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Patient Demographics

Personal

Date: _____

Patient Name: _____

Patient Birthday: _____

Social Security Number (SSN): _____

Address: _____

_____

Home Phone Number: _____

Work Phone Number: _____

Cellular Phone Number: _____

Medical Records

Family Doctor: _____

Referring Doctor: _____

Financial

Self Pay? yes no

Insurance Carrier: _____

Policy Holder's Name: _____

Policy Number: _____

Policy Holder's Phone Number: _____

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Medical History

Name: _____ Date: _____

Date of Birth: _____

Reason for appointment: _____

List all of your medical problems: _____

_____

_____

List all surgical procedures: _____

_____

_____

Health Habits

	Past	*Present*	*Never*	*How long? / How much?*
Tobacco				
Alcohol				
Drugs				

Are you pregnant? yes no Last menstrual period: _____

Are you allergic to any medications? If so, please list them below.

_____

Please list all medications that you are taking.

_____

_____

_____

Family History

Relationship	*Age*	*Heart Attack / Stroke / Cancer / Blood Clots, etc.*
Mother		
Father		
Sisters		
Brothers		

Review of Systems

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Symptoms (circle all that apply)

General
decreased appetite
chills
fever
fatigue
night sweats
weight gain or loss

HEENT
headache
head injury
blurred vision
double vision
eye pain
glaucoma
vision disturbance
decreased hearing
earache
ringing in the ears
nose bleeds
facial numbness
hoarseness

Neurological
decreased memory
difficulty speaking
dizziness
falls
numbness
seizures
stroke
T.I.A.

Neck
swollen glands

Cardiovascular
high blood pressure
high cholesterol
chest pain
leg swelling
fainting
dizziness
history of bypass
history of stent
palpitations
rapid heart rate
slow heart rate
calf cramps
congestive heart failure
P.A.D.
aneurysm

Gastrointestinal
abdominal
black stool
bloody stool
change in bowel habits
constipation
diarrhea
difficulty swallowing
hemorrhoids
heartburn
gallstones
jaundice
hepatitis
nausea
acid reflux (G.E.R.D.)

Breasts
breast mass
history of breast cancer

Psychiatric
depression
disorientation
early awakening
frequent crying
hallucinations
panic attacks
suicidal thoughts
memory loss

Respiratory
chronic cough
snoring
pulmonary fibrosis
C.O.P.D.
asthma
shortness of breath

Skin
bruising
excessive swelling
hair loss
rash
skin ulcers

Hematology
anemia
hemophilia
blood clots
abnormal bleeding
easy bruising
enlarged lymph nodes
sickle cell disease

Genitourinary
prostate cancer
blood in urine
kidney stones
difficulty emptying
nocturia
bladder
painful urination
excessive menstrual bleeding
non-menstrual bleeding

Endocrine
cold intolerance
hot intolerance
excessive thirst
change in libido
thyroid problems
diabetes

Musculoskeletal
joint pain
joint redness
muscle cramps
muscle weakness
joint replacement

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Medication List

Patient Name: _____

Patient Birthday: _____

Phone Number: _____

Pharmacy Name: _____

Pharmacy Phone Number: _____

NKDA ALLERGIES: _____

Date	Medication Name	Dosage	Instructions	Refills	Pain Mgmt

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Financial Policy

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Our policy is that patients are responsible for the full payment of their accounts. Payment is collected at check in for amounts known to be due at the time services rendered. This may represent a co-payment, co-insurance or deductible amount.

Veritas Healthcare Solutions participates with many insurance carriers and their various plans. Please contact your insurance provider to verify participation. If your insurance company is one with which we have a participation agreement, you will be expected to pay your portion of the charge on the date of service, and we will file your claim. If you have a co-pay amount, it will be due at the time of service. We will allow a period of forty-five (45) days for the filing date for your carrier to process and pay your claim. If your claim has not been paid within that period, full payment, as well as any follow up with the insurance company becomes your responsibility.

If your insurance company is not our list of participating carriers, we will file your claim as a courtesy, but you will be responsible for any out-of-network fees or co-insurance amounts at the time of service.

If we refer you to a specialist or schedule procedures or test we will try to send you to a facility that participates with your insurance. Ultimately it is the responsibility you the patient to call the insurance company and confirm that the provider is in network and the procedure or test is authorized.

If you are not covered by an insurance plan, payment in full of all charges will be expected at the time of service. In the event your account becomes a bad debt and we discontinue providing services we will require the entire balance be paid as well as a reinstatement fee of one hundred dollars ($100.00) prior to reinstating you as a patient.

I have read the financial policy, understand it and accept my responsibility.

date	patient name	patient signature

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Disclosure Agreement

HIPAA is the federal Health Insurance Portability and Accountability Act of 1996. The primary goal of the law is to make it easier for people to keep health insurance, protect the confidentiality and security of healthcare information and help the healthcare industry control administrative costs.

You may choose to allow staff of Veritas Healthcare Solutions to share or discuss your personal healthcare information with others. Please name the eligible person(s) and sign below.

I, _____, _____,
print patient name — date of birth

do hereby authorize the employees of Veritas Healthcare Solutions to discuss my personal medical information and treatment with;

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

In the event of an emergency, I authorize the employees of Veritas Healthcare solutions to contact;

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

on my behalf.

_____ Date: _____
patient signature

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Privacy Practices

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Notice of Privacy Practices and Patient Consent For Use and Disclosure or Protected Health Information

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain Patient Rights regarding my protected health information.

I understand that Veritas Healthcare Solutions may use or disclose my protected health information for treatment, payment or health care operations - which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Veritas Healthcare Solutions has a detailed document called 'The Notice of Privacy Practices'. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read 'The Notice of Privacy Practices' before signing this agreement. If I ask, Veritas Healthcare Solutions will provide me with the most current version of 'The Notice of Privacy Practices'.

My signature below indicates that I have been given the chance to review such copy of 'The Notice of Privacy Practices'. My signature means that I agree to allow Veritas Healthcare Solutions to use and disclose my protected health information to carry out treatment, payment and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Veritas Healthcare Solutions has taken action relying on this consent.

I have read and understand the policy regarding privacy practices.

date	patient name	patient signature

You may obtain a copy of 'The Notice of Privacy Practices' at any time by contacting us in the office or by visiting the website at veritashealthcaresolutions.com