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PATIENT INFORMATION

Patient's Name: _____ **Date:** _____

Date of Birth: ___/___/___ Age: _____ Social Security Number: _____ - _____ - _____

Check appropriate box: Married Single Widow(er) Divorced Separated

Check appropriate box: Male Female

Email : _____

Home Phone : (_____) _____ - _____ Emergency Contact Person: _____

Cell Phone : (_____) _____ - _____ Emergency Contact Phone: (_____) _____ - _____

Work Phone : (_____) _____ - _____

Patient Address

Street: _____

City: _____ State: _____ Zip: _____

Patient's Occupation: _____ Employer: _____

Employer's Address-Street: _____

City: _____ State: _____ Zip: _____

Responsible Party

Name of person responsible for this account: _____

Date of Birth: ___/___/___ Age: _____ Social Security Number: _____ - _____ - _____

Relationship to patient: Self Spouse Parent Other (specify) _____

Address (if different from patient's home address)

Street: _____

City: _____ State: _____ Zip: _____

Family Internist/Pediatrician: _____

Address-Street: _____

City: _____ State: _____ Zip: _____

Phone Number: (_____) _____ - _____

How did you learn about Dr. Salas : Friend Physician Internet Other (specify)

Patient Referred by: _____

Address-Street: _____

City: _____ State: _____ Zip: _____

Phone Number: (_____) _____ - _____

DESCRIBE THE REASON FOR YOUR VISIT

Reason for visit: _____

If injury, date: _____ Type of injury: _____

At work? Yes No

Motor Vehicle? Yes No

If injury, where you treated by **DR. SALAS** at a Hospital for this injury? Yes No

If Yes, describe: _____

Do you have or have you had any significant emotional problems? No Yes _____

Have you ever had psychiatric/psychological care? No Yes _____

Have you ever been advised to see a psychiatrist? No Yes _____

Do you take any mind altering drugs? No Yes _____

Health Insurance

Plan Name: _____ ID #: _____ Group #: _____
Subscriber's Name: _____

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Subscriber's Name: _____

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF INSURANCE BENEFITS (PLEASE SIGN)

- I, the undersigned,
 have insurance coverage (see information listed above)
 DO NOT have insurance coverage

I hereby authorize/designate the office of Dr. A. P. Salas, and/or whomever he may designate, to handle my insurance claims/appeals and all related issues for services rendered to me. Furthermore I authorize that payment of medical/surgical benefits be made directly to A. Peter Salas, M.D. I also consent that the office of A. Peter. Salas, M.D. be permitted to obtain/disclose any medical or other information regarding my son/daughter/spouse or myself needed to process this or future insurance claim(s). **I understand that, as the patient or the patient's responsible party, I am financially responsible to A. Peter Salas, M.D., for payment of all charges, regardless of my insurance carrier.** I further understand that payment for services rendered must be paid in full within sixty (60) days; otherwise I will incur service charges for which I am also financially responsible. If it should be necessary to turn my account over to an attorney or collection agency, the costs of collection will be added to my account and will be my financial responsibility. I am willing to allow photocopies or FAX of this authorization to be accepted with the same authority as the original. This authorization is to be regarded a continuing, valid authorization until such time as I specifically rescind it, in writing.

DATE: _____ SIGNED: _____
PRINT NAME: _____
DATE OF BIRTH: _____
PATIENT'S NAME: _____

Where an Attorney is involved

Attorney's name: _____
Address-Street: _____
City: _____ State: _____ Zip: _____
Phone Number: (_____) _____ - _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

DATE: _____ SIGNED: _____

FOR OFFICE USE ONLY

- We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because
- The patient refused to sign.
 - Due to an emergency situation it was impossible to obtain an acknowledgement.
 - We weren't able to communicate with the patient.
 - Other (Please provide specific details)

DATE: _____ SIGNED: _____

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices. This form does not constitute legal advice and covers only federal, not state law.

HEALTH HISTORY

(Confidential)

Name _____ Today's Date _____

Date of Birth _____ Date of last Physical Examination _____

Symptoms: Check symptoms you currently have or have had in the past year			
<p style="text-align: center;"><u>General</u></p> <input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats <p style="text-align: center;"><u>Muscle/Joint/Bone</u></p> Pain, weakness, numbness in: <input type="checkbox"/> Arms <input type="checkbox"/> Hips <input type="checkbox"/> Back <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders <p style="text-align: center;"><u>Genito-Urinary</u></p> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination	<p style="text-align: center;"><u>Gastrointestinal</u></p> <input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood <p style="text-align: center;"><u>Cardiovascular</u></p> <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins	<p style="text-align: center;"><u>Eye, Ear, Nose, Throat</u></p> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision-flashes <input type="checkbox"/> Vision-Halos <p style="text-align: center;"><u>Skin</u></p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't heal	<p style="text-align: center;"><u>Men only</u></p> <input type="checkbox"/> Breast lump <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Sore on penis <input type="checkbox"/> Other <p style="text-align: center;"><u>Women only</u></p> <input type="checkbox"/> Abnormal Pap Smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast lump <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Other Date of last menstrual period _____ Date of last Pap Smear _____ Number of children _____ Have you had a Mammogram? _____ Are you pregnant? _____ Number of Children _____
Conditions: Check conditions you currently have or have had in the past.			
<input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Breast Lump <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts	<input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> Herpes	<input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV Positive <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Mesles <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple Schlerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio	<input type="checkbox"/> Prostate Problem <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhoid Fever <input type="checkbox"/> Ulcers <input type="checkbox"/> Vaginal Infections <input type="checkbox"/> Venereal Disease
Medications		Allergies to medications and substances	

