

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request payment of authorized Medicare/**other** insurance company benefits to me or on my behalf for any services furnished me by Hope Health. I authorize any holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services. I understand that if I do not obtain an insurance referral *(if required) prior to services rendered by Hope Health, I will be responsible for any charges not covered by my insurance company. **I understand that I am financially responsible to Hope Health for any charges not covered by my insurance.**

***PLEASE NOTE:** If you are concerned about your ability to pay for healthcare services at Hope Health, please feel free to discuss payment options with the office manager.

CONSENT FOR TREATMENT

Permission is hereby given to Hope Health staff to render treatment to me/my ward and to order any necessary tests for evaluating my condition.

I permit a copy of this authorization to be used in place of the original.

I give the staff of Hope Health permission to leave messages on my home answering machine.
YES ___ NO ___

I give the staff of Hope Health permission to leave messages with anyone at my residence.
YES ___ NO ___

X Signed: _____ Date: _____
(Patient)

Signed: _____ Date: _____
(Parent must sign if patient is under 18)

Witnessed: _____ Date: _____
(Staff signature)

*If you are covered by an HMO policy through your insurance company, written permission for you to be treated by another provider other than your PCP (primary care provider) is required and should be obtained prior to services being rendered.

**HOPE HEALTH
PATIENT INITIAL HISTORY**

Date _____ Name _____ Date of birth _____

List all medications (**including dosage**) you are currently taking: (**Please include vitamins, supplements and herbs, etc.**)

Allergies or Drug reactions: _____
Food intolerance or dietary restrictions: _____

Operations:	Year	Procedure
	_____	_____
	_____	_____
	_____	_____

Hospitalizations:	When	Reason
	_____	_____
	_____	_____
	_____	_____

Major Accidents: _____

Reason for Today's Visit: _____

Other specialists/Health Care Providers or Alternative Therapist and/or Therapies:

Most Recent Immunizations (Please note year received)/Examinations
Tetanus _____ Flu shot _____ Pneumovax _____ Hepatitis B series _____
Last physical exam _____ Colonoscopy _____ Chest x-ray _____ EKG _____
Bone Density _____

Women only: Date of last Pap smear _____ Mammogram _____

Have you had your cholesterol checked? _____ When _____

Do you have a Living Will (a document that tells us what medical care/life support you want or do not want if you become irreversibly ill)? YES ___ NO ___

Do you wish to be an organ donor? YES ___ NO ___

Continued

Initial History/Review of Systems -Page 2

Please check if you have any ongoing problems with any of the following:

Constitutional

- None
- Weight Change
- Fever
- Weakness
- Fatigue
- Other _____

Gastrointestinal

- None
- Change in appetite
- Nausea/vomiting
- Rectal bleeding/black stool
- Diarrhea or constipation
- Change in bowel habits
- Hemorrhoids
- Excess gas
- Heartburn
- Difficulty swallowing
- Abdominal pain
- Other _____

Neurological

- None
- Seizure
- Weakness
- Fainting/blackouts
- Paralysis
- Tingling
- Memory loss
- Tremors
- Loss of coordination
- Headache
- Other _____

Eyes

- None
- Last eye exam _____
- Glaucoma
- Cataracts
- Blurring vision
- Other _____

Social

- Number of times you exercise weekly _____
- Use street drugs
- Number of alcoholic drinks per week _____
-

ENT

- None
- Deafness
- Ringing in ears
- Nosebleeds
- Sore throat
- Hoarseness
- Frequent colds
- Postnasal drip
- Last dental exam _____
- Chew tobacco
- Other _____

Genitourinary

- None
- Penile/vaginal discharge
- Sexually transmitted disease
- Frequent urination
- Burning/pain with urination
- Dribbling/trouble starting
- Getting up to urinate at night (If so, how many times _____)
- Incontinence
- Sexual problems
- Menstrual problems
- Other _____

Psychiatric

- None
- Anxiety
- Depression
- Stress
- Mood changes
- Difficulty concentrating
- Nervousness
- Irritability
- Sleep disturbance
- Other _____

Cardiovascular

- None
- Chest pain
- Palpitations
- Rheumatic fever
- High blood pressure
- Swelling in feet
- Varicose veins
- Other _____

Musculoskeletal

- None
- Back/neck pain
- Joint swelling
- Muscle tenderness
- Leg cramps/pain
- Do you take in at least 1500 mgs of calcium daily?
- Do you take a vitamin that contains folic acid
- Other _____

Endocrine

- None
- Diabetes
- Thyroid problems/goiter
- Excessive sweating
- Heat or cold intolerance
- Excess thirst/hunger
- Other _____

Respiratory

- None
- Cough
- Asthma
- Pneumonia
- Emphysema
- Bronchitis
- Shortness of breath
- Smoking
- How many per day _____
- Exposed to smoking
- Other _____

Skin & Breast

- None
- Hair/nail change
- Rashes
- Itching
- Change in skin color
- Moles-new or changing
- How often do you wear Sunscreen 100% 50% 0%
- Breast lumps or pain
- Other _____

Hematological

- None
- Anemia
- Bruising
- Blood transfusion
- Tender lymph nodes
- Other _____

Continued

Initial History – Page 3

FAMILY HISTORY:

- Anemia
- Arthritis
- Asthma
- Alcoholism
- Allergies
- Cancer
- Depression

- Diabetes
- Drug Use
- Epilepsy / seizures
- Glaucoma
- Heart Disease
- High blood pressure
- High cholesterol

- Liver disease
- Osteoporosis
- Mental illness
- Pancreatitis
- Rheumatic fever
- Stroke
- Tuberculosis

Other: _____

Age
(or age at death)

State of Health
(or cause of death)

Medical Problems

Father: _____

Mother: _____

Brothers: _____

Sisters: _____

Spouse: _____

Children: _____

Grandparents: _____

Aunts and Uncles related by blood: _____

Other: _____