PATIENT DEMOGRAPHICS Woodrome Medical PA

Name:_____ **DOB:**____/____/____ **Chart Number:**_____

Sex: ☐ M ☐ F Marital Status: ☐ Single☐ Married☐ Widowed☐ Divorced **SS#**_____-_____-_____

Email:_____

Address:_____ **City:**_____ **State**____ **Zip**_____

Home #:_____ **Cell #:** _____ **Other #:**_____

Occupation:_____ **Employer:**_____ **Phone:**_____

EMERGENCY CONTACT **Name:**_____ **Phone #:**_____

Ethnicity/Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American

☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Decline to answer

Primary Language: ☐ English ☐ Spanish ☐ ASL ☐ Other_____

Privacy Information Preferences

Have you completed any advanced directives? ☐ Y ☐ N Does anyone have Medical POA over you ☐ Y ☐ N

Do you want to exempt from public reporting? ☐ Y ☐ N Can we send mail to the address listed on file? ☐ Y ☐ N

Can we call the phone number on file? ☐ Y ☐ N Can we leave a voicemail on machine? ☐ Y ☐ N

Who can we leave messages with? ☐Spouse ☐ Parent ☐ Child ☐ Other_____ Name:_____

How did you hear about out office? ☐ Physician ☐ Website ☐ Phonebook ☐ Family ☐Friend ☐ Other _____

Primary Insurance:_____ **Are you the insured?**☐ Y ☐ N

Member ID #: _____ **Group #:**_____

Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other **Employer:**_____

Subscriber Name:_____ **DOB:**___/____/____ **Sex:** ☐ M ☐ F

Address:_____ **City:**_____ **State**_____ **Zip** _____

Secondary Insurance:_____ **Are you the insured?**☐ Y ☐ N

Member ID #: _____ **Group #:**_____

Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other **Employer:**_____

Subscriber Name:_____ **DOB:**___/____/____ **Sex:** ☐ M ☐ F

Address:_____ **City:**_____ **State**_____ **Zip**_____

PLEASE READ AND SIGN

The information on my intake forms is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician/staff of any and all updates to the information listed above. (Assignment of Benefits): I authorize payment of medical benefits to the practice named above. (Release of information): I authorize the release of any medical information necessary to process the claim. (HIPPA Privacy): I acknowledge that I received my HIPPA Privacy Practices Notice. (Medication History): I Authorize the Doctors office to retrieve my medication history.

Patient Signature: _____ Date: ____/_____/_____

Woodrome Medical, PA

Assignment of Benefit, Consent to Treat, AI, Preventive and Diagnostic Labs

Assignment of Benefits:

I hereby assign all medical and surgical benefits, to include major medical benefits which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment directly to Woodrome Medical, PA for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Consent for Treatment:

A physician assistant may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulation a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting at surgery
- Offering counseling and education
- Supplying sample medications and writing prescriptions
- Making appropriate referrals

I have read the above, and hereby consent to the services of a physician assistant and advance practice nurse for my health care needs.

AI Scribe during Medical Encounters

Your participation is completely voluntary. If you have any questions or concerns, please feel free to discuss them with us.

Preventive and Diagnostic Labs

A wellness exam is a scheduled medical evaluation of an individual that focuses on preventive care. It will include an age and gender specific history, an examination, a review of risk factors and the ordering of appropriate immunizations, screening labs or diagnostic procedures.

A preventive exam is a periodic exam that covers all prevention and health maintenance issues related to age, sex and family history; it is a Well Exam. A preventive exam is NOT a follow-up visit or problem-based visit. A preventive exam cannot be expected to address all that has been bothering you since your last medical exam. Depending on the judgment of the provider, new problems or chronic disease follow-up may be addressed as a SECOND service during the visit or the provider may ask you to make another appointment.

Note

If a follow-up visit, discussion of any chronic disease, or new problem is discussed during your preventive visit, a follow up visit will also be charged with your well visit and you will be required to pay your copay or pay towards your deductible if so dictated by your insurance policy. Please consult with your insurer or HR department to understand your insurance coverage benefits and requirements.

I further understand that fees are due and payable at the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original. This order will remain in effect until revoked by me in writing.
All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Date: _____ Patient Name: _____
Patient's Date of Birth: _____ Relationship to Patient: _____

Patient/Guardian Signature: _____

Woodrome Medical, PA
Health Assessment Form Page 1

Please fill out to the best of your ability

Are you allergic to any medications? ☐ Yes ☐ No **If answer is yes, please describe below:**

Medication Name	Describe the reaction (i.e. hives, rash, etc.)

Please list all medications you are currently taking (please include over-the-counter, supplements & contraceptives):

Medication Name	Strength/Dosage	Frequency	Reason Why?

PAST MEDICAL HISTORY: Please indicate if you have been diagnosed with any illnesses below by checking the box.

Illness	✓	Date of Diagnosis	Illness	✓	Date of Diagnosis
AIDS or HIV			Hepatitis (type _____)		
Anemia			High Blood Pressure		
Alcoholism			High Cholesterol		
Allergies (not medication)			Hernia		
Anorexia / Bulimia			Kidney Disease / Failure		
Appendicitis			Liver Disease		
Arthritis			Lung Disease		
Asthma			Measles		
Cancer (type_____)			Migraines		
Chemical Dependency			Mononucleosis		
Chicken Pox			Mumps		
Cataract			Pneumonia		
Depression			Psychiatric Care		
Diabetes			Rheumatic Fever		
Esophageal Reflux			Rubella		
Emphysema / COPD			Ovarian Cysts		
Epilepsy / Convulsions			Stomach Ulcer		
Frequent Kidney/Bladder Infections			Sexually Transmitted Disease		
Frequent Lung Infection			Stroke / Min Stroke		
Gallbladder Disease / Gallstones			Thyroid Problems (type_____)		
Glaucoma / Eye Disease			Tonsillitis		
Gout			Tuberculosis		
Heart Disease			Whooping Cough		

SURGICAL HISTORY: Please list any other operations, hospitalizations, or procedures you have had with date (MM/YY)

Surgery/Hospitalization	Date	Please Describe	Surgery/Hospitalization	Date	Please Describe

Signature of Patient or Guardian_____ **Date**_____

Woodrome Medical, PA
Health Assessment Form Page 1

Please fill out to the best of your ability

FAMILY HISTORY: Please indicate if your blood relatives have had any of the following

Illness	Relation	Illness	Relation
AIDS or HIV		Glaucoma / Eye Disease	
Arthritis		Heart Disease	
Asthma		High Blood Pressure	
Bleeding Disorder		Kidney Disease	
Bowel Disease		Lung Disease	
Epilepsy / Convulsions		Psychiatric Care	
Chemical Dependency		Stroke	
Depression		Thyroid Problems	
Diabetes		Tuberculosis	
Cancer (type _____)		Other ?	

SOCIAL HABITS: Have you used any of the following?

Substance	Check One	Amount Per Day?	For How Long?	When Stopped?
Alcohol	☐ Yes ☐ No			
Tobacco Products	☐ Yes ☐ No			
Caffeine	☐ Yes ☐ No			
Street Drugs (type _____)	☐ Yes ☐ No			

Are you sexually active? ☐ Yes ☐ No **How many partners have you had in the last year?**_____
Do you exercise safe sex precautions? ☐ Yes ☐ No **Would you like info on safe sex precautions?** ☐ Yes ☐ No

PREVENTATIVE: Please indicate the last time you had the following test/vaccine (MM/YY). Please note some are age dependent.

Exam	Date	Result?	Vaccine	Date
Cholesterol Testing			Tetanus/Diptheria/Whooping Cough Booser	
Eye Exam with Dilation			Flu Vaccine	
Colonoscopy			Hepatitis B Vaccine	
Tuberculosis Testing			Pneumonia Vaccine	
Stool Occult Blood Testing			Shingles Vaccine	
Males Only: Prostrate Exam			HPV Vaccine	
Males Only: PSA Level				

FEMALE PATIENTS ONLY - GYNECOLOGICAL HISTORY: Please answer the below questions if they are applicable for you.

Test / Exam	Date	Results	Performed By?
Pap Smear			
Clinical Breast Exam			
Mammogram			
Osteoporosis DEXA Scan			
STD and HPV Testing			

Age of onset of menstrual cycle _____ **Are they regular each month?** ☐ Yes ☐ No
Age of onset of menopause _____ **Hysterectomy?** ☐ Yes ☐ No **Have you taken estrogen therapy?** ☐ Yes ☐ No
Preferred Method of Contraception? _____ **Have you ever had an IUD?** ☐ Yes ☐ No
Tubal Ligation? ☐ Yes ☐ No **Number of Pregnancies** _____ **Number of Live Births** _____ **C-Section** ☐ Yes ☐ No
Have you had any miscarriage or complications with pregnancies or deliveries? ☐ Yes ☐ No
If yes, please explain:_____

Signature of Patient or Guardian_____ **Date**_____

Patient Name:_____

DOB:_____**Office Visit Date:**_____

AUDIT C

Did you have a drink containing alcohol in the past year?

- ☐ Yes
- ☐ No

If 'Yes': How often did you have a drink containing alcohol in the past year?

- ☐ Never (0 points)
- ☐ Monthly or less (1 point)
- ☐ Two to four times a month (2 points)
- ☐ Two to three times per week (3 points)
- ☐ Four or more times per week (4 points)

If 'Yes': How many drinks did you have on a typical day when you were drinking in the past year?

- ☐ 1 or 2 (0 points)
- ☐ 3 or 4 (1 point)
- ☐ 5 or 6 (2 points)
- ☐ 7 to 9 (3 points)
- ☐ 10 or more (4 points)

If 'Yes': How often did you have six or more drinks on one occasion in the past year?

- ☐ Never (0 points)
- ☐ Less than monthly (1 point)
- ☐ Monthly (2 points)
- ☐ Weekly (3 points)
- ☐ Daily or almost daily (4 points)

WOOODROME MEDICAL, PA

PATIENT HEALTH QUESTIONNAIRE

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 **+** _____ **+** _____ **+** _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS

By signing below, you acknowledge that you have received **Woodrome Medical PA** ***Notice of Privacy Practices*** or to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

_____

PRINTED NAMES & PHONE NUMBERS of people that confidential information can be released to:

Printed Name:_____Phone #:_____

Printed Name:_____Phone #:_____

Printed Name:_____Phone #:_____

Printed Name:_____Phone #:_____

Printed Name:_____Phone #:_____

Printed Name:_____Phone #:_____

Printed Name:_____Phone #:_____

Printed:
Patient Name:_____ Date of Birth:_____

CIRCLE ONE:
Patient or Legal Representative

_____
Signature

Date:_____

_____
Printed Name

If Legal Representative, relationship to Patient:_____

Woodrome Medical, PA
Patient Controlled Substance Agreement

The purpose of this agreement is to set out the rules that this office follows in order to prescribe medications that are controlled by the Drug Enforcement Agency (DEA). We are committed to making sure we address your needs while providing you with alternatives designed to minimize the addictive potential of the controlled substance treatments we use. In this regard, we may refer you to a Pain Management program to ensure you have access to the best, safest treatments available. If your controlled substance medication (pain, stimulant, sedative) requires ongoing prescriptions that have significant addiction potential we will be requesting you to see a s specialist as applicable. To clarify our expectations in giving you this medication and to emphasize the risk of taking these substances we are requesting you to read and sign this agreement.
I, understand that I am being prescribed controlled substance; therefore, I must adhere to the following restrictions. Failure to conform to any of the below listed restrictions may result in being dismissed as a patient and being reported to the police.

1. I will not use alcohol/illegal drugs while being prescribed medication(s).
2. I will not take any other prescribed medications without first notifying my doctor.
3. I will notify my doctor immediately of any other physician(s) currently prescribing me a controlled substance(s) or that have been prescribed to me in the past thirty days (including emergency rooms and immediate care center). Legally, failure to do so is a crime (obtaining or attempting to obtain drugs by fraud and/or deceit) and may be reported to the Police.
4. I will submit to random urine and/or serum drug screens as ordered.
5. I will only fill prescriptions for controlled substance at the pharmacy listed below. I will inform my doctor of any plans to change pharmacy. I will not obtain controlled substances from more than one pharmacy at a time. The only exception will be for acute need outside of the local area. I will authorize my doctor to communicate with my pharmacist.
6. I authorize my doctor to communicate with all physicians I have seen.
7. I understand it is illegal to share this medication.
8. I agree to keep my medication safe and secure in order to prevent loss or theft.
9. I understand that I will be taken off this medication if there is evidence of addiction and/or abuse.
10. I understand that some of these medications may cause drowsiness and slower reflexes, interfering with the ability to drive and operate machinery, and short-term memory impairment. I understand that overdose of this medication may cause death.
11. I agree to keep all scheduled appointments with my physician/therapist. My medication may be weaned and discontinued if I fail to attend my scheduled appointments.
12. I also understand that part of my treatment may involve reduction and discontinuation of any addictive medications. I understand and accept the risk of addiction that can occur with this medication.
13. I authorize this office to release a copy (or original) of this controlled substance agreement to the Police if I violate any of the listed terms or at their request.
14. (Y or N) Have you received any prescription medications from any other physician in the past thirty days? If yes, please list physician and medication below.
Physician: _____ Phone Number _____
Medication(s): _____
15. I understand I may be called at any time to the office for a count of all my remaining medications. I agree to arrive on the day notified and will be responsible for any costs this may incur.
16. I waive my right of privacy and authorize my doctor to contact any health care provider, legal authority, friend and/or relative in order to obtain or provide information about my care
(including abuse of controlled substances).
17. No refills will be authorized on weekends, holidays or after office hours. An exception may be made at the doctor's discretion if you are seen for an office visit with a copy of a completed police report.
18. Only the person for whom the official (previously known as triplicate) is written may retrieve the prescription.

Patient Name (PRINTED)_____ Date _____

_____ _____
Date of Birth Patient Signature