# PATIENT INFORMATION

DATE: ______________________

PATIENT NAME: ______________________ DATE OF BIRTH: ______________

ADDRESS: ______________________ HOME PHONE: ______________

______________________ CELL PHONE: ______________

EMAIL: ______________________ SSN: ______________

PHARMACY: (Please indicate which location): ______________________

PLACE OF EMPLOYMENT & OCCUPATION: ______________________

WORK PHONE: ______________ MAY WE CONTACT YOU AT WORK: YES NO

MARITAL STATUS: S M W D SEX: MALE FEMALE STUDENT: YES NO

RACE: (Please Circle) AMERICAN INDIAN OR ALASKAN NATIVE ASIAN AFRICAN AMERICAN WHITE PACIFIC ISLANDER REFUSE

ETHNICITY: HISPANIC NON-HISPANIC OR LATINO REFUSE

LANGUAGE SPOKEN: ______________________

HOW DID YOU HEAR ABOUT OUR OFFICE? ______________________

## EMERGENCY CONTACT

NAME: ______________________ PHONE: ______________

ADDRESS: ______________________ RELATION: ______________

## RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT)

NAME: ______________________ PHONE: ______________

ADDRESS: ______________________ RELATION: ______________

## INSURANCE INFORMATION

PRIMARY MEDICAL INSURANCE: NONE BLUE CROSS REGENCE MEDICARE MEDICAID OTHER: ______________

PRIMARY INSURANCE ID NUMBER: ______________ GROUP NUMBER: ______________

SECONDARY MEDICAL INSURANCE: NONE BLUE CROSS REGENCE MEDICARE MEDICAID OTHER: ______________

SECONDARY INSURANCE ID NUMBER: ______________ GROUP NUMBER: ______________

NAME OF POLICY HOLDER (IF DIFFERENT FROM POLICY HOLDER): ______________ DOB: ______________

# MEDICAL HISTORY

Patient Name_______________________________________________ Date of Birth ________________

Most Recent Physical Examination? _________________ For? ____________________________________

What is your estimate of your general health? Excellent Good Fair Poor

**DO YOU HAVE or HAVE YOU EVER HAD ANY OF THE FOLLOWING:** (check yes if so)

__1. Hospitalization for illness or injury?

__2. An allergic reaction to:

aspirin, ibuprofen, acetaminophen, codeine

penicillin

erythromycin

tetracycline

sulfa

local anesthetic

floride

metals (nickel, gold, silver, _____________)

latex

other ______________________________

__3. Heart problems, or cardiac stent within the last six months

__4. History of infective endocarditis

__5. Artificial heart valve, repaired heart defect (PFO)

__6. Pacemaker or implantable defibrillator

__7. Artificial prosthesis (heart valve or joints)

__8. Rheumatic or scarlet fever

__9. High or low blood pressure

__10. A stroke (taking blood thinners)

__11. Anemia or other blood disorder

__12. Prolonged bleeding due to a slight cut (INR > 3.5)

__13. Emphysema, shortness of breath, sarcoidosis

__14. Tuberculosis, measles, chicken pox

__15. Asthma

__16. Breathing or sleep problems (i.e. sleep apnea, snoring)

__17. Kidney disease

__18. Liver disease

__19. Jaundice

__20. Thyroid, parathyroid disease, or calcium deficiency

__21. Hormone deficiency

__22. High cholesterol or taking statin drugs

__23. Diabetes (HbA1c=___)

__24. Stomach or duodenal ulcer

__25. Digestive disorders (i.e. celiac disease, gastric reflux)

__26. Osteoporosis/osteopenia (i.e. taking bisphossponates)

__27. Arthritis, rheumatoid arthritis, lupus

__28. Glaucoma

__29. Contact lenses

__30. Head or neck injuries

__31. Epilepsy, convulsions (seizures)

__32. Neurologic disorders (ADD/ADHD, prion disease)

__33. Viral infections and cold sores

__34. Any lumps or swelling in the mouth

__35. Hives, skin rash, hay fever

__36. STI/STD or HIV/AIDS

__37. Hepatitis (type___)

__38. Tumor, abnormal growth

__39. Radiation therapy

__40. Chemotherapy, immunosuppressive

__41. Emotional problems

__42. Psychiatric treatment

__43. Antidepressant medication

__44. Alcohol / street drug use

**ARE YOU:**

__45. Presently being treated for any other illness

__46. Aware of a change in your health in the last 24 hours

__47. Taking medication for weight management

__48. Taking dietary supplements

__49. Often exhausted or fatigued

__50. Experiencing frequent headaches

__51. A smoker, smoked previously, or use smokeless tobacco

__52. Often unhappy or depressed

__53. FEMALE – taking birth control

__54. FEMALE – pregnant

__55. MALE – prostate disorders

If yes to any of the above, explain: ________________________________________________

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that my possibly affect your treatment:______________________________________________

List all medications, supplements, and or vitamins taken within the last two years:

| Drug | Purpose | Drug | Purpose |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Patient Signature ________________________________________ Date ____________________

RINDFLEISCH™
FAMILY PRACTICE
DALLAS G. RINDFLEISCH, DO

Name: ______________________________ Date:_______________

Over the last two weeks, how often have you been bothered by any of the following problems? (use "✔" to indicate your answer).

| **PHQ-DEPRESSION SCREENING** | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| Poor appetite or overeating | 0 | 1 | 2 | 3 |
| Feeling bad about yourself-or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 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 |
| Thoughts that you would be better off dead, or thoughts of hurting yourself | 0 | 1 | 2 | 3 |
| | | | | |
| Healthcare professional: For interpretation of TOTAL, please refer to the accompanying scoring card). | Add columns | + | + | |

Total: _______________

| 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 |
|---|---|---|---|---|

RINDFLEISCH™
FAMILY PRACTICE
DALLAS G. RINDFLEISCH, DO

Name: ______________________________ Date:_______________

| SOAPP-R | NEVER | SELDOM | SOMETIMES | OFTEN | VERY OFTEN |
|---|---|---|---|---|---|
| How often do you have mood swings? | | | | | |
| How often have you felt a new for higher doses of medication to treat your pain? | | | | | |
| How often have you felt impatient with your doctors? | | | | | |
| How often have you felt that things are just too overwhelming that you can't handle them? | | | | | |
| How often is there tension in the home? | | | | | |
| How often have you counted pain pills to see how many are remaining? | | | | | |
| How often have you been concerned that people will judge you for taking pain medication? | | | | | |
| How often do you feel bored? | | | | | |
| How often have you taken more pain medication than you were supposed to? | | | | | |
| How often have you worried about being left alone? | | | | | |
| How often have you felt a craving for medication? | | | | | |
| How often have others expressed concern over your use of medication? | | | | | |
| How often have any of your close friends had a problem with alcohol or drugs? | | | | | |
| How often have others told you that you had a bad temper? | | | | | |
| How often have you felt consumed by the need to get pain medication? | | | | | |
| How often have you run out of pain medication early? | | | | | |

RINDFLEISCH™
FAMILY PRACTICE
DALLAS G. RINDFLEISCH, DO

Name: ______________________________ Date: _______________

| | | | | | |
|---|---|---|---|---|---|
| How often have others kept you from getting what you deserve? | | | | | |
| How often, in your lifetime, have you had legal problems or been arrested? | | | | | |
| How often have you attended an AA or NA meeting? | | | | | |
| How often have you been in an argument that was so out of control that someone got hurt? | | | | | |
| How often have you been sexually abused? | | | | | |
| How often have other suggested that you have a drug or alcohol problem? | | | | | |
| How often have you had to borrow pain medications from your family or friends? | | | | | |
| How often have you been treated for an alcohol or drug problem? | | | | | |

Please include any additional information you wish about the above answers:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

# RINDFLEISCH FAMILY PRACTICE

## Request for Medical Records

***To be completed by the patient or the patient's authorized representative:***

_________________________________________ ____________________

*Patient's Name* *Date of Birth*

_________________________________________ ____________________

*Patient's or Parent or Personal Representative Signature* *Today's Date*

***To be completed by the doctor if he sees fit to request medical records from another provider:***

**I hereby authorize the below referenced provider to release confidential and protected health information, as described below:**

_________________________________

*Name*

_________________________________

*Organization Name*

_________________________________

*Street Address*

_________________________________

*City* *State* *Zip*

_________________________________

*Telephone*

_________________________________

*Fax*

**I hereby authorize the following person or organization to receive this information:**

Rindfleisch Family Practice
3155 Channing Way, Ste. A
Idaho Falls, ID 83404

208-522-6044 Telephone
208-523-4862 Fax

**Specific Information to released/disclosed is as follows:**

___ Physician notes
___Billing records - statements of charges and payments
___ Specific Lab/x-ray/Report:
___ **All records, or related to the period:** ____________ **and** ____________
(from) (to)

If you **do not** wish to release records containing information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted disease, drug and or alcohol abuse, mental illness or psychiatric, please initial here ______.
**Unless initialed here this information is deemed permissible to release.**

### Notice to Patient:

When information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. You have the right to revoke the authorization in writing except to the extent that the practice has acted in reliance upon this authorization. Your written revocation must be submitted to the Privacy Officer at IPMR. You do not have to sign this authorization and that your refusal to sign will not affect your consent to use or disclosure of your protected health information for purposes of treatment, payment or health care operations. Photocopies, facsimile or scan of this Authorization shall be considered to be the same as a signed original.

# FINANCIAL RESPONSIBILITY

I have requested medical services from Rindfleisch Family Practice on behalf of myself and/or my dependents, and understand that by making this request, I am financially responsible for all the charges incurred in the course of the treatment.

If you will have trouble affording the care or prescriptions you may be prescribed, please discuss with the receptionist now.

**I further understand that fees are due on the date that services are provided, and I agree to pay all such charges. If or when my balance is over $300.00, I will need to pay & keep the balance under $300.00 before being seen again.**

I hereby assign all insurance benefits from which I am entitled to Rindfleisch Family Practice and authorize my insurance carrier(s), including Medicare, Medicaid, private insurance and either health/medical plans, to issue payment directly to Rindfleisch Family Practice for medical services provided to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance including deductibles, co-pays, or other services or items not covered by my insurance plan(s).

**I understand that if an appointment is missed or cancelled without a 24 hour notice, there will be a $20 fee for all medical appointments and a $50 fee for pain management appointments.**

**Patient/Responsible Party Signature** ______________________________________________

**Print Name** ____________________________________ **Date** _________________________

# HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us, whether electronically, on paper, or orally, are kept confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we maintain the privacy of your health information and how we may use and disclose this information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations. We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

The following are your rights to your protected health information:
- The right to request restrictions on certain disclosures of protected health information, including those related to disclosures to family members, relatives, personal friends, or any other person identified by you. We are not required to agree to a requested restriction.
- The right to reasonable requests to receive confidential communications of protected health information.
- The right to inspect and copy your personal health information.

We are required by law to maintain the privacy of your health information and to provide you with notice of legal duties and privacy practices.

I understand that if I would like to review the full HIPAA Policy for Rindfleisch Family Practice, PLLC, a copy can be provided to me upon my request. I have read and reviewed the summarized policy above, and I agree to the terms listed.

Patient/Responsible Party Signature ______________________________

Print Name ______________________________ Date ______________

I give permission for the following people to have access to and discuss my records:

| Name | Relation | Phone Number |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |