ACKNOWLEDGEMENT
OF PRIVACY PRACTICES

CarePlus Medical Centers
14731 Aurora Avenue North
Shoreline, WA 98133
(206) 365-0220

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this inofrmation can and will be used to:

- Provide and coordinate my treatment among a number of healthcare providers who may be involved in that treatment directly or indirectly
- Obtain payment from third-party payers for my healthcare services
- Conduct normal healthcare operations such as quality assessment and improvement activities

I have been informed of my healthcare providers' *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices.* I understand that my healthcare provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations, and I understand that you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

Patient Name: ____ Date: ______________

Signature: ____

If you are signing as a legal guardian ** *Your relationship to patient* ______________________________

Dependent family members also covered by this acknowledement:

______________________________ ______________________________

______________________________ ______________________________

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason: (Circle one of the following)

- The patient refused to sign
- Communication barriers
- Emergency Situation
- Other (list please) ____

CarePlus MEDICAL CENTER

PATIENT'S REPORT OF MEDICAL HISTORY

(CONFIDENTIAL INFORMATION - WILL NOT BE RELEASED WITHOUT PATIENT CONSENT)

DATA BASE

1—PATIENT'S NAME LAST FIRST MIDDLE	2—DATE OF BIRTH	3—AGE	4—DATE OF EXAM

2—PURPOSE OF EXAM

6—HOW TO YOU JUDGE YOUR CURRENT STATE OF HEALTH
☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

3—CURRENT MEDICATIONS
(LIST DRUG AND DOSAGE IF KNOWN)

PAST MEDICAL HISTORY

9—HOSPITALIZATIONS: (LIST YEAR AND CONDICTION BEGINNING WITH MOST RECENT. IF NONE, SO STATE.)

10—SIGNIFICANT ILLNESSES: (HAVE YOU HAD OR DO YOU NOW HAVE ANY OF THESE CONDITIONS?)

YES	NO	
☐	☐	ANEMIA
☐	☐	TUBERCULOSIS OR POSITIVE TB SKIN TEST
☐	☐	THYROID DISEASE
☐	☐	CANCER OR TUMOR
☐	☐	KIDNEY DISEASE
☐	☐	RHEUMATIC FEVER
☐	☐	HEART DISEASE
☐	☐	LUNG DISEASE
☐	☐	DIABETES
☐	☐	ULCER DISEASE
☐	☐	LIVER DISEASE

SOCIAL HISTORY

11—DO YOU CURRENTLY SMOKE? ☐ YES ☐ NO
12—IF YES, ABOUT HOW MANY PACKS PER DAY?
13—IF NO, DID YOU SMOKE PREVIOUSLY? ☐ YES ☐ NO
14—MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED
15—DO YOU EXERCISE THREE OR MORE TIMES A WEEK? ☐ YES ☐ NO

16—DO YOU DRINK ALCOHOL? ☐ YES ☐ NO
17—HAVE YOU OR OTHERS EVER BEEN CONCERNED ABOUT YOUR DRINKING? ☐ YES ☐ NO
18—DO YOUR USE NON-PRESCRIBED DRUGS? ☐ YES ☐ NO
19—DO YOU FEEL YOU ARE UNDER A HIGH LEVEL OF STRESS AT HOME OR AT WORK? ☐ YES ☐ NO

FAMILY HISTORY

RELATION	AGE	STATE OF HEALTH	IF DECEASED, CAUSE OF DEATH	AGE OF DEATH
FATHER				
MOTHER				
SPOUSE				
BROTHERS AND SISTERS				
CHILDREN				

HAS ANY BLOOD RELATION HAD ANY OF THE FOLLOWING CONDITIONS: (PARENT, BROTHER, SISTER, OTHER)

YES	NO	CHECK EACH ITEM	RELATIONSHIP	AGE OF ONSET
		DIABETES		
		HIGH BLOOD PRESSURE		
		HEART DISEASE		
		STROKE		
		ASTHMA		
		TUBERCULOSIS		
		CANCER		
		TYPE:		
		ALCOHOLISM		
		PSYCHIATRIC PROBLEMS		
		OTHER INHERITED DISEASES		

SYSTEM REVIEW

20—GENERAL: (IN THE *RECENT* PAST HAVE YOU HAD ANY OF THESE SIGNS OR SYMPTOMS?)

YES	NO	
☐	☐	UNPLANNED GAIN OR LOSS OF WEIGHT
☐	☐	FATIGUE/WEAKNESS
☐	☐	APPETITE DISTURBANCE
☐	☐	FREQUENT TROUBLE SLEEPING
☐	☐	FREQUENT OR SEVERE HEADACHES
☐	☐	DIZZINESS OR FAINTING SPELLS
☐	☐	EXCESSIVE THIRST
☐	☐	FEELING MUCH HOTTER OR COLDER THAN OTHERS

21—HEENT

EYES

YES	NO	
☐	☐	VISUAL PROBLEMS
☐	☐	DOUBLE VISION
☐	☐	EYE PAIN
☐	☐	GLAUCOMA OR CATARACTS

NOSE

YES	NO	
☐	☐	FREQUENT OR TROUBLESOME NOSEBLEEDS
☐	☐	SINUS INFECTIONS
☐	☐	HAYFEVER OR OTHER ALLERGIES

EARS

YES	NO	
☐	☐	EAR ACHE
☐	☐	DRAINAGE
☐	☐	RINGING IN THE EARS
☐	☐	HEARING DIFFICULTY

THROAT

YES	NO	
☐	☐	MOUTH SORES
☐	☐	SORE THROAT
☐	☐	GUM DISEASE
☐	☐	SPECIAL TEETH PROBLEMS/DENTURES
☐	☐	HOARSENESS OR CHANGE IN VOICE

22—BREASTS (FOR BOTH MEN AND WOMEN)

YES	NO	
☐	☐	LUMPS
☐	☐	PAIN/TENDERNESS
☐	☐	NIPPLE DISCHARGE
☐	☐	CHANGE IN SIZE

23—CHEST

YES	NO	
☐	☐	CHRONIC COUGH
☐	☐	COUGHING UP BLOOD
☐	☐	SHORTNESS OF BREATH
☐	☐	WHEEZING OR ASTHMA
________		APPROXIMATE DATE OF LAST CHEST X-RAY

24—HEART AND BLOOD VESSELS

YES	NO	
☐	☐	PAIN OR PRESSURE IN CHEST
☐	☐	SHORTNESS OF BREATH WITH ROUTINE ACTIVITIES
☐	☐	TROUBLE SLEEPING BECAUSE OF SHORTNESS OF BREATH
☐	☐	SWELLING OF THE FEET OR LEGS
☐	☐	PALPITATIONS OR POUNDING OF THE HEART BEAT
☐	☐	HISTORY OF HEART MURMUR
☐	☐	HIGH OR LOW BLOOD PRESSURE
☐	☐	VARICOSE VEINS

25—STOMACH AND INTENSTINES

YES	NO	
☐	☐	DIFFICULTY SWALLOWING
☐	☐	“HEART BURN”
☐	☐	FREQUENT INDIGESTION
☐	☐	STOMACH PAINS
☐	☐	FREQUENT DIARRHEA OR CONSTIPATION
☐	☐	DARK OR BLOODY STOOLS
☐	☐	RECTAL DISEASE OR HEMORRHOIDS
☐	☐	HERNIA
☐	☐	JAUNDICE, HEPATITIS OR GALLBLADDER TROUBLE

26—URINARY TRACT

YES	NO	
☐	☐	FREQUENT URINATION
☐	☐	NEED TO URINATE DURING SLEEPING HOURS
☐	☐	LOSS OF CONTROL OF URINE
☐	☐	BURNING OR PAIN WITH URINATION
☐	☐	BLOOD IN URINE OR HISTORY OF KIDNEY STONE

27—REPRODUCTIVE SYSTEM

MEN ONLY

YES	NO	
☐	☐	DISCHARGE FROM PENIS
☐	☐	PAIN OR SWELLING OF THE TESTICLES
☐	☐	SEXUAL PROBLEMS
☐	☐	PROSTATE DISEASE

WOMEN ONLY

YES	NO	
☐	☐	VAGINAL DISCHARGE
☐	☐	DIFFICULTY WITH PERIODS
☐	☐	BLEEDING AFTER GOING THROUGH MENOPAUSE IF APPLICABLE
☐	☐	USE OF BIRTH CONTROL
☐	☐	SEXUAL PROBLEMS
________		AGE OF ONSET PERIODS
________		AGE WHEN PERIODS STOPPED, IF APPLICABLE
________		APPROXIMAGE DATE OF LAST PAP SMEAR

28—MUSCLES AND SKELETAL SYSTEM

YES	NO	
☐	☐	PAIN, STIFFNESS, OR SWELLING OF JOINTS
☐	☐	FREQUENT BACK PAIN
☐	☐	FOOT TROUBLE
☐	☐	SERIOUS INJURY

29—NERVOUS SYSTEM

YES	NO	
☐	☐	EPILEPSY OR SEIZURES
☐	☐	STROKE OR TROUBLE WITH SPEECH
☐	☐	PROBLEMS WITH MEMORY
☐	☐	COORDINATION DIFFICULTIES
☐	☐	NUMBNESS OF HANDS AND/OR FEET

30—EMOTIONAL

YES	NO	
☐	☐	ANXIETY
☐	☐	DEPRESSION
☐	☐	FAMILY/MARITAL PROBLEMS

PATIENT INFORMATION

PLEASE PRINT

PATIENT______ Last Name ______ First Name ______ Middle Initial ☐ MR. ☐ MISS ☐ MRS. ☐ MS. **TODAY'S DATE**______

ADDRESS______ HOME PH:______ WORK PH:______

______ City ______ State ______ Zip ______ EMAIL:______

PATIENT'S RELATIONSHIP TO PERSON RESPONSIBLE FOR BILL: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ DEPENDENT

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED BIRTHDATE______ AGE______

SEX: ☐ MALE ☐ FEMALE SOCIAL SECURITY#______ DRIVERS LICENSE#______

REFERRED TO THIS OFFICE BY:______

PATIENT'S EMPLOYER______ SPOUSE'S NAME______

EMPLOYER ADDRESS______ SPOUSE'S EMPLOYER______

______ City ______ State ______ Zip ______ HOME PH#______ WORK PH#______

OCCUPATION______ SPOUSE'S OCCUPATION______

PERSON RESPONSIBLE FOR BILL, IF NOT PATIENT

NAME______ SPOUSE'S NAME______

SOCIAL SECURITY#______ SPOUSE'S EMPLOYER______

MAILING ADDRESS______ EMPLOYER ADDRESS______

CITY, STATE, ZIP______ CITY, STATE, ZIP______

HOME PH#______ WORK PH#______ WORK PH#______

EMPLOYER______ OCCUPATION______

EMPLOYER ADDRESS______

CITY, STATE, ZIP______

DRIVER'S LICENSE#______

INSURANCE AND/OR INJURY INFORMATION

PRIMARY INSURANCE______ SECONDARY INSURANCE______

SUBSCRIBER'S NAME______ SUBSCRIBER'S NAME______

GROUP#______ GROUP#______

ID#______ ID#______

PATIENT'S RELATIONSHIP TO SUBSCRIBER: PATIENT'S RELATIONSHIP TO SUBSCRIBER:

☐ SELF ☐ SPOUSE ☐ CHILD ☐ DEPENDENT ☐ SELF ☐ SPOUSE ☐ CHILD ☐ DEPENDENT

SUBSCRIBER'S EMPLOYER______ SUBSCRIBER'S EMPLOYER______

IF INJURED, DATE OF INJURY:______ PLACE: ☐ HOME OR SCHOOL ☐ WORK ☐ AUTO ACCIDENT ☐ OTHER:______

NATURE OR CAUSE OF INJURY:______

IN CASE OF EMERGENCY, LOCAL FRIEND OR RELATIVE TO BE NOTIFIED (NOT LIVING AT SAME ADDRESS)

NAME:______ RELATIONSHIP TO PATIENT:______

HOME PHONE:______ WORK PHONE:______

ASSIGNMENT AND RELEASE: I herby authorize my insurance benefits be paid directly to the physician. I am financially responsible for any balance due. I also authorize the doctor or insurance company to release any information required for this claim.
MEDICARE PATIENTS: I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished by me or in (name of provider), including physician services. I authorize any holder of medical or other information about me to release to the health care financing administration and its agents any information needed to determin these benefits or benefits for relates services.

______
Signature of patient or authorized representative

______
Date

______
Printed name if signed on behalf of patient/Relationship (parent, legal guardian, personal representative, etc.) (Notation, if any, by staff)