DO NOT USE YOUR PHONE TO FILL THIS FORM... YOU MAY USE A PC BUT BE SURE AND SAVE IT UNDER YOUR NAME.

NEW PATIENT REGISTRATION

Today's Date: _____ DOB: _____

Last Name: _____ First Name: _____ Middle Name: _____

Welcome TO OUR HOME

Contact Information

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Street Address (if different from mailing address): _____

Cell Phone #: _____

Home phone #: _____

Alternate Phone #: _____

Email Address: _____

Emergency Contact Information

Contact Name: _____ Contact Phone: _____

Relationship: _____ Share information? _____

Preferred Pharmacy

Pharmacy Name and location: _____

Donald Ives, NP

New Patient Medical History Form

Date: _____

Name: _____ Date of Birth: _____ □ Male □ Female
Primary Care Physician: _____
Marital Status: □ Married □ Single □ Widowed □ Divorced □ Life partner
Did your doctor refer you here? □Yes □No Referring Physician: _____
Name of Employer: _____ Occupation: _____
Is this a work related Injury? □Yes □No

Have you had x-rays, MRI, CT or other tests for this problem? □Yes □ No
Do you have them with you? □ Yes □ No
Have you been to the Emergency Room for this problem? □ Yes □ No
If yes: Date seen: _____ Which Emergency Room? _____

Preferred Communication: □Written □ Visual □ Sign Language □ No preference
Primary Language: □ English □ Other _____ Interpreter Needed □ Yes □ No
Barriers to Learning?_____

Chief Complaint
Reason you are being seen today: _____
Which side of your body is injured: □ Right □ Left □ Bilateral
Where is your pain or problem? _____
When did it start? _____
Is it: □ Sharp □ Burning □ Dull □ Aching □ Throbbing
Is it □ Mild □ Moderate □ Severe
When does it occur? □Morning □Night □Constant □After Exercise □ During Exercise
□ Intermittent
Has it: □Improved □Stayed the same □Worsened
Describe what makes it better: _____
Describe what makes it worse: _____
Do you have any of the following: □Swelling □Numbness □Bruising □Tingling

Medications, Supplements, & Vitamins You Currently Take (List dosage and how often)
_____
_____

Medication Allergies - List approximate date of onset and severity:
_____

Do you smoke? □Yes □ No □Quit If yes, how much? _____ How many years? _____

Do you drink alcohol? □Yes □ No □Quit If yes, how much/often? _____

Do you have a cardiologist? □ Yes □No Who:_____

Are you: □Right Handed □Left Handed □Ambidextrous □Unknown at this time

Comprehensive History

Review of Systems: What are you experiencing today?

- □ Fatigue
- □ Fever
- □ Night Sweats
- □ Weight Gain
- □ Weight Loss
- □ Difficulty Swallowing
- □ Hoarseness
- □ Chest Pain
- □ Irregular Heart Beat
- □ Fainting
- □ Leg Ulcers
- □ Swelling in hands
- □ Swelling in feet
- □ Nausea
- □ Vomiting
- □ Heartburn
- □ Change in bowel habits
- □ Constipation
- □ Diarrhea
- □ GERD
- □ Incontinence
- □ Bladder Infection
- □ Urinary Frequency
- □ Urinary Urgency
- □ Back Pain
- □ Joint Pain
- □ Joint Swelling
- □ Muscle Aches
- □ Muscle Weakness
- □ Stiffness
- □ Neck Pain
- □ Leg Pain
- □ Muscle Spasm
- □ Gout
- □ Groin Pain
- □ Hair Changes
- □ Changes in Moles
- □ Skin Changes
- □ Itchiness
- □ Rash
- □ Bruises
- □ Bleeding
- □ Limping
- □ Headache
- □ Migraine
- □ Numbness
- □ Tingling
- □ Seizures
- □ Slurred Speech
- □ Frequent Falls
- □ Confusion
- □ Dropping Things Frequently
- □ Depression
- □ Anxiety
- □ Mental Illness
- □ Anemia
- □ Other_____

Past Medical History

- □ Hypertension
- □ Diabetes
- □ Kidney Disease
- □ Stroke
- □ Arthritis
- □ Previous Blood Clot
- □ Asthma
- □ Seizure Disorder
- □ Thyroid Disease
- □ Coronary Artery Disease
- □ Gout
- □ Blood Disorders
- □ Arrhythmia
- □ Hepatitis
- □ High Cholesterol
- □ Ulcers
- □ Skin Infection
- □ Joint Infection
- □ Bladder Infections
- □ MRSA
- □ Sleep Apnea/CPAP
- □ Fractures
- □ Osteoporosis
- □ Substance Abuse
- □ Alcoholism
- □ Multiple Sclerosis
- □ HIV
- □ AIDS
- □ Past Blood Transfusions
- □ Cancer(type) _____
- □ Mental Illness
- □ Other:_____

Previous Surgery(s), Include Dates

_____

_____

Family History Does anyone in your family have any of the following? ***Please list relative next to disorder***

- □ Diabetes Who?
- □ Thyroid Disease Who?
- □ Asthma Who?
- □ High Cholesterol Who?
- □ High Blood Pressure Who?
- □ Heart Disease Who?
- □ Kidney Disease Who?
- □ Stroke Who?
- □ Blood Clots Who?
- □ Epilepsy/Seizures Who?
- □ Congestive Heart Failure Who?
- □ Alcoholism Who?
- □ Depression Who?
- □ Substance Abuse Who?
- □ Osteoporosis Who?
- □ Cancer (type) Who?_____
- □ Other: What? Who?_____

Authorization for Release
of Protected Health Information

Please note that blank items on this form may cause major delays in processing your request. Complete this form as fully as possible.

Print patient's legal name: _____ Birth date: _____

Previous name(s): _____ Phone: _____

Patient address: _____

Please release my records from: *(Who has your records? Please list the specific hospitals and/or clinics:*

Name: _____ Phone: _____ Fax: _____

Address:_____City:_____State:_____ Zip:_____

Name: _____ Phone: _____ Fax: _____

Address:_____City:_____State:_____ Zip:_____

Name: _____ Phone: _____ Fax: _____

Address:_____City:_____State:_____ Zip:_____

1. **Release the records marked below for this condition or date(s) of treatment:** _____
   (if blank, we will release 1 year's worth of most recent records.)

   ☒ Pertinent clinic records (office visit, lab/radiology results, medications, immunizations)

   ☒ Pertinent hospital records (emergency, operative or discharge report, history and physical, lab/radiology results)

   ☒ X-ray/Radiology films/CDs ☐ Immunizations ☒ Emergency/Urgent Care ☒ EKG/echo reports

   ☒ X-ray/Radiology reports ☒ Lab/Pathology reports ☐ Pathology slides/tissue blocks

   ☒ History & physical ☒ Progress notes ☐ Diagnostic interview ☐ Billing information

   ☐ Psychological test results ☐ Psychiatric evaluation

   ☒ Health maintenance records such as immunizations.

   ☐ Other - Please specify: _____

3. **Please release my records to:** *(Who needs your records? Where do you want the information sent?)*

   Name: Donald Ives, FNP Phone: 503-754-3815 Fax: 334-539-9609

   Address: 21408 S Hwy 211 City: Colton State: OR Zip: 97017

   Name: _____ Phone: _____ Fax: _____

   Address:_____City:_____State:_____ Zip:_____

   Name: _____ Phone: _____ Fax: _____

   Address:_____City:_____State:_____ Zip:_____

This is a 2-page form. You must sign on page 2 to release records.

4. **Delivery/format:** ☐ E-mail (address: _____) ☐ US mail ☐ CD
☒ Fax (only for continuing care) ☐MyChart (patient portal) ☐ Will pick up **Date needed by:** _____

5. **Purpose:** ☐ Continuing care ☐ Insurance ☐ Personal use ☐ Disability ☐ Legal ☐ Other _____

6. **I understand that:**
   - If I change my mind, I may write to the address in Section 1 to stop the release of my records. This will not apply to records that have already been released.
   - Once the records are released to the name above, the place releasing my records cannot prevent them from being shared with a third party. At that point, the records may no longer be protected by state and federal privacy laws.
   - My records may include records that you received from other organizations. If you have used these records and filed them in the record you maintain about me, then they may also be included in any release of information.
   - I approve the release of records for future visits, starting from the date I sign this form through:_____.
   - There may be a fee for releasing these records.
   - A photocopy of this completed, signed form is considered valid if not altered.
   - I understand that, except for research related treatment, you will not condition my treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.
   - This form expires one year after I sign it, or on _____, except in certain situations specified by law.

_____	_____	_____	_____
Date	***Time***	***Signature of patient or authorized person***	***If authorized person, print name and description of authority to sign for patient (may require proof)***

HIPAA Privacy Practices and Patient Rights

How Your Information Is Used

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider

Health Care Options: As needed, we may use or disclose, your protected health information in order to support the business activities of your physician's practice

Admissible Unauthorized Disclosures

Law:
When required by local, state, or federal law.

Legal Proceedings:
We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Criminal Activity:
We may disclose your protected health information if we believe it is necessary to prevent or lessen a threat to the health or safety of a person or the public. Also, we may disclose this information to assist in the identification and apprehension of an individual.

Inmates:
We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Public Health/Communicable Disease:
We may disclose your protected health information if it may assist in the preventing or controlling disease, injury or disability.

FDA:
We may disclose your protected health information to a person or company required by the Food and Drug Administration

Child Abuse or Neglect:
We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect

Coroners, Organ Donation:
We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law.

Close Identifiable Persons:
Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care.

Health Oversight:
We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

Research:
We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Worker's Compensation:
We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Your Rights

You have the right to inspect and copy your protected health information:
Exceptions: : Psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information

You have the right to request a restriction of your protected health information:
You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You may have the right to have your physician amend your protected health information:
This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information:
This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices.

You have the right to obtain a paper copy of this notice from us.