MAIN STREET MEDICAL

NEW PATIENT QUESTIONNAIRE

Patient Name: _____Date: _____

Date of Birth: _____SSN:_____ Male__ Female__

Guarantor Name:_____ SSN:_____DOB:_____

Home Phone:_____ Cell Phone:_____

Street Address:_____ Apt#: _____

City:_____ State:_____ Zip: _____

Billing Address (if different):_____

Email address: _____

Ethnicity (circle): Not Hispanic or Latino/ Hispanic or Latino/Decline to State

Race (circle): Caucasian/Black/Asian/Hispanic/Other

Marital Status (circle): Married/Single/Separated/Widow

Referred By:_____ Are we your Primary Care Physician: Yes__ No__

Emergency contact:_____ Phone:_____

INSURANCE INFORMATION:

Name of Insured_____ Relationship to Patient_____

SSN:_____ Birth date:_____

PAST MEDICAL HISTORY: Indicate if you have suffered from any of the following:

High Blood Pressure	☐	**Thyroid Disease**	☐	**Seasonal Allergies**	☐
High Cholesterol	☐	**Hormone Abnormalities**	☐	**Skin Problems**	☐
Heart Disease	☐	**Heartburn/GERD**	☐	**Epilepsy**	☐
Stroke	☐	**Liver Disease**	☐	**Depression/Anxiety**	☐
Cancer	☐	**Gastrointestinal Problems**	☐	**Neurologic Disease**	☐
Asthma	☐	**Kidney Disease**	☐	**Joint Problems/Arthritis**	☐
Lung Disease	☐	**Anemia**	☐	**OTHER:**	
Diabetes	☐	**Glaucoma**	☐	_____	

PREVIOUS HOSPITALIZATIONS / SURGERIES / PROCEDURES:

DATE:	PROCEDURE:

MEDICATION OR FOOD ALLERGIES:

MEDICATION/FOOD:	REACTION:

CURRENT MEDICATIONS:

NAME OF MEDICATION:	DOSAGE:	FREQUENCY:

HEALTH MAINTENANCE:

EXAM:	(ESTIMATED) DATE OF LAST EXAM:
Mammogram	
Pap Smear	
Colonoscopy	
Lipid Panel	
Glaucoma Screening	
VACCINE:	**DATE ADMINISTERED:**
Pneumovax	
Flu Shot	
Tetanus	
Shingles	

SOCIAL HISTORY:

Occupation:	
Employer:	
Do you smoke?	**Yes / No**
Have you ever smoked?	**Yes / No**
When did you quit smoking?	
Do you drink alcoholic beverages?	**Yes / No**
How much alcohol do you drink per week?	
Do you use recreational drugs?	**Yes / No**
Do you exercise regularly?	**Yes / No**
Are you able to care for your personal needs?	**Yes / No**
Do you feel safe in your home?	**Yes / No**

FAMILY HISTORY:

Father: Alive___ Deceased___

Mother: Alive___ Deceased___

Does anyone in your immediate family have the following? If so, list their relationship to you.

PROBLEM:	RELATIONSHIP TO PATIENT:
Asthma	
Arthritis	
Bleeding Disorder	
Cancer/Type	
Depression / Mental Illness	
Diabetes	
Epilepsy	
Gallbladder Disease	
Glaucoma	
High Cholesterol	
High Blood Pressure	
Heart Attack	
Migraines	
Stroke	
Alcoholism/Substance Abuse	

Any other problems not listed: _____

Authorization of Treatment: I authorize the administration and cost of all medical and surgical procedures, breathing treatments, physicals, x-rays and medication for myself and/or dependents.

_____ _____

Signature of Patient or Guardian **Date**

MAIN STREET MEDICAL

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Main Street Medical to use and disclose my protected health information (PHI) about me to carry out treatment, payment and health care operations.

I have the right to review the notice of privacy practices prior to signing this consent. Main Street Medical reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Practice Manager at Main Street Medical, 93 Main St, Hilton Head, SC 29926.

With this consent, Main Street Medical may call my home or other alternative location and leave a message on the voicemail or in person in reference to any items that assist the practice in carrying out health care operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results among others.

With this consent, Main Street Medical may mail to my home or other alternative location any items that assist the practice in carrying out health care operations, such as appointment reminder cards and patient statements.

With this consent, Main Street Medical may email to my home or other alternative location any items that assist the practice in carrying out health care operations, such as appointment reminders ans patient statements. I have the right to request that Main Street Medical restrict how it uses or discloses my PHI to carry out health care operations. The practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Main Street Medical to use and disclose my PHI to carry out health care operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Main Street Medical may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Print Patient's Name

_____ _____

Date Print Name of Legal Guardian, if applicable

MAIN STREET MEDICAL

HIPAA FORM

Main Street Medical has made their HIPAA privacy policies available to me by posting the information in the office waiting room. I may also request a copy of the policies, which I may borrow to read, by requesting them at the front desk or can view online by visiting the following website: https://www.hhs.gov/sites/default/files/privacysummary.pdf

If I have any other questions, I may contact the Privacy Officer at 843-681-3777 during regular business hours.

_____

Patient or Legal Guardian Signature

_____

Date