Date: _____

LEGACY MEDICAL CENTERS

Patient information

Name: _____ **Date of Birth:** _____ **mm/dd/yyyy Sex:** ☐ **Male** ☐ **Female**

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Email: _____ **Preferred Contact Method:** ☐ **Cell** ☐ **Home** ☐ **Work**

Cell Phone: _____ **Home Phone:** _____ **Work Phone:** _____

Emergency Contact Name: _____ **Emergency Contact Phone Number:** _____

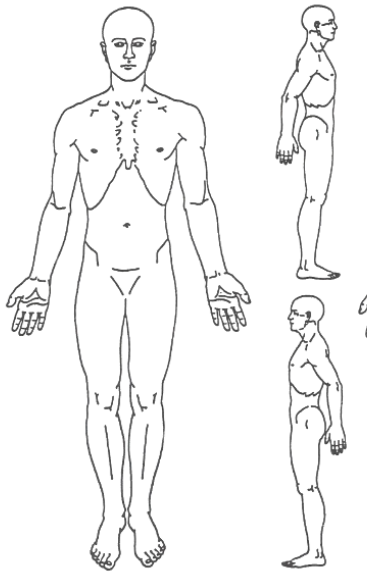
Relationship to Patient: _____ **(Spouse, Parent, Guardian, Other)**

Primary Care Physician: _____ **PCP Phone Number:** _____

Problems/reasons for consultation

Prior Treatments/Tests for Issues Listed:

A = Ache B = Burning R = Radiating Pain D = Dull Pain
N = Numbness S = Stabbing P = Pins & Needles O = Other



Please indicate how you would rate your pain (LOW) 0 1 2 3 4 5 6 7 8 9 10 (HIGH)

Medications (dose & frequency)	Allergies (medications, food, environmental)	Vitamins & Supplements

Prior Surgery or Implant, Illnesses, Injuries, Hospitalizations or Trauma	Date

Health History: Please indicate if you have any of the following:

YES	NO	
☐	☐	Alcohol abuse
☐	☐	Anemia
☐	☐	Anxiety
☐	☐	Arthritis
☐	☐	Asthma
☐	☐	Atherosclerosis
☐	☐	Autoimmune disorder
☐	☐	Bleeding disorder
☐	☐	Blood clots
☐	☐	Cancer
☐	☐	Concussion
☐	☐	COPD/emphysema
☐	☐	Depression
☐	☐	Diabetes
☐	☐	Diverticulitis
☐	☐	Heart attack
☐	☐	Herniated disc
☐	☐	High blood pressure
☐	☐	HIV
☐	☐	Inflammatory bowel disease
☐	☐	Irritable bowel syndrome
☐	☐	Irregular heartbeat
☐	☐	IV drug abuse
☐	☐	Kidney disease
☐	☐	Kidney stone
☐	☐	Liver disease
☐	☐	Memory loss
☐	☐	Migraines
☐	☐	Multiple sclerosis
☐	☐	Osteoporosis
☐	☐	Reflux or GERD
☐	☐	Seizure disorder
☐	☐	Stroke
☐	☐	Stomach problems
☐	☐	Thyroid problem
☐	☐	Transient ischemic attack
☐	☐	Urinary tract infections
☐	**Other:**	

Review of systems: Please indicate (check/circle) if you have the following:

YES	NO		
☐	☐	General	Unexplained weight loss or gain, night sweats, fatigue, sleeping pattern changes, appetite changes, fever, itch, rash, trauma, lumps, masses
☐	☐	Eyes	Visual changes, headache, eye pain, double vision, blind spots, floaters
☐	☐	Ears, nose, mouth, throat	Sinus pain, ear pain, ringing in ears, toothache, sore throat, difficulty or pain with swallowing
☐	☐	Cardiovascular	Chest pain, exercise intolerance, leg swelling, palpitations, leg pain with walking, fainting
☐	☐	Respiratory	Cough, sputum, wheeze, shortness of breath
☐	☐	Gastrointestinal (Abdominal)	Pain, indigestion, bloating, cramping, anorexia, nausea, vomiting, diarrhea, constipation, bloody stool
☐	☐	Genitourinary	Incontinence, pain with urination, blood in the urine, inability to urinate, timing/frequency of urination, decreased force of stream, irregular menses, or bleeding
☐	☐	Skin, breast	Itchiness, rashes, stretch marks, excessive dryness and/or discoloration, breast pain or soreness
☐	☐	Neurological	Changes in smell, hearing, taste, seizures, headache, pins and needles, numbness, weakness, poor balance, speech problems, tremor
☐	☐	Psychiatric	Depression, anxiety, difficulty concentrating, personality change
☐	☐	Endocrine	Prefer cold or hot weather, thin hair, heavy periods, constipation, dry skin, excessive thirst, excessive urination, dizziness, sweating
☐	☐	Hematologic	Anemia, prolonged or excessive bleeding after injury

Family History: Indicate any immediate family member who has had:

Condition:	Relationship to you	Age diagnosed
☐ Arthritis		
☐ Cancer		
☐ Diabetes		
☐ Heart disease		
☐ High blood pressure		
☐ Thyroid disease		
☐ Other		

Social history:

Marital Status:	☐ Single	☐ Married	☐ Other
Employment Status:	☐ Employed	☐ Unemployed	☐ Student
Occupation:			
Do you smoke cigarettes?	☐ YES	☐ NO	If yes, years, packs per day
Do you drink alcohol?	☐ YES	☐ NO	If yes, drinks per week
Do you use recreational drugs?	☐ YES	☐ NO	If yes, which?
Do you manage stress well?	☐ YES	☐ NO	☐ Not sure
Do you exercise regularly?	☐ YES	☐ NO	If no, why?
Do you enjoy your job?	☐ YES	☐ NO	If no, why?
Do you sleep soundly?	☐ YES	☐ NO	If no, why?
Are you currently pregnant?	☐ YES	☐ NO	☐ Not sure

Name: _____ **Date of birth:** _____ **mm/dd/yyyy**

Thank you for choosing Legacy Medical Centers!

From time to time, Legacy Medical Centers would like to keep in touch with you via email.

Legacy Medical is committed to protecting and respecting your privacy, and we'll only use your personal information to administer your account and to provide the products and services you requested from us.

We would be sharing tips for your health, advice on sports and activities, invitations to events, new treatment options and exclusive offers.

You can unsubscribe from these communications at any time. For more information on how to unsubscribe, our privacy practices, and how we are committed to protecting and respecting your privacy, please review our Privacy Policy, on our website or available at the front desk.

If you AGREE to receive emails from Legacy Medical Centers, check here: ☐

If you prefer NOT to receive emails from Legacy Medical Centers, check here: ☐

Email address: _____

How did you hear about us?

[Please check all that apply]

☐ **Referral from Patient**

Name of Patient: _____

☐ **Referral from Doctor**

Name of Doctor: _____

Social Media

- ☐ Internet Search (Google, Yahoo)
- ☐ Facebook
- ☐ Twitter
- ☐ Instagram
- ☐ Yelp

Other

- ☐ Electronic Billboard/Marquee
- ☐ 'IN Community' Magazine
- ☐ High School Sporting Event
- ☐ Local Community Event
- ☐ _____

Patient Consent for Use and Disclosure of Protected Health Information

Thank you for choosing **Legacy Medical Centers** for your health care needs. This consent form specifies your rights in regards to your Protected Health Information (PHI) and our Treatment, Payment, and Health Care Operations (TPO). You have the right to review our Notice of Privacy Practices prior to signing this consent, as the Notice of Privacy Practices outlines the use and disclosure of PHI and TPO in detail. **Legacy Medical Centers** reserves the right to revise its Notice of Privacy Practices at any time, and will provide a revised copy upon request. Please carefully read the terms and conditions below:

I hereby give my consent for **Legacy Medical Centers** to use and disclose my Protected Health Information (PHI) to carry out Treatment, Payment, and Health Care Operations (TPO).

With this consent, **Legacy Medical Centers** may call my home (or other alternative location) and leave a message on voicemail (or speak with me directly) in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and issues pertaining to my clinical care.

With this consent, **Legacy Medical Centers** may mail to my home (or other alternative location) any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **Legacy Medical Centers** may send me e-mails regarding any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that **Legacy Medical Centers** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Legacy Medical Centers** to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. I understand that if I do not sign this consent form, or later revoke it, **Legacy Medical Centers** may decline to provide treatment to me.

Patient Name (printed): _____ Date: _____

Signature: _____ Relationship to Patient: Self / Parent / Spouse / Guardian / Other: _____

Acknowledgement of Privacy Practices

I acknowledge that I have received a copy of, and have read, the Notice of Privacy Practices.

Patient Name (printed): _____ Date: _____

Signature: _____ Relationship to Patient: Self / Parent / Spouse / Guardian / Other: _____

Patient Financial Responsibility Agreement

Thank you for choosing Legacy Medical Centers for your healthcare needs. This agreement specifies your financial responsibility for all medical claims related to the treatment and services rendered at our facility.

Legacy Medical Centers verifies health insurance benefits as a courtesy to our patients, however, it is the patient's responsibility to verify his or her own benefits, including (but not limited to) the deductible, out-of-pocket maximum, copayments, and coinsurance. Verification of benefits does not guarantee payment, as benefits are not guaranteed until the Explanation of Benefits are received from your insurance company.

Legacy Medical Centers will submit your claims to your primary (and/or secondary) health insurance carrier, and all claims submitted to your health insurance carrier are subject to the deductible, copayments, and/or coinsurance specified by your healthcare plan. If you do not have health insurance, you will be charged a 'cash' rate as a self-pay patient. All copayments and self-pay fees are due on the dates that services are rendered. Please carefully read the terms and conditions of our agreement below.

I, _____, authorize the use of my signature on all insurance submissions, and understand that I am financially responsible for all costs not paid by my primary (and/or secondary) insurance carrier. I understand that verification of benefits does not guarantee payment, and it is my responsibility to verify my coverage and benefits for medical claims.

Furthermore, I agree to pay my copayments (and/or self-pay fees) on the dates that services are rendered. I agree to pay any and all additional costs billed to me upon receipt, and understand that if I do not pay my bills on or before the due date, my balance will be sent to a collections agency to collect my unpaid debt.
I understand that I am entering into a legally binding agreement by signing this form, and accept the terms and conditions herein.

_____ _____

Patient Signature Date

Relationship to Patient: Self / Parent / Spouse / Legal Guardian / Other: _____