Bradenton East Integrative Medicine

PATIENT DATA

NAME_____ HOME PH# ( ) _____ CELL PH# ( )_____

ADDRESS_____ CITY_____ STATE_____ ZIP _____

AGE _____ BIRTHDATE_____ MARITAL STATUS _____ NUMBER OF CHILDREN _____

SOCIAL SECURITY #_____ DRIVERS LICENSE # _____ STATE _____

OCCUPATION _____ EMPLOYED BY_____

WHO DO YOU RESIDE WITH?_____

SPOUSES NAME _____ email _____

WHEN WAS YOUR LAST PHYSICAL?

WHAT WAS YOUR PREVIOUS PHYSCIAN'S NAME? _____

PREVIOUS PHYSCIANS PHONE #_____

HISTORY OF PREVIOUS SURGERIES?____ YES ____NO _____

FOR WHAT CONDITION? DATES?_____

_____

ALLERGIC TO ANY MEDICATION? ___YES ___NO PLEASE LIST ALLERGIES / REACTIONS_____

_____

OTHER ALLERGY'S _____

OTHER SENSITIVITIES: _____

DO YOU HAVE AN ADVANCED DIRECTIVE ON FILE? YES___ NO___

PREFERRED PHARMACY_____

REASON FOR TODAY'S VISIT (INCLUDE DATE OF ONSET)_____

_____

_____

_____

NAME _____ DATE OF BIRTH _____ DATE:_____

PERSONAL HABITS/SOCIAL HISTORY

1) DO YOU CURRENTLY SMOKE?__YES__ NO # OF YRS _____
2) NUMBER OF CIGARETTES PER DAY?_____ CIGARS _____ PIPES_____
3) QUIT?___YES___NO # OF YEARS AGO___ PREVIOUS # OF PACKS PER DAY___

4) USED CHEWING TOBACCO ___YES __NO # OF YRS_____
5) DO YOU CURRENTLY DRINK ALCOHOL?_____YES_____NO # OF DRINKS DAILY_____
6) ANY HISTORY OF RECREATIONAL DRUG USE?___YES___NO
IF YES WHAT TYPE? _____

FAMILY HISTORY

WHO IN YOUR FAMILY HAS/HAD (CIRCLE IF CAUSE OF DEATH AND AGE AT DEATH)

Heart disease _____ Genetic Disorder _____ Cancer _____

Diabetes _____ Alcoholism _____ Arthritis _____

Thyroid Disease _____ Stomach Problems _____ Asthma _____

Mental Illness _____ High Blood Pressure _____ Tuberculosis _____

Stroke_____ Heart attack_____ High Cholesterol _____

*Please indicate if Maternal or Paternal side of the family

MEDICAL HISTORY

Please check any Symptoms or Diseases you may have

GENERAL HEALTH	**Any history of Stroke?**	
Do you have any in this section now?	( ) Yes ( ) No	**HEART AND LUNGS CONT.**
( ) Fever	**Any history of TIA?**	( ) Congestive heart failure
( ) Anemia, low iron in the blood	( ) Yes ( ) No	
( ) Swollen glands	**NECK**	( ) Shortness of breath w/ exercise
( ) Unexplained tiredness	( ) Pain	( ) Shortness of breath at rest
( ) Unplanned weight loss	( ) Goiter/enlarged thyroid	( ) Unable to lay down flat
( ) Dialysis	( ) Stiffness	( ) Ankles swelling
NEUROLOGICAL	**HEART AND LUNGS**	( ) Pain in chest or back
( ) Fainting	( ) High blood pressure	
( ) Tremors	( ) Heart attack	( ) Cough
( ) Seizures	( ) Palpitations/ irregular heartbeat	( ) Phlegm: Colored ___ Clear ___
( ) Numbness/ weakness	( ) Bypass surgery	
( ) Headaches ( ) History of head trauma	( ) Stent ( ) Pacemaker	

DIGESTIVE SYSTEM	BREASTS	DIABETES / ENDOCRINE
( ) Loss of appetite	( ) Tenderness	Are you a diabetic?
( ) Indigestion	( ) Lumps	( ) YES ( ) NO
( ) Heartburn	( ) Change in color in skin	# of years since diagnosis ( )
( ) Nausea	( ) Discharge	Have you had diabetes education?
( ) Vomiting		( ) YES ( ) NO
( ) Abdominal pain	URINARY	Last fasting blood sugar ( )
( ) Diarrhea		Last HbgA 1c ( )
( ) Recent Antibiotic	( ) Pain/burning when urinating	Are you insulin dependent?
( ) Constipation	( ) Leaking of urine	( ) YES ( ) NO
( ) Food Intolerance / allergies	( ) Frequent urination	( ) Thyroid problems
( ) Gall Stones	( ) Urination at night	( ) Hair change / loss
( ) ulcer	( ) Blood in urine	
HAVE YOU HAD A COLONOSCOPY?	ANY HISTORY OF HIGH CHOLESTEROL?	ANY HISTORY OF MAJOR CANCER?
( ) YES ( ) NO	( ) YES ( ) NO	( ) YES ( ) NO
DATE?	# of years since diagnosis ( )	IF YES WHAT TYPE?
Was it normal?		
( ) YES ( ) NO		
	MUSCLES AND JOINTS	IMMUNIZATIONS / DATE (YEAR)
EYES	( ) Paralysis	( ) Flu shot
( ) Macular Degeneration	( ) Pain	( ) Pneumonia shot
( ) Had Laser or Lasik Surgery	( ) Weakness	( ) Hepatitis A
( ) Glaucoma		( ) Hepatitis B
( ) Cataracts	History of broken / Fractured bones?	( ) Tetanus shot
( ) Blurred Vision	( ) YES ( ) NO	( ) Shingles
( ) Wear glasses or contacts		( ) HPV (Gardasil)
	MENTAL	( ) Meningitis
EARS	( ) Memory problems	
( ) Ringing in ears	( ) Trouble sleeping	OTHER QUESTIONS
( ) Discharge	( ) Anxiety disorder	Any history of?
( ) Pain	( ) Depression	( ) HIV Positive
( ) Hearing loss		( ) Tuberculosis or exposure
	SKIN PROBLEMS	( ) Treatment for MRSA or
MOUTH		Other resistant bacteria
	( ) Abnormal or growing moles	( ) Hepatitis B or C
( ) Sore throat	( ) Rashes	
( ) Swallowing difficulty	( ) Lumps	
( ) Hoarseness	( ) Easy bruising	Do you have an IV port?
( ) Ulcers	( ) Psoriasis / Eczema	( ) Yes ( ) No
( ) Dentures	( ) History of skin cancer	

REPRODUCTIVE SYSTEMS

WOMEN	#of children ( )	# of Pregnancies ( )
( ) Heavy periods		
( ) Irregular Periods	( ) Bad cramps	( ) Bleeding after Menopause
( ) Infertility	( ) PMS	( ) Hot flashes
( ) Vaginal dryness	( ) Vaginal discharge	( ) Abnormal Pap Smear
( ) Vaginal itching	( ) Pain with sexual intercourse	( ) Abnormal mammogram

Date of last Menstrual period_____

Date of last Bone Density Scan_____ Normal? ( ) Yes ( ) No_

Date of last Mammogram _____Normal? ( ) Yes ( ) No_

Date of Last Pap Smear_____ Normal? ( ) Yes ( ) No

MEN			
( ) Testicular Cancer	( ) Erectile Dysfunction	( ) Prostate Cancer	( ) Other
( ) Blood in semen	( ) Pain with intercourse		

Please List Medications and Supplements

Name	Dosage	How Taken

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I hereby authorize the Providers(and its entities) to furnish information to the insurance carriers, and I hereby assign to all physicians all payment for medical services. I understand that I am responsible for non-covered fees.

SIGNATURE _____ **DATE** _____

Bradenton East Integrative Medicine, P.A.

6120 53RD AVENUE EAST, BRADENTON, FL 34203

PATIENT AUTHORIZATION FOR DISCLOSURE OF INFORMATION

Do we have permission to?..

Leave the following information on your home answering machine or voice mail:

Appointment information	Y	N
Medical information	Y	N
Billing information	Y	N
Contact you at work	Y	N

List family members, friends or personal care givers that you give permission to receive the following information about you:

Appointments: _____

Medical or health information: _____

Billing / payments: _____

I understand that if the person or entity receiving Authorized Information is not a health plan or health care provider covered by federal privacy regulations, the authorized information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I may revoke this authorization at any time by notifying Bradenton East Integrative Medicine in writing.

I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

I have received a copy of the "Notice of Privacy Practices" to review and acknowledge that I may request a copy.

Patient signature_____ Date___/___/___

REQUEST TO RELEASE MEDICAL RECORDS

TO:_____
PHYSICIAN'S NAME

_____
ADDRESS

_____
CITY, STATE & ZIP

I HEREBY REQUEST THAT MY:

____COMPLETE RECORDS	____ LAB TESTS
____ X-RAYS	____ EKG/ECG
____ CONSULT REPORTS	____ OTHER_____

RELEASE TO:

BRADENTON EAST INTEGRATIVE MEDICINE, PA

* KAREN BRAINARD, MD_____* ROBIN JAMES, ARNP_____
*JAMES LEIBER,DO_____*MAUREEN O'REILLY,ARNP_____

6120 53RD AVENUE EAST
BRADENTON, FL. 34203
PHONE: (941) 727-1243
FAX: (941)751-9039

FOR THE PURPOSE OF CONTINUITY OF CARE

_____
PATIENT'S NAME

_____-_____-_____ _____-_____-_____
DATE OF BIRTH SOCIAL SECURITY #

_____ _____-_____-_____
SIGNATURE DATE

THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE OF SIGNING UNLESS OTHERWISE INDICATED. THE PATIENT MAY REVOKE THIS AUTHORIZATION AT ANYTIME UPON REQUEST. THE DISCLOSED INFORMATION MAY NO LONGER BE PROTECTED BY THE PRIVACY PRACTICES OF THIS PRACTICE.

Medical Symptoms Questionnaire

Name _____ Date _____

Rate each of the following symptoms based upon your typical health profile for:

☐ *Past 30 days* ☐ *Past 48 hours*

Point Scale

0 - *Never* or *almost never* have the symptom
1 - *Occasionally* have it, effect is *not severe*
2 - *Occasionally* have it, effect is *severe*
3 - *Frequently* have it, effect is *not severe*
4 - *Frequently* have it, effect is *severe*

HEAD

_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia

Total _____

EYES

_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision (does not include near or far-sightedness)

Total _____

EARS

_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss

Total _____

NOSE

_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation

Total _____

MOUTH/THROAT

_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, lips
_____ Canker sores

Total _____

SKIN

_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating

Total _____

HEART

_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain

Total _____

Medical Symptoms Questionnaire

LUNGS	____	Chest congestion	
	____	Asthma, bronchitis	
	____	Shortness of breath	
	____	Difficulty breathing	Total ____
DIGESTIVE TRACT	____	Nausea, vomiting	
	____	Diarrhea	
	____	Constipation	
	____	Bloated feeling	
	____	Belching, passing gas	
	____	Heartburn	
	____	Intestinal/stomach pain	Total ____
JOINTS/MUSCLE	____	Pain or aches in joints	
	____	Arthritis	
	____	Stiffness or limitation of movement	
	____	Pain or aches in muscles	
	____	Feeling of weakness or tiredness	Total ____
WEIGHT	____	Binge eating/drinking	
	____	Craving certain foods	
	____	Excessive weight	
	____	Compulsive eating	
	____	Water retention	
	____	Underweight	Total ____
ENERGY/ACTIVITY	____	Fatigue, sluggishness	
	____	Apathy, lethargy	
	____	Hyperactivity	
	____	Restlessness	Total ____
MIND	____	Poor memory	
	____	Confusion, poor comprehension	
	____	Poor concentration	
	____	Poor physical coordination	
	____	Difficulty in making decisions	
	____	Stuttering or stammering	
	____	Slurred speech	
	____	Learning disabilities	Total ____
EMOTIONS	____	Mood swings	
	____	Anxiety, fear, nervousness	
	____	Anger, irritability, aggressiveness	
	____	Depression	Total ____
OTHER	____	Frequent illness	
	____	Frequent or urgent urination	
	____	Genital itch or discharge	
			Total ____
GRAND TOTAL			*TOTAL* ____

Bradenton East Integrative Medicine
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 REVIEW IT CAREFULLY.

Bradenton East Integrative Medicine is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (example)

> *"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with* **Bradenton East Integrative Medicine.***"*
>
> *"It is our policy to provide a substitute health care provider, authorized by Your Company name here to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."*

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

> *"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to* **Bradenton East Integrative Medicine** *for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."*

Workers' Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting

child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings.
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement.
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons.
We may disclose your health information to coroners or medical examiners.

Organ Donation.
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research.
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety.
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies.
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing.
We may contact you for marketing purposes or fundraising purposes, as described below: (example)

> *"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."*
>
> *"It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of*

Bradenton East Integrative Medicine *sponsored fund-raising events."*

Change of Ownership.
In the event that **Bradenton East Integrative Medicine** is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that **Bradenton East Integrative Medicine** is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that **Bradenton East Integrative Medicine** amend your protected health information. Please be advised, however, that **Bradenton East Integrative Medicine** is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s)and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by **Bradenton East Integrative Medicine.**
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices
Bradenton East Integrative Medicine reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, **Bradenton East Integrative Medicine** is required by law to comply with this Notice.

Bradenton East Integrative Medicine is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: **Greg Gould** by calling this office at 941.727.1243. If **Greag Gould** is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints
Complaints about your Privacy rights, or how **Bradenton East Integrative Medicine** has handled your health information should be directed to **HEATHER JOHNSON** by calling this office at 000-000-0000 If **HEATHER JOHNSON** is not available, you may make an appointment for a personal conference in person or by telephone within 2

working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of _____/_____/_____

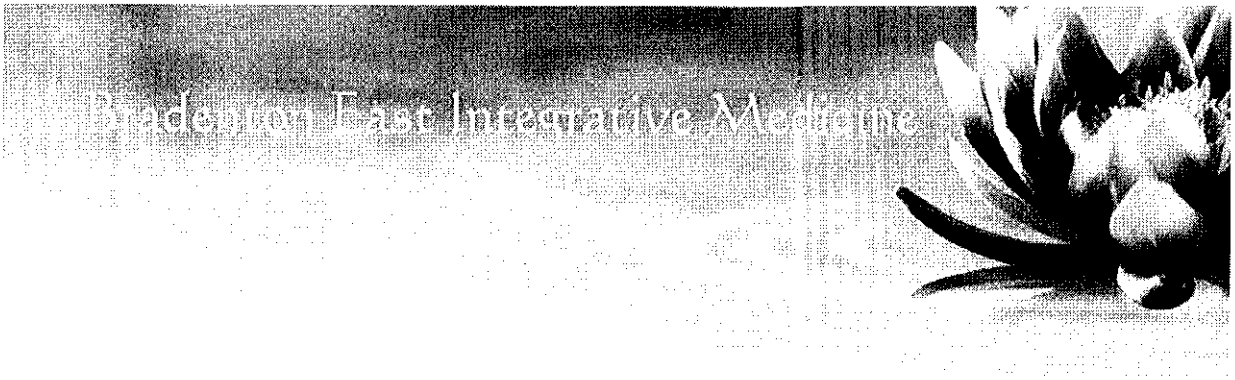
I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide **Bradenton East Integrative Medicine** with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

_____
Patient's Name (print)

_____ _____
Patient's Signature Date

_____ _____
Authorized Facility Signature Date



KNOW YOUR INSURANCE – Your insurance is a contract between you and your insurance company.

We want to inform you that your health insurance benefits may or may not cover specific services depending on your policy. These services may include but are not limited to routine physical exams, ultrasound testing, massage, acupuncture, and laboratory services.

If your coverage denies this claim, you may be financially responsible.

Signature

Please print name