PACKER HEALTH CLINIC

ADULT INFORMATION SHEET

Date_____

Patient Information

Name _____ Social Security Number_____

Sex: M / F Race_____ Date of Birth_____ Age_____

Street Address_____

City_____ State _____ Zip Code_____ County _____

Home telephone _____ Cell Pone _____

Person to Notify in Case of Emergency (other than patient)

Name _____Relationship to patient_____

Street Address _____

City_____ State_____ Zip Code_____ County_____

Home Phone_____ Cell Phone_____ Other_____

In order for you to receive services at the Packer Health clinics, this Consent form must be completed and proper documentation of insurance obtained.

I hereby voluntarily give my consent for _____ to receive services through Packer Telehealth clinics. I authorize any physician or designated health/mental health professional working for the Packer Telehealth clinics to provide care.

Signature_____ Date_____

TELEHEALTH CONSENT

I hereby voluntarily give my consent for my child listed below to receive telehealth services through Packer Health Clinic for the purpose of healthcare service(s) and/or procedure(s). I authorize any physician or designated health/mental health professional working with Packer Health Clinic to provide care. I understand that additional consent will be obtained prior to each appointment. I understand that during the telehealth consult, details of my child's medical history, examinations, x-rays, and tests will be discussed with other health professionals through the use of interactive video, audio, and telecommunication technology. I understand that a physical examination may take place. I understand that a non-medical technician may be present in the telemedicine studio to aid in the video transmission. I understand that video, audio and/or photo recordings may be taken of the patient during the procedure(s) or service(s). I understand that all existing laws regarding access to my child's medical records apply to these telehealth consultations. Not all telecommunications are recorded and stored. Additionally, dissemination of any patient identifiable images or information for telemedicine interactions to researchers or other entities shall not occur without your consent. Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and Georgia state law apply to information disclosed during a telemedicine consultation. It is your right to withhold or withdraw consent to the telemedicine consultation at any time without effecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. You agree that any dispute arriving from a telemedicine consult will be resolved in Georgia, and that Georgia law shall apply to all disputes. I have been advised and understand all potential risks, benefits, and consequences of telemedicine. Your healthcare provider has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented in this consent and about the telemedicine consultation. All your questions have been answered, and you understand the written information provided above. I agree to participate in telemedicine consultations for the procedure(s) and/or service(s) described above.

Patient Name:_____ **Date of Birth:**_____

Parent/Guardian Signature_____ **Date**_____

MEDICAL HISTORY

Name of Primary Care Physician_____

Address_____

Phone Number _____ Date Last Seen_____

Name of Dentist_____

Address_____

Phone Number_____ Date Last Seen_____

Name of any other Health Care Provider_____

Address_____

Phone Number_____ Date Last Seen_____

Name of Pharmacy_____

Address_____

Phone Number_____

List Medication Allergies_____

_____

List all Medical Problems_____

_____

_____

List all Previous Surgeries_____

Family History **Mother**_____

Father_____

Medication List (Include dosage and time)_____

_____

_____

_____

Are there any religious/personal beliefs that the Packer Health clinics need to be aware of in addressing your care? If yes, please explain

_____

_____

MEDICAL HISTORY CONTINUED

PLEASE MARK ALL THAT APPLY

ENDOCRINE

____ Swelling under arms or neck
____ Weakness and tiredness
____ Always hungry
____ Increased thirst
____ Increased urination
____ Tends to be too hot
____ Tends to be too cold
____ Frequent fever and chills
____ Night sweats
____ Problems going to sleep
____ Problems waking up after falling asleep
____ Recent weight gain
____ Recent weight loss
____ Diabetes
____Other_____

INFECTIONS

____ Chicken pox
____ Hepatitis B
____ Hepatitis C
____ HIV/AIDS
____ Strep Throat
____Other_____

PULMONARY

____ Chronic snoring
____ Persistent cough
____ Coughing up blood
____ TB (or exposure to)
____ Sleep apnea
____ COPD, emphysema or chronic bronchitis
____ Asthma
____ Other_____

NEUROLOGY

____ Frequent headaches
____ Migraines
____ Seizures
____ Stroke or paralysis
____ Memory problems
____ Meningitis
____ Nerve damage to feet/hands
____Other_____

EARS, NOSE & THROAT

____ Wears glasses or contacts
____ Eye drainage
____ Blurry vision
____ Recent changes in vision
____ Decreased hearing
____ Earache or drainage
____ Ringing in ears
____ Allergies (Seasonal)
____ Sinus problems
____ Frequent nose bleeds
____ Frequent sore throat
____ Tongue/mouth sores
____ Goiter/thyroid problems
____ Neck pain or lumps
____ Any change in voice
____ Dental problems
____ Other_____

HEMATOLOGY

____ Anemia/low blood count
____ Sickle cell disease

____ Bleeding/bruising easily
____ Cancer (Please list_____)
____ Chemo/Radiation exposure
____Other_____

MUSCULOSKELETAL

____ Frequent pain in fingers or hands
____ Muscle or joint pain
____ Leg camps with exercise
____ Leg cramps at night
____ Arthritis
____Other_____

GENITOURINARY

____ Frequent urination
____ Burning on urination
____ Difficulty starting urination
____ Incontinence
____ Kidney stones
____ Kidney disease
____ Other_____

CARDIOVASCULAR

____ Chest pain
____ Heart palpitations
____ Dizziness upon standing
____ Swelling in feet/hands
____High blood pressure
____ High cholesterol
____ Fainting spells
____ Shortness of breath with exercise
____Heart murmur
____Other_____

GASTROINTESTINAL

____ Frequent heartburn
____ Decreased appetite
____Frequent nausea or vomiting
____ Liver disease
____ Jaundice or hepatitis
____ Difficulty swallowing
____ Stomach pain
____ Recent change in bowel habits
____ Frequent diarrhea
____ Frequent constipation
____Incontinence
____ Bloody stools
____ Rectal pain
____ Hemorrhoids
____ Rectal fissure
____ Parasites or worms
____ Pancreatitis
____Other_____

BEHAVIORAL / MENTAL

____ Nightmares
____ Bedwetting
____ Eating problems
____ Thumb sucking
____ Discipline problems
____ Overactive/hyperactive
____ Shyness/social avoidance
____ Sleeping problems
____ Developmental delays
____ Learning disabilities
____ Depression
____ Anxiety
____ Cries often
____ Feels sad
____ Hears voices
____ Anger
____ Diagnosed behavioral/mental disorder (Please list_____)
____ Other

My signature indicates that all medical history is true and accurate to the best of my knowledge.

Patient /Guardian Signature_____ Date _____

AUTHORIZATION TO BILL INSURANCE

Patient's Name_____

Patient's Birth Date_____ Patient's Social Security Number _____

Primary Insurance Company _____

Name of person insured _____

Insured's Birth Date _____ Insured's Social Security Number_____

Group Number_____

Policy or Member Number _____

Secondary Insurance Company _____

Name of person insured _____

Insured's Birth Date _____ Insured's Social Security Number_____

Group Number _____

Policy or Member Number_____

Responsible Party

Name_____Date of Birth_____

Social Security Number _____ Employer _____

A COPY OF YOUR INSURANCE CARD IS REQUIRED

Information on this form is protected health information (PHI) and is to be treated as confidential under HIPPA rules, privacy & security. All services are charged directly to the patient or the patient's representative and/or insurance company by the provider. Acknowledgement: I consent to the use of PHI for purposes of treatment, payment and operations. I authorize the entity to use the PHI as needed. I authorize that payment of benefits be made on my behalf directly to the provider. I understand that I am financially responsible for all charges not covered by insurance including copays. If I have Medicaid, I also am aware that there are only five visits allowed outside of my listed medical provider.

Patient/Parent/Guardian Signature_____ Date_____

HIPAA AND OUR PATIENTS

The HIPAA (Health Insurance Portability and Accountability Act) Privacy Rule became law in 1996. The Office for Civil Rights enforces the HIPAA Privacy Rule, which protects the privacy of identifiable health information. This rule essentially controls the use and disclosure of what is known as Protected Health Information. We are required to provide you with the attached notice. We encourage you to read the information concerning our privacy practices. It is your copy so feel free to keep it with you.

I acknowledge receipt of the HIPAA Notice of Privacy Practices from the Packer Health Clinic.

Patient/Parent/Guardian Signature_____ Date_____