HOMETOWN WELLNESS

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PATIENT INFORMATION

Patient **FULL** Name:_____

Date of Birth: _____/_____/_____ Sex: ☐Male ☐Female

Mailing Address:_____

Physical Address:_____

City:_____ State:_____ Zip Code:_____

Cell Phone:_____ Email: _____

Responsible Party: _____

Patient Social Sec #:_____ **(Required)**

Why are you visiting the doctor today? _____

1. **RACE (Please check one)**
   - ☐ American Indian/Alaska Native
   - ☐ Asian
   - ☐ Black/African American
   - ☐ More than one race
   - ☐ Native Hawaiian
   - ☐ Pacific Islander
   - ☐ White/Caucasian
   - ☐ Decline
2. **ETHNICITY (Please check one)**
   - ☐ Hispanic/Latino
   - ☐ Non-Hispanic/Latino
   - ☐ Decline

EMERGENCY CONTACT

Name:_____Phone #:_____Relationship:_____

Name:_____Phone #:_____Relationship:_____

INSURANCE INFORMATION

Insurance Name:_____

Insurance Number: _____

Insurance Card MUST be shown at each visit.

ALLERGIES for Patient.

Have you had an allergic reaction to any of the following? ☐**No Known Drug Allergies**

☐Adhesive Tape ☐Anesthesia ☐Aspirin ☐Latex ☐Iodine/Shellfish/Contrast Dye ☐Codeine ☐Morphine

☐Penicillin ☐Sulfa Drugs ☐Other:_____

SOCIAL HISTORY for Patient.

Occupation:

☐ Full-Time
☐ Part-Time
☐ Retired
☐ Disabled
☐ Unemployment
☐ Student

Marital Status:

☐ Single
☐ Married
☐ Divorced
☐ Widowed
☐ Domestic Partner
☐ Separated

Do you?

SMOKE: ☐ Yes ☐ No ☐ Former
How many years?_____
How many packs per day?_____
CHEW: ☐ Yes ☐ No ☐ Former
How many years?_____
ALCOHOL: ☐ Never ☐ Weekly ☐ Seldom
VAPE: ☐ Never ☐ Daily ☐ Former
Type:_____

Have you ever abused alcohol? ☐ Yes ☐ No

Have you ever used any illicit substances? ☐ Yes ☐ No

Have you ever been addicted to or misused prescription drugs? ☐ Yes ☐ No Type:_____

MEDICAL HISTORY for Patient: Do you have a history of any of the following?

☐Seasonal Allergies ☐ Anemia ☐ Anxiety ☐ Arthritis ☐ Asthma ☐ Bleeding Problems

☐Cancer, Type: _____ ☐ Chest Pain ☐ Congestive Heart Failure ☐ Coronary Artery Disease

☐ Depression ☐ Diabetes: (Type 1) (Type 2) ☐ Fibromyalgia ☐ Heart Disease ☐ Hypertension

Last A1C:_____

☐ Headaches: (Migraine) (Cluster) (Tension) ☐ Hepatitis ☐ HIV or AIDS ☐ Kidney Failure

☐ Infection Problems:_____ ☐ Liver Disease ☐ Neuropathy ☐ Osteoporosis

☐Shortness of breath ☐ **NONE of the problems Listed** ☐ Other:_____

FAMILY HISTORY--Patients IMMEDIATE Family

☐ **Adopted, family history unknown**

	M	F	S	B		M	F	S	B		M	F	S	B
Anesthesia Problems					Headache/Migraine					Osteoporosis				
Arthritis					Heart Disease					Seizures				
Bleeding Disorders					Hypertension					Stroke				
Cancer (Type):					Kidney Disease					Substance Abuse				
Chronic Pain					Liver Disease					Other:				
Diabetes: Type 1 or 2 Circle one					Mental Illness					Other:				

Please circle the appropriate answer

Mother: Living Deceased **Father:** Living Deceased **Sister/Brother:** Living Deceased

Sister/Brother: Living Deceased **Sister/Brother:** Living Deceased **Sister/Brother:** Living Deceased

OTHER PROVIDERS

Please list Specialists and any other providers you may also be seeing or have seen in the past ☐ N/A

Provider Name	Specialty

SURGICAL HISTORY

Please list all previous surgeries ☐ N/A

Type of Surgery	Right or Left	Year/Date	Doctor and/or Location

CURRENT MEDICATIONS

Please list all prescriptions, OTC, herbal, and/or vitamin (nutritional) supplements you are currently taking. ☐ N/A

Your medication information can be transferred from the pharmacy into the record if you mark " yes" here: YES ☐ NO ☐ (If you mark yes here you may skip writing the prescription medications below)

Name of Medication	Dosage (mg, mcg, mL)	Frequency

Consent for Evaluation and Treatment

Hometown Wellness (HTW) is committed to providing primary care services to the area residents. Information about Patient will NOT be given to anyone outside HTW, including family and friends, unless Patient (parent or legal guardian, if a minor) gives written permission. Patient may consent to release his/her information if Patient is age 16 or older for behavioral care and 18 or older for primary or dental care. However, we may release Patient's information to others without the Patient's permission if: 1) Patient poses a threat to him/herself or others; 2) Patient is unable to protect him/herself from risk of harm; 3) Patient is in the legal custody of a government agency or facility; 4) there is evidence of child abuse; 5) Patient's clinical records are requested under court order including a subpoena to which Patient does not object promptly.

There are fees for all services, and Patient should pay on the day Patient is seen. Health insurance policies may cover a portion of the fees but Patient understands that this may not cover every service. Patient shall tell HTW staff about changes in financial status including insurance.

PATIENT is responsible for payment for services not covered by insurance.

The providers and staff at HTW will depend on statements made by Patient, Patient's medical history, and other information to evaluate his/her condition and decide on the best treatment. The evaluation and treatment of children and adolescents often requires the involvement of the parent(s) and/or other family members.

Some services at HTW may involve the use of telemedicine equipment and interaction with providers who are not physically onsite. These sessions are transmitted via secure, dedicated high-speed lines and are not videotaped, routed through the internet or saved in any way.

Health professions are not exact sciences and no guarantees are made concerning the course or effect of treatment proposed by the provider nor outcomes of treatment. Any questions about the benefits, risks, available options, or the limits of confidentiality should be directed to the provider and staff.

In treating patients, studies including x-rays, laboratory tests, EKGs or psychological tests may be warranted. There are risks involved in taking any medications and any questions about medications will be answered by the medical staff. **Patient accepts the risks of medication and other treatment, and understands additional fees may occur that Patient may be responsible for.**

I understand, that if I am 16 years of age or older, I may consent for mental health services; if I am 18 years of age or older, I may consent for all other health services; otherwise my parent or legal guardian will need to consent for services. By signing this form, (parent or legal guardian signature, if required) I agree that I have read or had this form read and/or explained to me, that I understand it and that any questions I asked have been answered. I understand that I agree to be truthful in providing information.

Thus, I hereby ask, agree, and consent to evaluation and treatment for myself and/or my child(ren) as set forth above, including any studies or procedures that HTW professional staff decide are necessary or appropriate. If signing as parent or guardian, I hereby represent and warrant that I am legally empowered and entitled to make such decisions.

Patient Name: _____ Date: _____

Parent or Guardian Signature: _____

Current Phone Number: _____

Office Staff: _____ Date: _____

HOMETOWN WELLNESS

PLEASE READ THE FOLLOWING CAREFULLY

HIPAA AND RELEASE OF INFORMATION

Federal and State law requires us to maintain the privacy of your health information under the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Hometown Wellness is NOT allowed to give your information to anyone without your expressed **written** consent. You have the right to expect your PHI (Protected Health Information) will be treated confidentially within Hometown Wellness. If you need your medical records for your personal use, you will need to sign our "Personal Medical Release Form". If another doctor's office requires your medical records, you will need to get a "Medical Release Form" from that doctor's office, it will need to be signed and sent to us for those records to be released. Hometown Wellness has the right to give your information to your insurance company for billing purposes and reserves the right to change our privacy policy and the terms of this notice at any time, law permitting. You may request a copy of this notice at any time. By signing this form, you acknowledge that you have read and understand the above information.

RELEASE OF INFORMATION

The following release of information allows Hometown Wellness to communicate MY information, such as medication refills, making or cancelling appointments, getting test results, and any billing information to the following individuals, who are NOT medical professionals, assisting in my health care. I authorize Hometown Wellness to release the aforementioned information to the following individuals.

1. _____ Printed full name of authorized individual
   _____ Relationship to patient
2. _____ Printed full name of authorized individual
   _____ Relationship to patient
3. _____ Printed full name of authorized individual
   _____ Relationship to patient
4. _____ Printed full name of authorized individual
   _____ Relationship to patient
5. _____ Printed full name of authorized individual
   _____ Relationship to patient

☐ **I do not want anyone except myself to have access to my PHI (protected health information).**

_____ Printed patient full name
_____ Patient date of birth

_____ Signature of patient or patient representative

_____ Relationship to Patient
_____ Todays Date

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS AND PROTECTED HEALTH INFORMATION (PHI). THIS AUTHORIZATION IS FOR THE CONTINUING MEDICAL CARE AND MUST BE COMPLETED IN ITS ENTIRETY TO BE VALID.

PATIENT NAME _____ DATE OF BIRTH _____

SOCIAL SECURITY NUMBER _____ PHONE NUMBER _____

ADDRESS _____

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MEDICAL RECORDS TO BE RELEASED FROM:

NAME OF CLINIC/PROVIDER _____

ADDRESS _____

PHONE NUMBER _____ FAX NUMBER _____

DATE(S) OF SERVICE _____

Information to be released: History & Physical, Consultation Reports, Emergency Room Records, Operative Reports, Discharge Summary, Face Sheets, Lab/Pathology Reports, Radiology Reports/Images, Consultation Notes, Other:

I understand that my records are confidential and cannot be disclosed without my written authorization. I also understand that signing this release is voluntary.

□ I consent to the release of my PHI to Hometown Wellness, LLC.

PATIENT SIGNATURE _____ DATE _____

If a patient is under 18, or unable to sign for themselves then a parent, legal guardian, or representative must fill out the section below.

PARENT/GUARDIAN SIGNATURE _____ RELATIONSHIP TO PATIENT _____

Hometown Wellness, LLC 1070 N Hildale ST # 750 Hildale UT 84784 P: 435-216-5488 F: 435-216-5969