Park
MEDICAL GROUP

PATIENT'S PERSONAL HISTORY

Date of First Appointment: _____/____/_____
MONTH DAY YEAR

Name: _____ _____ _____
LAST M FIRST

Birthdate_____/_____/_____
MONTH DAY YEAR

Address: _____ _____ Age: _____Sex: ___F__M
STREET APT#

_____Telephone: Home ( ) _____
CITY STATE ZIP

Name of Employer_____ Employer's Phone ( ) _____

Referred by: (Check one)

Self _____ Family _____ Friend_____ Doctor_____ Other_____

Name of person making referral_____

Date of Last Physical Examination_____ Doctor_____

Family or Last Physician _____ Address _____

_____

Describe briefly your present medical symptoms: _____

_____

_____

_____

_____

_____

_____

_____

DRUG ALLERGIES: Yes_____ No _____ Which Drug? _____

_____

Describe the reaction _____

_____

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MEDICATIONS

Present: (List any medication you are taking at this time. Please include vitamins, nutritional supplements, diet pills, laxatives, aspirin, chronic steroid use such as Prednisone, etc.)

Name of Drug	Dose (ex: mg/pill)	How often?	Date medication started
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			
21.			
22.			

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SYSTEMS REVIEW

As you review the following list, Please check any and all the problems that apply to you.

GENERAL:
_____ Recent weight gain/ amount
_____Recent loss of weight/ amount
_____Fatigue
_____Weakness
_____Fever

NERVOUS SYSTEM:
_____ Headaches
_____ Dizziness
_____ Fainting
_____ Muscle spasm
_____ Loss of consciousness
_____ Sensitivity or pain of hands
_____ Sensitive feet
_____ Memory loss

EARS:
_____Pain
_____Loss of hearing
tenderness

EYES:
_____Pain
_____Redness
experienced in last 5 months:
_____Loss of vision
_____Double or blurred vision

_____Dry eye
_____Feels like something is in eye

NOSE:
_____Nosebleeds
_____Loss of smell
_____Dryness

NECK:
_____Swollen glands
_____Tender glands

HEART AND LUNGS:
_____Pain in chest
_____Irregular heartbeat
_____Sudden changes in heart beat
_____Shortness of breath
_____Difficulty in breathing at night
_____Swollen legs or feet
_____High blood pressure
_____Heart murmurs
_____Cough
_____Cough of blood
_____Wheezing
_____Night sweats

STOMACH/ AND INTESTINES:

_____Nausea
_____Vomiting of blood or
coffee ground material
_____Stomach pain relieved by
food or milk
_____Yellow jaundice
_____Increased constipation

_____Persistent diarrhea
_____Blood in stool
_____Black stools
_____Heartburn

SKIN:
_____Easy bruising
_____Redness
_____Rash
_____Hives
_____Sun sensitivity
_____Tightness
_____ Nodules/bumps
_____ Hair loss
_____ do hands/feet
change color in the cold

MUSCLE/ JOINT/ BONE:
_____Morning stiffness
lasting how long?
_____ Minutes
_____ Hours
_____ Joint pain
_____ Muscle weakness
_____Muscle
_____Joint swelling

List any joint issue you have
_____
_____
_____
_____
_____
_____
_____
_____

MENSTRUAL (Women Only):
Age when periods began: _____Periods regular: ____Yes _____ No. Date of last period_____
Date of last Pap smear: _____ Bleeding after menopause: ____Yes ____No
Date of last mammogram_____

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MOUTH:

_____Sore tongue
_____Bleeding gums
_____Sores in mouth
_____Loss of taste
_____Dryness

THROAT:

_____ Frequent sore throats
_____ Hoarseness
_____ Difficulty in swallowing

KIDNEY/URINE/BLADDER:

_____Difficult urination
_____Pain or burning on urination
_____Blood in urine
_____Cloudy looking urine
_____Pus in urine
_____Discharge from penis/vagina
_____Frequent urination
_____Getting up at night to urinate
_____ Vaginal dryness
_____ Rash/ulcers
_____Sexual difficulties
_____Prostate troubles

SOCIAL HISTORY:

Drink coffee ___Y___N
Cups per day? _____
Do you smoke? ___Y ____N
If you quit, when_____
Cigarettes per day? _____
Medical marijuana card?
_____Y _____N

Consumes alcohol beverage?
___Y____N /per day_____
Sleep issues? ____Y____N
Wake feeling rested___Y __N

Date of last eye exam_____
Date of last chest x-ray_____
Date of last Tuberculosis test _____

PAST PERSONAL HISTORY:

Do you have or have you ever had? (Check if yes)

Cancer_____	Heart Problems_____	Asthma _____	Goiter_____
Leukemia_____	Stoke _____	Cataracts _____	Glaucoma _____
Epilepsy _____	Nervous Breakdown _____	Stomach Ulcers _____	Rheumatoid fever _____
Migraines _____	Jaundice _____	Colitis _____	Kidney Disease _____
Pneumonia _____	Psoriasis _____	Anemia _____	Arthritis _____
Celiac _____	Osteoporosis _____	Diabetes _____	High Blood pressure _____

Other Significant Illness (Please List) _____

PREVIOUS OPERATIONS:

	TYPE	YEAR	SURGEON	CITY/STATE
1.)	_____	_____	_____	_____
2.)	_____	_____	_____	_____
3.)	_____	_____	_____	_____
4.)	_____	_____	_____	_____
5.)	_____	_____	_____	_____
6.)	_____	_____	_____	_____

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Any previous fractures? _____Y _____N Describe _____
Any other serious injuries? _____Describe_____

FAMILY HISTORY

Family History		If Living		If Deceased	
	Sex	**Age**	**Health**	**Age at Death**	**Cause**
Father					
Mother					
Brother/Sisters' (Circle Sex)					
	M F				
	M F				
	M F				
	M F				
	M F				
Husband / Wife					
Sons/Daughters' (Circle Sex)					
	M F				
	M F				
	M F				
	M F				
	M F				

Do you know of any blood relatives who have or have had: (Circle and give relationship to you)

Stroke _____ Epilepsy _____ Heart Attack_____ Nervous Breakdown _____

Cancer _____ Suicide _____ Stomach Ulcer _____ Rheumatic Fever _____

High Blood Pressure _____ Migraines _____ Kidney Disease _____Insanity_____

Tuberculosis _____ Asthma _____ Goiter_____Congenital Heart _____

Diabetes _____ Hay Fever _____ Arthritis _____ Leukemia _____

Bleeding Tendency _____ Colitis _____ Celiac Disease _____

MARITAL STATUS:

_____ Never Married _____ Married _____ Divorced _____ Separated

Spouse _____ Alive/ Age _____ Deceased/ Age _____ Major Illnesses: _____

HOME CONDITIONS:

Check One: ___ House____ Apartment

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Do you have stairs to climb? _____Y _____N If yes, how many? _____

Number of people in your household _____ Relationship, and age of each?

_____

Who does most of the housework? _____

Who does most of the shopping? _____

Do you all cook together/ eat together? _____

On the scale below, circle a number, which best describes your situation; most of the times, I function...

1	2	3	4	5
VERY POORLY	POORLY	OK	WELL	VERY WELL

Because of health problems, do you have difficulty:
(Please check the appropriate response for each question)

	Usually	Sometimes	No
Using your hands to grasp small objects? (Button, toothbrush, pencil, etc.) ...	_____	_____	_____
Walking?	_____	_____	_____
Climbing stairs?.....	_____	_____	_____
Descending stairs?	_____	_____	_____
Sitting down?	_____	_____	_____
Getting up from a chair?.....	_____	_____	_____
Touching your feet while seated?.....	_____	_____	_____
Reaching behind your back?.....	_____	_____	_____
Reaching behind your head?.....	_____	_____	_____
Dressing yourself?.....	_____	_____	_____
Going to sleep?.....	_____	_____	_____
Staying asleep due to pain?.....	_____	_____	_____
Obtaining restful sleep?.....	_____	_____	_____
Bathing?.....	_____	_____	_____
Eating?.....	_____	_____	_____
Working?.....	_____	_____	_____
Getting along with other family members?.....	_____	_____	_____
Issues in your sexual relations?.....	_____	_____	_____
Difficulty engaging in leisure activities?.....	_____	_____	_____

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With morning stiffness?..... _____ _____ _____

Do you use a cane, crutches, a walker, or a wheelchair? (Circle item used)

What is the hardest thing for you to do? _____

Are you receiving disability? ..... Yes_____ No_____

Are you applying for disability?..... Yes_____ No_____

Do you have a medically related lawsuit pending? ..... Yes_____ No_____

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PATIENT INFORMATION

Patient's Name: _____
Last First Middle Initial Preferred

Date of Birth: _____ Marital Status: S/M/D/W/Other Sex: Female/Male

Mailing Address: _____
Box/Street City State Zip

Street Address: _____
Street City State Zip

Primary Phone #: _____ Type: Home/Cell/Work/Other

Secondary Phone #: _____ Type: Home/Cell/Work/Other

Email Address: _____ Social Security #: _____

May we leave message for you on a voicemail? Yes/No If yes, what number? _____
May we call you at work? Yes/No If yes, what number? _____

RACE AND ETHNICITY

(Insurance Requirement)

Race: White/Hispanic/American Indian or Alaska Native/Asian/Black or African American/Native Hawaiian Pacific Islander/Other _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino

GUARANTOR

(Responsible Party for Patient)

☐ Self ☐ Spouse ☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Power of Attorney ☐ Other

Responsible Party's Name: _____

Mailing Address: _____
Box/Street City State Zip

Employer: _____ Work Phone: _____

EMERGENCY CONTACT

Full Name: _____ Relationship: _____ Phone: _____

1813 W. Harvard, Suite 140
Roseburg, OR 97471
Office: 541-229-7275 Fax: 541-229-7276

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PRIMARY INSURANCE

☐ Self ☐ Spouse ☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Power of Attorney ☐ Other

Insured/Employee's Name: _____
Last First Middle Initial

Insurance Name: _____ Group/Employer Name: _____

ID #: _____ Group #: _____

Insured's Date of Birth: _____ Insured's SSN: _____

SECONDARY INSURANCE

☐ Self ☐ Spouse ☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Power of Attorney ☐ Other

Insured/Employee's Name: _____
Last First Middle Initial

Insurance Name: _____ Group/Employer Name: _____

ID #: _____ Group #: _____

Insured's Date of Birth: _____ Insured's SSN: _____

WHO CAN WE TALK TO?

Please provide a list of all the parties we may speak with or leave a message with regarding the patient's medical care, appointment scheduling, or payment information. **This information is very important.**

_____
Full Name Relationship Phone

_____
Full Name Relationship Phone

ASSIGNMENT OF BENEFITS

I hereby assign to Park Medical Group, LLC any insurance or other third-party benefits available for healthcare services provided to me. I understand Park Medical Group, LLC has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Park Medical Group, LLC, I agree to forward Park Medical Group, LLC all health insurance and other third-party payments I receive for services rendered to me immediately upon receipt.

_____
Signature of Patient/Legal Guardian **Date**

1813 W. Harvard, Suite 140
Roseburg, OR 97471
Office: 541-229-7275 Fax: 541-229-7276

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General Consent for Care and Treatment

To The Patient: You have the right to be informed about your condition and the procedure(s) or treatment(s) your provider recommends. Your provider shall explain that there may be alternative procedures or methods of treatment, if any, and that there are risks, if any to those procedures or treatments. Your provider shall ask if you want a more detailed explanation. If you do, your provider shall provide you with additional information. Since you are a new patient to Park Medical Group, LLC, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended.

The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

I voluntarily request a physician or advanced practice provider and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment. I understand if invasive or interventional procedures are recommended, I may be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Signature or Patient or Personal Representative Date

_____ _____

Printed Name of Patient or Personal Representative Relationship to Patient

Park Medical Group, LLC Financial Policy

We are pleased you have selected Park Medical Group (PMG) as your health care provider. The payment of your bill and a clear understanding of our financial policy is important to our professional relationship. If you have questions regarding this policy, please contact our office at 541-229-7275.

Insurance Billing

- PMG will bill your insurance carrier as a courtesy to you as long as you provide us with a copy of your insurance card(s) at the time of service.
- If you do not provide PMG with accurate insurance information you will be responsible for all charges incurred.
- It is your responsibility to contact your insurance company regarding disputed insurance claim(s).

Patient Responsibility for Payment

- Copayments are due at the time of service. PMG does not bill for copays.
- After your insurance has responded, you will receive a statement which details all services, payments, adjustments as well as any payment for which you are responsible.
- Payment is due upon receipt of your statement.
- PMG does not routinely offer payment plans.
- We accept payment by cash, check, VISA and MasterCard.
- There is a $35.00 fee for all non-sufficient funds (NSF) checks. After two NSF checks, we will no longer accept checks as a form of payment.

Self-Pay Patients

- PMG requires payment in full at the time service(s) are rendered.
- PMG offers Self-Pay patients a 25% same day discount.

Delinquent Accounts

- If you do not pay your bill within 30 days of the statement date, your account will be referred to our collection department.
- Delinquent accounts are subject to dismissal from our practice in accordance with our policy on the termination of patient relationship.

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Other Healthcare Providers

Your provider may order additional medical services from other providers such as laboratory, radiology or pathology tests. These bills are separate from our clinic and are your responsibility.

Patient Signature:_____ **Date:**_____

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PATIENT CONSENT FORM/NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in my treatment directly and indirectly
- Obtain payment from third party payers
- Conduct healthcare operations

I have been informed by you of your *Notice of Privacy Practices* which contain a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand this organization has the right to change its *Notice of Privacy Practices* from time to time. I am aware that I may contact this organization at their address to obtain a current copy of the *Notice of Privacy Practices*.

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

I understand I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:_____

Signature:_____

Relationship to the patient:_____

Date:_____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Name	Reason

Park
MEDICAL GROUP
1813 W Harvard Ave – Suite 140 – Roseburg, OR - 97471
Phone (541) 229-7275 Fax (541) 229-7276

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
"THIS AUTHORIZATION MUST BE WRITTEN, COMPLETE, DATED AND SIGNED BY THE PATIENT OR BY A PERSON AUTHORIZED BY LAW TO GIVE AUTHORIZATION"
INCOMPLETE FORMS WILL BE RETURNED TO THE REQUESTING INDIVIDUAL ENTITY FOR COMPLETION

I authorize : _____

Address: _____ ( ) _____ ( ) _____
Phone# Fax#

_____
City State Zip

To release a copy of the protected health information for: _____ _____
Name of patient DOB

_____
Social Security Number

To: Park Medical Group, LLC
Name of Recipient

1813 W. Harvard, Suite 140,
Roseburg, Oregon 97471
Address

541-229-7276 541-229-7275
Fax No. Phone No.

The information will be used on my behalf for the following purpose: (check all that apply)
_____Transferring/Establishing Care with Provider

Other: **(must specify)** _____

By initialing the spaces below, I specifically authorize the release of the following records, if such records exist:

_____All records
_____Clinician office progress notes
_____Pathology reports/Pap **reports**
_____Diagnostic imaging reports/Mammography reports
_____Laboratory reports
_____Operation/Procedure reports
_____Hospital records

Other_____(be specific)

Dates of service from: _____to:_____(please note that only the most recent records will be released if not specified)

If the information to be disclosed containing any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____ HIV/AIDS information
_____ Mental health information (Including diagnosis and medication management)
_____ Genetic testing information
_____ Drug/alcohol diagnosis, treatment and/or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care Services are solely for the purpose of providing health information to someone else and the authorization is necessary to make the disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

To revoke this authorization, please send a written statement to Records Custodian at the address listed above.

I have read this authorization and I understand it. Unless revoked, this authorization expires when records are released.

By: _____ _____
Signature of patient or representative Date

Description of patient's representative's **authority**:_____ **Rev: 10/16**