Welcome to our office
New Patient Consent Forms

Please complete the following questionnaire. This will become part of your office record and will be held in strict confidence.

Date _____

Information on patient

Name (Mr/Mrs/Miss) _____ Nickname: _____ ☐ Male ☐ Female

Address _____

City _____ State _____ Zip _____ Race _____

Home phone _____ Cell _____ Work _____

Date of birth _____/_____/_____ Social Security # _____

Occupation _____ Email address _____

Marital Status _____ Referred by _____

Information on party responsible for payment

☐ Check here if this information is the same as in the box above

Home address _____

City _____ State _____ Zip _____

Home phone _____ Cell _____ Work _____

Date of birth _____/_____/_____ Social Security # _____

Employer _____ Relationship to patient _____

Insurance Information

1st Insurance company	Policy #	Group#	Insured's name
2nd Insurance company	Policy #	Group#	Insured's name

I agree to be responsible for any charges for services and materials supplied by *Anthony E. Jones, MD*, and its doctors for the above patient.

_____

Signature of party responsible for payment Date

Anthony E. Jones, MD

Consent for Purposes of Treatment, Payment and Health Care Operations

I understand that as a condition to my receiving treatment from **Anthony E. Jones, MD, Anthony E. Jones, MD** may use or disclose my personally identified health information for treatment to obtain payment for the treatment provided and as otherwise necessary for the operations of **Anthony E. Jones, MD**.

While I am here, I permit the employees, the doctor and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand the attending physician will explain to me the nature of my condition, his or her recommended treatment and any associated risks involved. I also understand that he or she will explain to me other ways this condition could be treated. I further understand that this care may include diagnostic testing, examinations, and medical and/or surgical treatment, and that no guarantees have been made to me about the outcome of this care.

"Personally identifiable health information" refers to health and demographic information collected about me by my physician (or other health care provider, public health authority, health plan, employer, life insurer, school or university, or health care clearinghouse) that relates to my past, present or future physical or mental health or condition or payment for provision of health care. The information identifies me, or there is a reasonable basis to believe that the information may identify me.

I understand that privacy practices described in the Notice of Privacy Practices may change over time and that I have a right to obtain any revised Privacy Notice by contacting **Anthony E. Jones, MD** to make such a request. I also understand that I have the right to request **Anthony E. Jones, MD** to restrict how my health information is used or disclosed. **Anthony E. Jones, MD** does not have to agree to my request for the restriction, but if **Anthony E. Jones, MD** does agree, **Anthony E. Jones, MD** is bound to abide by the restriction as agreed.

Finally, I understand that I have the right to revoke/withdraw this consent, in writing, at any time. My revocation/withdrawal will be effective except to the extent that Anthony E. Jones, MD has taken action in reliance on my consent for use or disclosure of my health information. Provision of future treatment may be withdrawn my consent.

1. _____

Patient acknowledgement (Signature) *Date*

Medicare lifetime consent & Medicaid: I certify that the information given by me in applying under Title XVII of the Social Security Act is correct, and I authorize any holder of medical or intermediaries or carrier as needed for this or a related Medicare claim. I assign the benefits payable for the physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

1. _____

Patient acknowledgement (Signature) *Date*

The Office of Anthony E. Jones, MD

HEALTH HISTORY FORM

Date _____ Name _____ DOB ____/____/____

Your answers on this form will help your health care provider better understand your medical concerns and condition better. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please provide your best guess.

Age _____ How would you rate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Main reason for today's visit: _____

Other concerns: _____

Review of symptoms: Please check any current symptoms you have.

Constitutional
___ Recent fevers/sweats
___ Unexplained weight loss gain

Eyes
___ Change in vision

Ears/Nose/Throat/Mouth
___ Difficulty hearing/ringing in ears
___ Hay fever/allergies/congestion
___ Trouble swallowing

Cardiovascular
___ Chest pains/discomfort
___ Palpitations
___ Short of breath with exertion

Breast
___ Breast lump
___ Nipple discharge

Respiratory
___ Cough/wheeze
___ Coughing up blood

Gastrointestinal
___ Heartburn/reflux
___ Blood or change in bowel movement
___ Nausea/vomiting/diarrhea
___ Pain in abdomen

Genitourinary
___ Painful/bloody urination
___ Leaking urine
___ Nighttime urination
___ Discharge: penis or vagina
___ Unusual vaginal bleeding
___ Concern with sexual functions

Musculoskeletal
___ Muscle/joint pain
___ Recent back pain

Skin
___ Rash
___ New or change in mole

Neurological
___ Headaches
___ Memory loss
___ Fainting

Psychiatric
___ Anxiety/stress
___ Sleep problem

Blood/Lymphatic
___ Unexplained lumps
___ Easy bruising/bleeding

Endo
___ Cold/heat intolerance
___ Increase thirst/appetite

In the past month, have you had little interest or pleasure in doing things, or feel down, depressed or hopeless? □ Yes □ No

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

Medications	**Dose (e.g. mg/pill)**	**How many times per day**

Allergies or reactions to medications: _____

Date of your most recent IMMUNIZATIONS:

Hepatitis A _____ Hepatitis B _____ Influenza (flu shot) _____ MMR _____ Pneumovax (pneumonia) _____

Meningitis _____ Tetanus (Td) _____ Varicella (Chicken Pox) _____ Tdap (Tetanus & pertussis) _____

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (Cholesterol) _____ Date _____ Abnormal? □ Yes □ No

Sigmoidoscopy _____ Colonoscopy _____ Date _____ Abnormal? □ Yes □ No

Women: Mammogram _____ Date _____ Abnormal? □ Yes □ No Pap Smear _____ Date _____ Abnormal? □ Yes □ No

Dexascan (osteoporosis) _____ Date _____ Abnormal? □ Yes □ No

Men: PSA (Prostate) _____ Date _____ Abnormal? □ Yes □ No

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems (with dates).

_____ Heart disease: _____ High blood pressure _____ High cholesterol _____ Kidney disease
_____ Diabetes _____ Thyroid problem _____ Asthma/Lung disease _____ Cancer: (Specify)

SURGICAL HISTORY: Please list all prior operations (with dates):

_____

FAMILY HISTORY: Please indicate the current status of your immediate family members:
Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism _____ High cholesterol _____

Cancer, specify type _____ High blood pressure _____

Heart disease _____ Stroke _____

Depression/suicide _____ Bleeding or clotting disorder _____

Genetic disorders _____ Asthma/COPD _____

Diabetes: _____ Other: _____

SOCIAL HISTORY

Tobacco Use

Cigarettes □ Never □ Quit Date _____
□ Current smoker: packs/day _____ # of years _____
Other Tobacco: □ Pipe □ Cigar □ Snuff □ Chew
Are you interested in quitting? □ Yes □ No

Alcohol Use

Do you drink alcohol? □ No □ Yes # drinks/week _____
Is your alcohol use a concern for you or others? □ Yes □ No

Drug Use

Do you use any recreational drugs? □ No □ Yes
Have you ever used needles to inject drugs? □ No □ Yes

Sexual Activity

Sexually active: □ Yes □ No □ Not currently
Current sex partner(s) is/are: □ Male □ Female
Birth control method: _____ □ None needed
Have you ever had any sexually transmitted diseases (STDs)?
□ No □ Yes
Are you interested in being screened for sexually transmitted diseases? □ No □ Yes

OTHER CONCERNS

Caffeine Intake: □ None □ Coffee/tea/soda _____ cups/day
Weight: Are you satisfied with your weight? □ No □ Yes
Diet: How do you rate your diet? □ Good □ Fair □ Poor
Do you eat or drink four servings of dairy or soy daily or take calcium supplements? □ No □ Yes

Exercise: Do you exercise regularly? □ No □ Yes
What kind of exercise? _____
How long (minutes) _____ How often? _____
If you do not exercise, why? _____

Safety: Do you use a bike helmet? □ No □ Yes □ NA
Do you use seat belts consistently? □ No □ Yes
Is violence at home a concern for you? □ No □ Yes
Have you ever been abused? □ No □ Yes
Do you have a gun in your home? □ No □ Yes

Have you completed a living will or durable power of attorney for health care? □ No □ Yes

SOCIOECONOMICS Occupation: _____ Employer: _____

Years of education/highest degree: _____ Marital Status: Single Partner/Married Divorced Widowed
Spouse/partner's name _____ Number of children/ages: _____
Who lives at home with you? _____

WOMEN'S HEALTH HISTORY #pregnancies _____ #deliveries _____ #abortions _____ #miscarriages _____

Age at start of periods _____ Age at end of periods _____

HIPPA Privacy Policy

The **Anthony E. Jones, MD** Notice of Privacy Practices provides a thorough explanation of how we may use and disclose your protected health information, as well as your right as a patient.

I choose to designate the individuals listed below as my primary contacts. **Anthony E. Jones, MD** and personnel may share information with the primary contact that is consistent with the Notice of Privacy Practices.

#1 Contact Name _____ Relationship _____

Contact Phone _____

#2 Contact Name _____ Relationship _____

Contact Phone _____

Patient Signature _____ Date _____

(Patient, Parent, and authorized representative)

Inability to obtain acknowledgement

To be completed by **Anthony E. Jones, MD** or representative _____
It was not possible to obtain the individual's acknowledgement for the following reason(s):

_____ Emergency situation

_____ Patient physically unable to sign

_____ Patient refused

_____ Patient left office prior to obtaining signature

_____ Other reasons (list below)

Comments

_____

Signature of representative _____ Date _____