



**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.**)

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**Allergies** or Drug reactions: \_\_\_\_\_  
Food intolerance or dietary restrictions: \_\_\_\_\_

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Operations:	Year	Procedure
	_____	_____
	_____	_____
	_____	_____

Hospitalizations:	When	Reason
	_____	_____
	_____	_____
	_____	_____

Major Accidents: \_\_\_\_\_  
\_\_\_\_\_

Reason for Today's Visit: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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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: \_\_\_\_\_