DICKSON STREET CLINIC

NAME_____DOB_____DATE_____

PREVIOUS PROVIDER_____DATE LAST SEEN_____

PRESCRIPTION MEDICATIONS/DOSE/FREQUENCY _____ _____

_____ _____ _____

OVER THE COUNTER MEDICATIONS: _____ _____ _____

PAST OPERATIONS: _____ _____ _____

ASPIRIN Y___N___
MULTIPLE VITAMINS Y___N___
FISH OIL (OMEGA 3) Y___N___
FOLIC ACIDS Y___N___
GLUCOSAMINE/
CHONDROTEN Y___N___

DRUG ALLERGIES
CAN YOU TAKE:
PENICILLIN Y___N___
SULFA Y___N___
ASPIRIN Y___N___
USE IODINE Y___N___

GLASSES Y___N___
CONTACTS Y___N___
CATARACTS Y___N___
GLAUCOMA Y___N___

SMOKE Y___N___ #____YEARS

1) SKIN CANCER Y___N___
2) PSORIASIS Y___N___
3) HBP Y___N___
4) BLOOD SUGAR PROBLEMS Y___N___
5) BLOOD CLOTS Y___N___
6) STROKES Y___N___
7) HEART TROUBLE Y___N___
8) HEART ATTACK Y___N___
9) THYROID PROBLEMS Y___N___
10) ASTHMA Y___N___
11) COPD Y___N___
12) HEPATITIS Y___N___
13) LIVER DISEASE Y___N___
14) IBS Y___N___
15) CROHN'S DISEASE Y___N___
16) COLON POLYPS Y___N___
17) FIBROYMYALGIA Y___N___
18) ARTHITIS Y___N___
19) JOINT PROBLEMS Y___N___
20) JOINT REPLACEMENT Y___N___
21) BUNIONS Y___N___

WEIGHT GAIN_____LOSS_____

LAST CHEST X-RAY_____ YEAR_____NEVER_____ CAN'T REMEMBER_____
COLONOSCOPY_____YEAR_____NEVER_____CAN'T REMEMBER_____
MAMMOGRAM_____YEAR_____NEVER_____CAN'T REMEMBER_____
PAP/PELVIC_____ YEAR_____NEVER_____CAN'T REMEMBER_____
BONE DENSITY_____YEAR_____NEVER_____CAN'T REMEMBER_____
PSA/PROSTATE EXAM_____YEAR_____NEVER_____CAN'T REMEMBER_____
CHOLESTEROL/TRIGLYCERIDES_____YEAR_____GOOD_____BAD_____
FAMILY HISTORY:_____
_____

REFERRED BY_____

PREFERRED PHARMACY

_____

DICKSON ST. CLINIC

PATIENT INFORMATION

Chart # _____ Date _____

Name (No Nicknames) _____ Sex: M F
(Last) (First) (Middle)

Date of Birth _____ Age _____ Social Security # _____ Marital Status _____

Address _____ Home Phone ( ) _____
(Street and P.O. Box if applicable)

_____
(City) (State) (Zip Code)

Employer _____
(Name) (Address) (Phone Number)

Spouse's Name (or parent if patient is a child) _____

Spouse or Parent's Social Security # _____ Spouse or Parent's Date of Birth _____

Spouse or Parent's Employer and Address _____

Spouse or Parent's Business Phone _____

_____
(Signature) (Date)

INSURANCE INFORMATION

Medicare # _____ Medicaid # _____ Arkansas Mo Ok (circle one)

1st Commercial Insurance _____

Address _____

Group # _____ ID # _____ Policy Holder _____

2nd Commercial Insurance _____

Address _____

Group # _____ ID # _____ Policy Holder _____

See Reverse Side

INSURANCE PAYMENT AUTHORIZATION & ASSIGNMENT

I authorize Dickson Street Clinic to furnish information to insurance carriers concerning my illnesses and treatments and I assign to the doctor all payments for medical services rendered to my dependents or myself. I understand I am responsible for any amount not covered by insurance.

Patient's Name_____

Insured's Signature_____

MEDICARE SIGNATURE ON FILE

I request that payment of authorized benefits be made on my behalf to Dickson Street Clinic for any services furnished me by the doctor. I authorize any holder of medical information about me to release to Medicare any information needed to determine these benefits.

I request that payment be made and authorize release of medical information necessary to pay the claim. The doctor agrees to accept the charge determination of Medicare as the full charge, and the patient is responsible only for the deductible and co-insurance.

1. Patient's Signature:_____
2. Date:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient: _____

Signature: _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

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