BestMed PRIMARY CARE

PATIENT MEDICAL HISTORY

Name: _____ DOB: _____ Date: _____

Sex at Birth:_____ Gender Identity: _____ Preferred Pronoun: _____ Preferred Pronoun: _____

Do you have an Advanced Directive or a POLST form? YES: _____ NO: _____

PAST/PERSONAL MEDICAL HISTORY:

List most RECENT date completed for the following exams of screenings:

Colonoscopy/Cologuard	PSA (Males only)
Eye Exam	Mammogram (Females Only)
DEXA (Bone Density Scan)	PAP (Females Only

Have you ever been diagnosed with any of the following? Check all that apply and indicate year of diagnosis:

	GENERAL		HEART DISEASE		KIDNEY/BLADDER
	Allergies/ Hay fever		Angina/ Chest Pain		Incontinence
	Anemia		Bypass Surgery		Infection
	Bleeding Disorder/Clotting		Congestive Heart Failure		Prostate Disorder
	Blood Transfusion		Heart Attack		Stones
	Cancer: Type		Heart Infection		**MENTAL HEALTH**
	Diabetes		Irregular Heartbeat		Alcoholism
	Glaucoma		Murmur		Anxiety
	High Blood Pressure		Rheumatic Fever		Depression
	High Cholesterol		Valve Replacement		Drug Abuse
	Migraines/ Headache		**GASTROINTESTINAL**		Nervous Breakdown
	Paralysis		Bleeding/Ulcer		Mental Illness
	Seizure Disorder		Colitis		Bipolar
	Stroke		Diverticulosis		**GYNECOLOGICAL**
	Thyroid Problems		Gallstones		Abnormal PAP
	INFECTIOUS DISEASE		Hemorrhoids		Cyst
	AIDS or HIV positive		Hepatitis: Type		Endometriosis
	Tuberculosis		Hiatal Hernia		Irregular Bleeding
	Sexually Transmitted Disease		Irritable Bowel Syndrome		Age of first menses:
	LUNG DISEASE		Polyps		Last menstrual cycle:
	Emphysema/COPD		Spastic Colon		Contraception:
	Asthma		Ulcers		
	Chronic Bronchitis		**MUSCULOSKELETAL**		**Regular Exercise:** Yes or No
	Pneumonia		Arthritis		
			Gout		
			Joint Pain		

SURGERIES (Please list surgeries and date):

_____

_____

HOSPITALIZATION:

_____

_____

CURRENT MEDICATIONS (**name and dosage**; including supplements and vitamins)**:** □ See List

ALLERGIES (Include medicines, foods, bee stings, hay fever)**:**

_____

FAMILY HISTORY: Please fill in name, age and whether they are living or deceased.

Condition	**Relationship to you**	**Age at diagnosis**	**Died from condition?**
Breast Cancer			
Colon Cancer			
Clots			
Diabetes			
Heart Disease			
Stroke			
Other			

Family members	**Ages**	**Living or deceased**	**If deceased, cause**
Mother			
Father			
Your sibling(s)			
Grandparents			

SOCIAL HISTORY:

Marital Status: □ Married □ Single □ Separated □ Divorced □ Widowed

Employer: _____ Occupation: _____

HABITS: (Please state "yes" or "no" and specify how much/how often)

Tobacco- circle one and please fill in the blanks if appropriate-			
Are you a tobacco user (vape, chew, etc) YES__ NO __ FORMER __	Former Smoker -How many years did you smoke?	Sometimes Smoker	Daily Current Smoker- How many years have you been smoking?
	Year you quit:	How Much?	Packs per day: Do you want to quit? YES__ NO __

Alcohol Use:	**Beer**	**Wine**	**Mixed Drinks**
Frequency and amount			
Drug Use:	**Marijuana**	**Methamphetamine**	**Other**
Frequency and amount			
Caffeine Use:	**Coffee**	**Tea**	**Soda**
Frequency and amount			

BestMed PRIMARY CARE

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

This authorization must be written, dated and signed by the patient or by a person authorized by law to give this authorization.

_____ ____/____/____

Patient Name (Printed) **DOB**

_____ _____

Address **Phone Number**

RELEASE RECORDS FROM
Facility Name: _____
Facility Address: _____
_____
Facility Phone Number: _____
Facility Fax Number: _____

RELEASE RECORDS TO
Facility/Individual Name:
_____
Address: _____
Phone Number: _____
Fax Number: _____

The purpose for the release of this information is for:

☐ Medical purposes ☐ Billing / Insurance purposes ☐ Legal ☐ Transferring Care

☐ At my request ☐ Other: _____

By checking the boxes below, I authorize release of the following medical information to the person/entity named above:

☐ All information held about me, including medical records, billing record information and all items listed below (even if boxes are not checked)

☐ Medical records, including diagnosis ☐ Billing record information ☐ Imaging Reports

☐ Lab and/or Pathology Reports ☐ Workers' Comp Injury Records ☐ Immunization Records

☐ Other: _____

The following must be initialed to be included in the release:

_____ HIV/AIDS related records _____ Mental Health _____ Alcohol or Drug Abuse

_____ Psychiatric records _____ Genetic testing

Your health care and payment for that health care cannot be conditioned upon receipt of this signed Authorization unless your health care or treatment is for the purpose of: (i) Creating health information about you to be disclosed to a third party; or (ii) For the purpose of research. You have the right to revoke this Authorization at any time, provided that you do so in writing. If you revoke your Authorization, we will no longer use or disclose information for the reasons covered by your written Authorization, but we cannot prohibit any uses or disclosures already made with your permission. To revoke this Authorization, please email a written statement to compliance@ccpartners.com that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization, and state that you are revoking this Authorization.

The Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

This Authorization will expire on the earlier of _____(date), or 12 months from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose.

_____ _____ _____

Patient's or Patient's Representative's Signature Print Patient Name Date

_____ _____

Patient Representative Relationship Print Patient Representative Name

BestMed

Authorization to Communicate

First Name _____ MI _____ Last Name _____ Date of Birth (MM/DD/YYYY) ___/___/___

CONSENT FOR LEAVING MESSAGES:

I understand that my healthcare information is protected. In order for Practice to leave detailed messages containing specific health information on my voicemail or answering machine, I need to give permission to do so.

I give permission for messages to be left on the phone number(s) listed below:

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Messages may be left regarding the following:

- ☐ Appointment Reminders/Changes
- ☐ Account Payments/Balances
- ☐ Cost Estimates
- ☐ Medical Treatment (Needed/Completed)

CONSENT TO VERBALLY SHARE INFORMATION:

By completing the information and signing below, I authorize Practice to verbally discuss my medical care and other protected information.

The name(s) listed below are individuals to whom I grant permission for Practice representatives to *verbally discuss* information using their best judgment that is relevant to my care or relevant payment for such care.

This authorization to communicate will NOT authorize the release of (a) STI, HIV/AIDS, drug and/or alcohol use, or any mental health conditions to the individuals listed below or (b) medical or billing records. The release of such information or records will require my signature on an Authorization to Use/Disclose Health Information.

1) Name: _____ Phone: _____ Emergency Contact? ☐ Yes ☐ No

Relationship to Patient: (check one) ☐ Spouse ☐ Partner ☐ Parent/Guardian ☐ Child ☐ Sibling ☐ Other: _____

2) Name: _____ Phone: _____ Emergency Contact? ☐ Yes ☐ No

Relationship to Patient: (check one) ☐ Spouse ☐ Partner ☐ Parent/Guardian ☐ Child ☐ Sibling ☐ Other: _____

Individual(s) above may be contacted regarding the following:

- ☐ Appointment Reminders/Changes
- ☐ Account Payments/Balances
- ☐ Cost Estimates
- ☐ Medical Treatment (Needed/Completed)

It will be my responsibility to keep this information up to date, as I recognize relationships may change over time. This consent will be considered valid until such time that I revoke it in writing. I reserve the right to revoke it at any time. I understand revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

By: _____ _____ Date: _____

Patient's or Patient's Representative's Signature — Print Patient Name

_____ _____

Patient Representative Relationship — Print Patient Representative Name

New Patient Registration Information

Patient Information:

First Name:_____ Last Name: _____MI: ____

Social Security #:_____Date of Birth:_____/_____/_____Language: _____

Gender at birth: □ Male □ Female Gender Identity: _____

Preferred Pharmacy:_____

Contact Information:

Street Address: _____

City:_____ State:_____ Zip:_____

Home Phone: _____Mobile Phone: _____

E-Mail: _____ Preferred Contact Method: □ Home □ Mobile □ Email

Patient Emergency Contact:

Contact Name: _____ Phone Number: _____

Relationship to Patient: (check one) ☐ Spouse ☐ Partner ☐ Parent/Guardian ☐ Child ☐ Sibling ☐ Other: _____

Authorization to Share Information with Family Member or Representative

If you would like to designate a family member or other individual with whom the provider may discuss your medical condition and / or billing records, the release of such information will require your signature on an Authorization to Use / Disclose Health Information. Please ask a member of our team for a copy.