Holy Cross Medical Group

PATIENT HISTORY FORM

Patient's Name: _____ **Date:** _____

It is helpful to gather information about your medical history for the physician to use in your examination. Please complete this form completely for the physician's review.

1. CONSTITUTIONAL SYMPTOMS

Good general health lately	❑ No	❑ Yes
Recent weight change	❑ No	❑ Yes
Fever	❑ No	❑ Yes
Fatigue	❑ No	❑ Yes
Headaches	❑ No	❑ Yes

2. INTEGUMENTARY (Skin, Breast)

Rash or itching	❑ No	❑ Yes
Change in skin color	❑ No	❑ Yes
Change in hair or nails	❑ No	❑ Yes
Varicose veins	❑ No	❑ Yes
Breast pain	❑ No	❑ Yes
Breast lump	❑ No	❑ Yes
Breast discharge	❑ No	❑ Yes

3. NEUROLOGICAL

Frequent or recurring headaches	❑ No	❑ Yes
Lightheaded or dizzy	❑ No	❑ Yes
Convulsions or seizures	❑ No	❑ Yes
Numbness or tingling sensations	❑ No	❑ Yes
Tremors	❑ No	❑ Yes
Paralysis	❑ No	❑ Yes
Stroke	❑ No	❑ Yes
Head injury	❑ No	❑ Yes

4. HEMATOLOGIC / LYMPHATIC

Slow to heal after cuts	❑ No	❑ Yes
Bleeding or bruising tendency	❑ No	❑ Yes
Anemia	❑ No	❑ Yes
Phlebitis	❑ No	❑ Yes
Past transfusion	❑ No	❑ Yes
Enlarged glands	❑ No	❑ Yes

5. PSYCHIATRIC

Memory loss or confusion	❑ No	❑ Yes
Nervousness	❑ No	❑ Yes
Depression	❑ No	❑ Yes
Insomnia	❑ No	❑ Yes

6. ENDOCRINE

Glandular or hormone problem	❑ No	❑ Yes
Thyroid disease	❑ No	❑ Yes
Diabetes	❑ No	❑ Yes
(Insulin or Non-Insulin – Circle one)		
Excessive thirst or urination	❑ No	❑ Yes
Heat or cold intolerance	❑ No	❑ Yes
Skin becoming dryer	❑ No	❑ Yes
Change in hat or glove size	❑ No	❑ Yes

7. EYES, EARS, NOSE MOUTH

Hearing loss or ringing	❑ No	❑ Yes
Earaches or drainage	❑ No	❑ Yes
Chronic sinus problem or rhinitis	❑ No	❑ Yes
Nose bleeds	❑ No	❑ Yes
Mouth sores	❑ No	❑ Yes
Bleeding gums	❑ No	❑ Yes
Sore throat or voice change	❑ No	❑ Yes
Swollen glands in neck	❑ No	❑ Yes

8. CARDIOVASCULAR

Heart trouble	❑ No	❑ Yes
Chest pain or angina pectoris	❑ No	❑ Yes
Palpitation	❑ No	❑ Yes
Shortness of breath with walking	❑ No	❑ Yes
Swelling of feet, ankles or hands	❑ No	❑ Yes

9. RESPIRATORY

Chronic or frequent coughs	❑ No	❑ Yes
Spitting up blood	❑ No	❑ Yes
Shortness of breath	❑ No	❑ Yes
Asthma or wheezing	❑ No	❑ Yes

10. MUSCULOSKELETAL

Joint pain	❑ No	❑ Yes
Joint stiffness or swelling	❑ No	❑ Yes
Weakness of muscles or joints	❑ No	❑ Yes
Muscle pain or cramps	❑ No	❑ Yes
Back pain	❑ No	❑ Yes
Cold extremities	❑ No	❑ Yes
Difficulty in walking	❑ No	❑ Yes
Use ambulatory assistive device	❑ Walker	❑ Cane
	❑ Crutches	❑ Wheelchair
	❑ Prosthetic Limb	❑ Hold person's arm
Sports injury	❑ No	❑ Yes

11. GASTROINTESTINAL

Loss of appetite	❑ No	❑ Yes
Change in bowel movements	❑ No	❑ Yes
Nausea or vomiting	❑ No	❑ Yes
Frequent diarrhea	❑ No	❑ Yes
Constipation	❑ No	❑ Yes
Rectal bleeding or blood in stool	❑ No	❑ Yes
Abdominal pain	❑ No	❑ Yes
Peptic ulcer (stomach or duodenal)	❑ No	❑ Yes

ALLERGIC / IMMUNOLOGIC

History of reaction to:

Medication	❑ No	❑ Yes
List: _____		
Other	❑ No	❑ Yes
List: _____		

"PLEASE COMPLETE OTHER SIDE"

12. GENITOURINARY

Frequent urination ..... ❑ No ❑ Yes
Burning or painful urination ..... ❑ No ❑ Yes
Blood in urine ..... ❑ No ❑ Yes
Incontinence or dribbling ..... ❑ No ❑ Yes
Kidney stones ..... ❑ No ❑ Yes
Sexual difficulty ..... ❑ No ❑ Yes
MALE – Testicle pain ..... ❑ No ❑ Yes

FEMALE – Pain with periods ..... ❑ No ❑ Yes
Use douche ..... ❑ No ❑ Yes
Irregular periods ..... ❑ No ❑ Yes
Vaginal discharge ..... ❑ No ❑ Yes
Age at onset of menstruation: _____
Number of days menstruation lasts: _____
Date of last pap smear: _____
Date of last menstrual period: _____

List all pregnancies with dates, weights and problems (Please include miscarriages, terminations and pre-term):

_____

_____

PAST MEDICAL HISTORY	CURRENT MEDICATIONS
Previous Hospitalizations/Surgeries/Serious Injuries	

PATIENT SOCIAL HISTORY

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Partner
Use of Tobacco: ❑ Never ❑ Previously but quit ❑ Current packs per day: _____
Use of Alcohol: ❑ Never ❑ Rarely ❑ Moderate ❑ Daily
Use of Drugs: ❑ Never ❑ Type/Frequency: _____
Exposure to: ❑ Fumes ❑ Dust ❑ Solvents ❑ Airborne particles ❑ Noise
History of Domestic Violence: ❑ Verbal ❑ Physical ❑ Other: _____
Abuse is identified as a nation-wide problem and health concern. We are required to ask you the following personal questions.
Has anyone hurt you or threatened to hurt you? ❑ Yes ❑ No ❑ Comments: _____
Are people taking belongings without your permission? ❑ Yes ❑ No ❑ Comments: _____

FAMILY MEDICAL HISTORY

	Age	Diseases	If deceased, cause of death
Father:			
Mother:			
Siblings:			
Spouse:			
Children:			

Patient Signature: _____ **Date:** _____

Physician Reviewed: _____ **Date:** _____ **Time:** _____

Holy Cross Medical Group

PATIENT INFORMATION RECORD

Allergies:_____ Age:_____

Patient's Legal Name: _____ Today's Date: _____
First M.I. Last

Address: _____
Street City State Zip

Phone #'s – Daytime:_____ Evening:_____ Emergency: _____ Cell:_____

Where do you prefer to receive calls?: ❑ Home Number ❑ Work Number ❑ Cell Number ❑ In Writing
❑ OK leave message with detailed info ❑ Leave message with call-back number only

Patient's Date of Birth:_____ Sex: ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Partner Religion: _____ Primary Language: _____

Ethnicity: _____ Race: _____

Social Security No.:_____ – _____ – _____ Referred By: _____

Email Address:_____

Responsible Party: _____ Telephone: (___)-_____
First M.I. Last

Address: _____
Street City State Zip

Responsible Party Social Security No.:_____ – _____ – _____ Date of Birth: _____

Employer:_____ Telephone: (___)-_____

Address: _____
Street City State Zip

Next of Kin: _____ Relationship:_____ Telephone: Res:(___)-_____ Work:(___)- _____

I. INSURANCE INFORMATION:

Is Your Insurance a: ❑ PPO ❑ HMO ❑ Medicare ❑ Medicaid ❑ Other:_____

II. IS PATIENT'S CONDITION RELATED TO:

Employment (Current or Previous): ❑ Yes ❑ No Auto Accident: ❑ Yes ❑ No Other Accident: ❑ Yes ❑ No

PRIMARY

INSURANCE COMPANY NAME: _____

Address: _____
Street City State Zip

Group Number:_____ Medicare/Policy Number: _____

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

Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Student over 18

Other (Please describe): _____

SECONDARY

INSURANCE COMPANY NAME: _____

Address: _____
Street City State Zip

Group Number:_____ Medicare/Policy Number: _____

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

Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Student over 18

Other (Please describe): _____

****** FOR OFFICE USE ONLY ******

Identification Presented: ❑ Passport ❑ Driver's License ❑ State I.D. ❑ Insurance Card

TURN OVER AND COMPLETE

Holy Cross Medical Group

MEDICARE AND MEDICAID SIGNATURE AUTHORIZATION

Medicare and Medicaid patient certification - patient certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVIII and/or TITLE XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services. I request that this authorization apply to all claims, present and future. I understand that I am responsible for my health insurance deductible and coinsurance. I authorize the Hospital and all of its employees, independent contractors, business associates, agents and/or affiliates of same (collectively "Hospital") to contact me through the use of any dialing equipment or an artificial voice or prerecorded voice, at any telephone number associated with my account including wireless telephone numbers, provided by me or found by means of skip tracing methods or otherwise even if I am charged for the call. I expressly consent to such automated calls and with such consent, I specifically waive any objection or claim I may have against the Hospital, for making such calls, including any claim under the Telephone Consumer Protection Act and any similar law and regulations as amended. This consent may not be orally revoked or modified but may be withdrawn at any time in writing.v

Date: _____

Print Patient's/Beneficiary's Name: _____

Patient's/Beneficiary's Signature: _____

****

COMMERCIAL INSURANCE, MANAGED CARE MEMBERS AND SECONDARY PAYOR AUTHORIZATION

I authorize the release of any medical information necessary to process my insurance claim(s). I request that the payment authorized be made on my behalf. I assign the benefits payable for physician services to the HOLY CROSS MEDICAL GROUP / HOLY CROSS HOSPITAL. I request that this authorization apply to all insurance claims, present and future. I understand that I am responsible for payment of any balance not paid by my insurance company. I authorize the Hospital and all of its employees, independent contractors, business associates, agents and/or affiliates of same (collectively "Hospital") to contact me through the use of any dialing equipment or an artificial voice or prerecorded voice, at any telephone number associated with my account including wireless telephone numbers, provided by me or found by means of skip tracing methods or otherwise even if I am charged for the call. I expressly consent to such automated calls and with such consent, I specifically waive any objection or claim I may have against the Hospital, for making such calls, including any claim under the Telephone Consumer Protection Act and any similar law and regulations as amended. This consent may not be orally revoked or modified but may be withdrawn at any time in writing.

Date: _____

Print Patient's/Insured's Name (Parent's Signature if child): _____

Signature of Insured: _____

Patient's/Insured's Signature: _____

Holy Cross Hospital

PATIENT ACKNOWLEDGEMENT

I have been given a copy of the Holy Cross Hospital, Inc, Notice of Privacy Practices, version effective September 23, 2013.

Date of Birth:_____

Signature of Patient or Representative:_____ Date:_____

Print Name of Patient or Representative:_____

Relationship of Representative to Patient:_____

Test Results may be left on my answering machine: ☐ YES ☐ NO

When calling my phone, results can also be left with – Name:_____

IN EMERGENCY SITUATIONS ONLY:

PLEASE CHECK ONE BOX:

☐ DO NOT RELEASE ANY OF MY MEDICAL INFORMATION TO A FAMILY MEMBER OR FRIEND

☐ PLEASE RELEASE MY MEDICAL INFORMATION IF NEEDED TO : _____

_____

Relationship:_____ Phone: _____

* *

FOR HOLY CROSS HOSPITAL, INC. USE ONLY

If acknowledgement of receipt of the Notice of Privacy Practices is not obtained from the Patient or the Patient's Representative, please explain your efforts to obtain their acknowledgement and the reason you could not obtain it: _____

_____

_____

Holy Cross Medical Group

CONSENT TO RELEASE MEDICAL, PSYCHIATRIC, AIDS/ARC/HIV TESTING, ALCOHOL OR DRUG ABUSE PATIENT RECORDS

1. I hereby authorize my physician at Holy Cross Medical Group:
   - ☐ To RELEASE copies of my medical records to: _____
   - ☐ To RECEIVE copies of my medical records from: _____
2. I understand that my records may contain information pertaining to my diagnosis or treatment of my medical, psychiatric, AIDS/ARC/HIV testing, alcohol or drug abuse condition. I also understand that any topic discussed during my medical treatment was documented, and therefore, will be released: _____ (Signature) _____ (Date)
3. Information to be released/requested: (please circle)

OFFICE NOTES	LAB	X-RAYS	EKG	HOLTER	ECHO
D/C SUMMARY	OP NOTES	H & P	BILLING INFO	DX	ALL

   Dates of service(s): _____
4. I understand that this release can be revoked at any time, except to the extent that disclosure made in good faith has already occurred in reliance on this consent. To revoke this consent, written notice must be given.
5. This consent expires in 90 days.
6. Holy Cross Medical Group is release from any legal responsibility of liability; for the release of the above information to the extent indicated and authorized herein.

COMPLETE AND PRINT CLEARLY

Patient Signature: _____ **Date:** _____

Print Patient Name: _____ **Witness:** _____

Date of Birth: _____ **Patient SS#:** _____

Patient Address: _____

_____

Phone #: _____

Print name of person signing for the patient and their relationship to the patient:

Name: _____ Date: _____

Send requested information to (complete below information):

NAME: _____

ADDRESS: _____

PHONE: _____ **FAX:** _____

Holy Cross Medical Group

24 Hour Cancellation & "No Show" Fee Notice

Recognizing that everyone's time is valuable and the appointment time is limited, we ask that you provide a **24 hour notice** if you are unable to keep your appointment. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, the physicians of Holy Cross Medical Group reserve the right to charge a fee of $25.00 for each missed (**No Show**) appointment, which is - absent for a compelling reason, and is *not cancelled within a 24 hour advance notice.*

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "no shows" in any 12 month period may result in termination from our practice.

Thank you for your anticipated cooperation.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____/_____/____

Printed - Last Name, First Name Date of Birth

_____ _____

Signature Date

Holy Cross Medical Group

ADVANCE MEDICAL DIRECTIVE

Many people have become aware that medicine today has the ability to keep people alive for extended periods of time, even in hopeless situations. For many, this is a great concern and question, how can you be sure this does not happen to you? If you are at least 18 years of age and of sound mind, there is something you can do to make your wishes known. You have the right to execute an Advance Directive/Living Will. An Advance Directive is a witnessed statement, usually written and made in advance of a future event, that states a person's wishes about what life-sustaining treatments would be wanted if he/she became incapacitated and unable to express his/her wishes. There is no legal requirement to complete and Advance Directive. However, if you have not made and Advance Directive or Designated Healthcare Surrogate, healthcare decisions may be made for you by a court appointed guardian, your spouse, adult child, your parent, your adult sibling, and adult relative or a close friend, in that order. This person would be called a proxy.

DO YOU HAVE A LIVING WILL?

☐ YES ☐ NO

WOULD YOU LIKE TO HAVE A LIVING WILL?

☐ YES ☐ NO

Patient's Name: _____

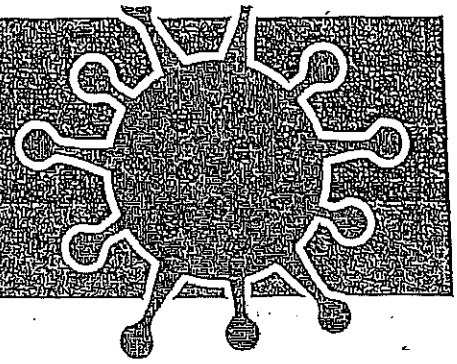
Patient's Signature: _____

Date: _____

If you have a Living Will or Advance Directive, or plan to have one in the future, it is your responsibility to provide this office with a copy so that we may abide by your directives.

CORONAVIRUS DISEASE 2019 (COVID-19)

Patient intake form for all ambulatory sites



Trinity Health Holy Cross Hospital

Today's Date:

Name: Date of Birth:

Do you have:

- Fever? YES or NO
- Cough? YES or NO
- Shortness of breath? YES or NO
- Have you recently travelled to any areas where coronavirus outbreaks are occurring? Y / N
- Have you been potentially exposed to anyone who has been diagnosed with the coronavirus? Y / N
- Have you been in any public gathering where coronavirus cases have been confirmed? Y / N

For clinical staff: One yes = positive