EASTSIDE INTERNAL MEDICINE, PC

PATIENT INFORMATION

(PLEASE PRINT)

Patient Name: *(LAST)* *(FIRST)* *(MI)*

Street Address: | City: | State: | Zip Code:

Home Phone: | Cellular: | Work Phone: Ext: | Email:

What number/method would you prefer we use for appointment reminders and what time of day:

☐ *Home* ☐ *Work* ☐ *Cell-Call* ☐ *Cell-Text* ☐ *Morning* ☐ *Afternoon* ☐ *Evening*

DOB: | Sex: ☐ *M* ☐ *F* | Marital Status: ☐ *S* ☐ *M* ☐ *D* ☐ *W* | Social Security Number:

May we leave messages (ex: test results) on your voice mails?

☐ No If yes, which number(s)? ☐ Home: ☐ *Brief* ☐ *Extended* ☐ Cell: ☐ *Brief* ☐ *Extended*

Employment Status:

☐ *FT* ☐ *PT* ☐ *Self Employed* ☐ *Unemployed* ☐ *Retired*

Who should we contact in case of an emergency?

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Ethnicity:

☐ *White* ☐ *African American* ☐ *Asian* ☐ *Hispanic/Latino* ☐ *Native Hawaiian/Pacific Islander*

Preferred Language:

☐ English ☐ Other: _____

Please provide your primary pharmacy information:

Name: _____ Location: _____ Phone: _____

PRIMARY INSURANCE (please supply us with a copy of your card)

Insurance Company: | Effective Date: | Relationship to Subscriber: ☐ *Self* ☐ *Spouse* ☐ *Child* ☐ *Other*

Subscriber's Name: *(if other than self)* | Subscriber SSN: | Subscriber DOB:

SECONDARY INSURANCE *(please supply us with a copy of your card)*

Insurance Company: | Effective Date: | Relationship to Subscriber: ☐ *Self* ☐ *Spouse* ☐ *Child* ☐ *Other*

Subscriber's Name: *(if other than self)* | Subscriber SSN: | Subscriber DOB:

Patient Signature: _____ ***Date:*** _____

☐ *Updated* ☐ *No Changes* *Patient Signature:* _____ *Date:* _____

☐ *Updated* ☐ *No Changes* *Patient Signature:* _____ *Date:* _____

☐ *Updated* ☐ *No Changes* *Patient Signature:* _____ *Date:* _____

☐ *Updated* ☐ *No Changes* *Patient Signature:* _____ *Date:* _____

EASTSIDE INTERNAL MEDICINE
PATIENT HISTORY FORM

DATE: _____ **NAME:** _____ **DOB:** _____

Note: This is a confidential record and will be kept in your medical file.
Please check the appropriate box(s) and give explanation if asked.

Please check if you have had any of the following and indicate the month & year when last performed:

Vaccines:
- ☐ Influenza _____
- ☐ Hepatitis B _____
- ☐ Pneumonia _____
- ☐ Tetanus _____
- ☐ TB Skin Test _____
- ☐ Chicken Pox/Shingles _____

Tests:
- ☐ bone density _____
- ☐ chest x-ray _____
- ☐ colonoscopy _____
- ☐ stress test _____
- ☐ CT/MRI (type?) _____

Females only:
- ☐ GYN exam _____
- ☐ PAP test _____
- ☐ mammogram _____

Males only:
- ☐ prostate exam _____
- ☐ PSA test _____

Hospitalizations/Surgeries/Procedures ☐ None

What/Why	*When (year)*	*What/Why*	*When (year)*

Specialist visits *(ie: cardiologist, chiropractor, dentist, eye dr., foot dr., OB/GYN, etc)*

Physician Name	*Speciality*	*Date of last visit*

Allergies to medications ☐ None Known

Drug	*Reaction*	*Drug*	*Reaction*

Prescription medicines: ☐ None

Name of drug	*dose (mg)*	*# times/day*	*Name of drug*	*dose (mg)*	*# times/day*

OTC medicines ☐ None *(pain relievers, diet pills, antacids, laxatives, vitamins, herbals, etc)*

over

FAMILY HISTORY

Father: ☐ Living ☐ Deceased: At Age: _____ Cause of Death: _____

Mother: ☐ Living ☐ Deceased: At Age: _____ Cause of Death: _____

Children: # Living Sons:_____ Ages:_____ # Living Daughters: _____ Ages:_____

Any Deceased?_____ Cause:_____ Age:_____

Siblings: # Living Brothers: _____ # Deceased: _____ Causes:_____

Living Sisters: _____ # Deceased: _____ Causes:_____

Check all that apply: Y=yourself M=Mother F=Father D/S=Daughter/Son S/B=Sister/Brother GP=Grandparent

	Y	M/F	D/S	S/B	GP		Y	M/F	D/S	S/B	GP
Bleeding disorder						High cholesterol					
Cancer:						Kidney problems					
Diabetes						Lung disease					
Eating disorder						Mental illness					
Gastrointestinal						Seizures					
Genetic disorders						Sex. Trans. Disease					
Heart disease						Stroke/TIA					
High blood pressure						Other:					

SOCIAL HISTORY

Occupation: _____ **Education** (Highest grade completed in school):_____

Caffeine use: ☐ none ☐ Yes # cups a day/week/month?_____

Nutrition/ Exercise: Are you generally satisfied with your weight? ☐ Yes ☐ No

Would you like some information about nutrition counseling? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No How often per week?_____

What kind of exercise?_____ How long (minutes)?_____

Safety: Do you wear a: sunscreen?☐ Yes ☐ No Do you feel safe in your home? ☐Yes ☐ No

Do you have excessive exposure at home/work to: ☐ Yes ☐ No (*check any/all that apply)*

☐ Fumes ☐ Dust ☐ Solvents ☐ Airborne particles ☐ Noise

Are you a victim of abuse? ☐ Yes ☐ No If yes, which? ☐ Physical ☐ Emotional ☐ Sexual

Tobacco Use: ☐ never ☐ former, quit date:_____ ☐ current, Are you ready to quit? ☐ Yes ☐ No

How soon after awakening in the morning do you smoke? # of Mins: _____ # of Hrs:_____

Do you smoke every day? _____ How many cigarettes/day _____

Alcohol use: ☐ none ☐ Yes How often in the past year?_____ How many drinks each time? _____

Drug use: Have you ever used any recreational drugs (ex: marijuana, cocaine, heroin, intravenous drugs)? ☐ Yes ☐ No

Depression: Do you have little interest or pleasure in doing things? ☐ Yes ☐ No

Are you currently feeling down, depressed, or hopeless? ☐ Yes ☐ No

Patient Signature:_____ ***Date:***_____

☐ *Updated* ☐ *No Changes* *Patient Signature:*_____ *Date:*_____

☐ *Updated* ☐ *No Changes* *Patient Signature:*_____ *Date:*_____

☐ *Updated* ☐ *No Changes* *Patient Signature:*_____ *Date:*_____

☐ *Updated* ☐ *No Changes* *Patient Signature:*_____ *Date:*_____

EASTSIDE INTERNAL MEDICINE, PC

Authorization for Disclosure of Protected Health Information

Please print all information. Form must be signed and dated each year, see reverse side

Patient Name:_____ DOB:_____

Purpose of request (who will be authorized to receive information) - I authorize the practice to disclose or provide protected health information, about me to the individual(s) listed below (list each family member, friend, or other individual):

Name:_____ Phone: _____ Relationship: _____

Name:_____ Phone: _____ Relationship: _____

Name:_____ Phone: _____ Relationship: _____

Name:_____ Phone: _____ Relationship: _____

Name:_____ Phone: _____ Relationship: _____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ **Entire patient record**; **or**, check **only** those items of the record to be disclosed:

☐office notes ☐lab results ☐x-rays; hospital, ☐nursing home, home health, hospice, and other physician records

☐record of HIV and communicable disease testing ☐record of mental health or substance abuse treatment

☐financial history report (previous 3 years only). ☐only the following: _____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

☐ Patient Request X Other (please specify): Request of EIM

Expirations or termination of authorization: This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You have the right to terminate this authorization at any time.

Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. You may revoke an authorization at any time, in writing, except to the extent that your Healthcare Provider or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Non-Conditioning statement: The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

Redisclosure: We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

_____ _____

Patient signature Date

_____ _____

Patient signature Date

_____ _____

Patient signature Date

_____ _____

Patient signature Date

_____ _____

Patient signature Date

You have the right to receive a copy of signed authorizations upon request.

EASTSIDE INTERNAL MEDICINE, PC

Payment Responsibility & Insurance Release of Information

Patient Name: _____ DOB: _____

- I request payment of approved benefits be made directly to Eastside Internal Medicine, PC (EIM) for all services provided to me by them. I authorize the release of my medical information to my insurance company or its agents to assist in determining benefits payable.

- I authorize EIM to release to the Social Security Administration, Health Care Financing Administration, its intermediaries, or any other insurance carrier any information needed to process any medical claim I may incur.

- I understand that it is my responsibility to understand my benefits. My insurance is a contract between myself and my insurance company. I will contact my insurance company regarding any questions about my benefits.

- I will inform EIM immediately when there are any changes to my insurance coverage.

- I understand that I am responsible for my deductibles, co-payments, co-insurance payments, percentages, deductibles, non-covered services, or services rendered without proper referral authorization, or denied services.

- EIM accepts cash, personal checks, money orders, Visa or Mastercard. All copays must be paid at the time of service. Outstanding balances are due within 30 days.

- I understand that I may be charged for any appointments that I miss without notifying the office and for any returned checks.

- This authorization for release of information is effective so long as necessary. This authorization may be revoked at any earlier time unless the facility has already asked or released information in reliance to it.

**A copy of our complete financial policy is available upon request.*

Patient Signature:_____ ***Date:***_____

DATE: _____ NAME: _____ DOB: _____

REVIEW OF SYMPTOMS

Please check any/all symptoms that you have experienced recently

General
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Sleepiness (excessive)
- ☐ Night sweats
- ☐ Sleep problems
- ☐ Weight gain
- ☐ Weight loss

Eyes
- ☐ Blurred vision
- ☐ Decreased/Loss of vision
- ☐ Flashes of light in vision

Ear/Nose/Throat/Mouth
- ☐ Hearing changes
- ☐ Nose bleeds
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Sore throat
- ☐ Hoarseness/Voice changes

Endocrine/Glands
- ☐ Change in libido
- ☐ Dissatisfied w/sexual perform.
- ☐ Excessive thirst
- ☐ Hair Loss
- ☐ Swollen glands

Respiratory
- ☐ Shortness of breath
- ☐ Coughing (frequent)
- ☐ Coughing up blood
- ☐ Wheezing (frequent)

Cardiovascular
- ☐ Chest pain
- ☐ Fainting/passing out
- ☐ Swelling in ankles/legs
- ☐ Irregular heartbeat
- ☐ Palpitations (heart pounding)

Patient Signature:

_____

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Black/bloody stools
- ☐ Constipation
- ☐ Decreased appetite
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Heartburn/indigestion
- ☐ Jaundice (yellow eyes/skin)
- ☐ Nausea
- ☐ Vomiting

Urinary System
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Incontinence

Musculoskeletal
- ☐ Joint pain/stiffness
- ☐ Muscle cramps
- ☐ Back pain
- ☐ Neck pain/stiffness
- ☐ Weakness

Skin
- ☐ Bruising (frequent)
- ☐ Itchy skin
- ☐ Changing moles
- ☐ Rash(s)

Neurological
- ☐ Dizziness
- ☐ Headaches
- ☐ Memory loss
- ☐ Numbness/tingling
- ☐ Tremors/shakes

Mental Health
- ☐ Aggression/fits of anger
- ☐ Social withdrawal
- ☐ Loneliness
- ☐ Obsessions/addictions
- ☐ Mood swings
- ☐ Panic Attacks
- ☐ Unwarranted fears

Date reviewed: _____ Physician signature: _____

Eastside Internal Medicine offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. Because the connection channel between your computer and the Web site uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the Web site and your computer.

Protecting Your Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it.

Only you can make sure these two factors are present. We need you to make sure we have your correct email address and are informed if it ever changes. You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us.

If you pick up secure messages from a web site, you need to keep unauthorized individuals from learning your password. If you think someone has learned your password, you should promptly go to the web site and change it.

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures Regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein and including the policies and procedures as set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. All of my questions have been answered and I understand and concur with the information provided in the answers.

In the very near future Eastside Internal Medicine will be starting a Patient Portal. It will allow you to have access to test results, request refills on medications, update demographics, and verify appointments. If you are interested, please fill in your email address below and sign form.

Name _____

Email Address_____

___ Yes, I am interested in Patient Portal

___ No, I am not interested in Patient Portal

Please sign after you have been given and read our Patient Portal Acknowledgement and Agreement form.

Sign_____

Date_____