize the doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my medicine. I authorize my doctor to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

____I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance. If my insurance does not cover the expense of these random screenings, I understand that I will be responsible for the cost out of pocket.

____I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time. I understand that my medicine will not be filled early due to my noncompliance of the prescribed dosing. If I feel that I need to take more medication than I am prescribed. I understand that I need to call and make an appointment to discuss these changes. I understand by not having the approval of the doctor in these changes, I am breaking my agreement.

____I will bring all unused controlled medicines to every office visit to ensure proper usage.

____I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been offered.

____I understand that there are risks to the long term use of controlled medications and take full responsibly to the use of them.

I agree to use_____ pharmacy, located at _____ with telephone number _____, for filling prescriptions for all of my controlled medications. If this changes, I will notify Rock Ridge Family Medicine immediately.

This agreement is entered on this _____day of _____, _____.

Patient Signature: _____

Provider Signature: _____

Witness Signature: _____