PATIENT INFORMATION

Personal Information

Last Name:_____ First Name:_____ Middle Initial:_____

Address:_____ City:_____ Zip:_____

Residence: (circle one) Rental/ Own Family/ Friend/ Emergency / Shelter/ Homeless

Home Phone #:_____ Cell #:_____

Date of birth:_____ Social Security #:_____

US Military Veteran:___Yes ___ No

Gender:_____ Sexual Orientation:_____ Prefered Pronoun:_____

Have you had more than one sexual partner in the last year: No Yes

Race:(circle one) Caucasian Black Asian Other Ethnicity: Non-Hispanic Hispanic

What is your primary language:_____

Marital Status: (circle one) Married Single Divorced Widowed Separated

Spouses Name:_____ Phone #:_____

Emergency Contact Information:

Name:_____ Relationship:_____ Phone #:_____

Employer:_____ Phone #:_____

(circle one) Full-time Part-time At home Disabled Retired Student

Insurance Information

Are you covered by insurance? Yes No Type:_____

Domestic violance victim/ survivor? Yes No If yes, how long ago:_____

I understand Avicenna DOES NOT prescribe PAIN or Controlled medications.

Patient's Signature:_____ Date:_____

Name:_____ Date:_____

ALLERGIES: List all medication, enviromental and food allergies and type of reaction

_____

_____

MEDICATION: List name of **medication, dosage and frequency**, include list if needed.

1._____ 6._____

2._____ 7._____

3._____ 8._____

4._____ 9._____

5._____ 10._____

MEDICAL CONDITIONS (check all that apply)

__Allergies
__Anemia
__Anxiety
__Emphysema/COPD
__Asthma
__Bipolar
__Blood transfusion
__Cancer
__Clotting Disorder
__Congestive heart failure
__Depression
__Diabetes Type 1 Type 2
__GERD/ reflux disease
__Schizophernia
__Glaucoma
__Heart murmur
__HIV/AIDS
__High blood pressure
__High Cholesterol
__Kidney Disease
__Myocardial nfarction
__ Nerve/ muscle disease
__Osteoporosis __Arhritis
__Seizures
__Sickle cell anemia
__Substance abuse
__Thyroid disesae
__ Tuberculosis

Any medical conditions not listed:_____

_____

SURGICAL HISTORY (check all that apply)

__Appendectomy
__Brain surgery
__Breast surgery
__CABG
__Cholecystectomy
__Colon surgery
__Tonsillectomy (T&A)
__Weight reduction surgery
__Thyroid surgery
__C-section
__Eye surgery
__Fracture surgery
__Hernia repair
__Hysterectomy
__Joint surgery
__Bunionectomy
__Varicosevein surgery
__Prostate surgery
__Small intestine surgery
__Spine surgery
__Tubal ligation
__Valve replacement
__Vasectomy
__Vascular surgery
__Cardiac stent
__Bladder surgery
__Lung surgery

Any other surgeries not listed: _____

_____

IMMUNIZATIONS

Vaccination	Approximate Date	Never
Pneumonia (pneumovax)		
Tetanus booster (Tdap)		
TB test (PPD)		
Hepatitis B vaccine		
Hepatitis A vaccine		
Varicella (chicken pox)		
Shingles (Zostavax)		
MMR		
Flu		

PREVENTIVE CARE

Test or procedure	Approximate Date and result	Never
Physical		
Pap smear		
Mammogram		
Chest X-ray		
Colonoscopy		
Bone density test (DXA)		
PSA (prostate cancer)		
EKG		
HIV test		

GYNECOLOGICAL and OBSTETRIC

Do you contraception? __No __Yes, what kind? _____
Age at menopause? ____ Do you have hot flashes or other symptoms (specify)? _____
Any gynecological conditions or problems? _____ Name _____

FAMILY HISTORY (check all that apply)

	Mother	Father	Sister	Brother	Daughter	Son	Relative
alcohol abuse							
breast cancer							
ovarian cancer							
prastate cancer							
other cancers							
diabetes							
heart disease							
high cholesterol							
hypertension							
mental disorder							

SOCIAL HISTORY

Tobacco use? __ No __Yes, what form?_____ How much?_____ How long?_____
How many years ago did you quit?_____ Would you like to quit?__No __Yes
Do you drink alcohol?__No __In the past __Yes, how many drinks weekly?_____
Do you drink caffeine?__No __Yes, how many weekly?_____
Do you, or have you ever used recreational drugs?__No __Yes, describe:_____
Do you get regular exercise?__No __Yes, what kind?_____ How often?_____

List hobbies or leisure activities:

_____

_____

Do you feel unsafe or have been harmed in a physical, emotional or sexual manner, in any relationship or recent encounter?__No __Yes, describe:_____

PATIENT DEPRESSION QUESTIONAIRE – 2 (PHQ-2)

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

PATIENT DEPRESSION QUESTIONAIRE- 9 (PHQ-9)

3. Trouble falling or staying asleep or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about self—or that you are a	0	1	2	3
7. Trouble concentrating on things, such as Reading the newspaper or watching TV	0	1	2	3
8. Moving or speaking so slow that other people could have noticed? Or the opposite being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or hurting yourself in some way	0	1	2	3

For office coding 0 + _____ + _____ + _____

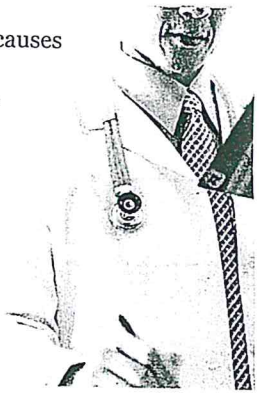
If you checked <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult at all	Somewhat difficult	Very difficult	Extremely difficult

"In medicine we ought to know the causes of sickness and health."
(Avicenna) 980A.D - 1037A.D.

Avicenna Clinic
1838 Frankford Ave.
Panama City, Fl 32405

Ph. 850-215-8200 Fax 850-215-8226
www.avicennaclinic.org



AVICENNA FREE CLINIC

Avicenna Free Clinic provides primary healthcare for those individuals that are uninsured and qualify under the Florida State guidelines.

Any individual that has applied for disability, has retained a lawyer or on workers compensation or an auto accident claim will only be provided primary care services.

No laboratory, diagnostic services or Baycare referrals will be provided for free to assist in disability, auto accident or workers compensation claims. Please have lawyer to refer you to appropriate doctor for those services.

Avicenna Free Clinic Staff

Print name:_____

Sign name:_____

Date:_____

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HIPPA RELEASE OF PROTECTED HEALTH INFORMATION

Patient Authorization for Use and Disclosure of protected Health Information

By signing this form I authorize Avicenna Free Clinic to use and /or disclose certain protected health information (PHI) about me to _____

This authorization permits Avicenna Free Clinic to use and/or disclose the following indiviually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc)

The information will be used or disclosed for the following purpose:
(If disclosure is requested by patient, purpose may be listed as "at request of the individual")

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on_____20___

I do not have a sign this authorization in order to receive treatment from Avicenna Free Clinic. In fact, I have the right to refuse to sign this authorization.

I have the right to revoke this authorizationin writing at any time. My written revocation must be submitted to the office at:

Avicenna Free Clinic
1838 Frankford Ave.
Panama City, Fl 32405

Siganture of Patient or Legal Guardian:_____

Relationship to Patient:_____

Date:_____

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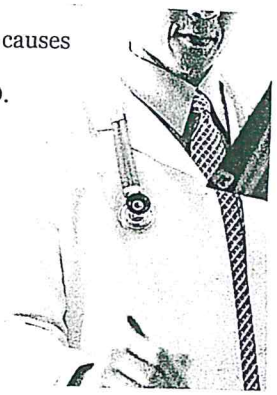

MEDICAL RECORDS RELEASE

Name:_____ DOB:_____

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

Doctor or Facility to receive records from:

_____

_____

_____

I authorize the release of my medical records to Avicenna Clinic from the above named doctor/facility. Please release up to two years of office notes, labs, radiology, and medication list.

Patient's Rights Reguarding this Disclosure

I understand I have the right to revoke this athorization at any time. If I revoke the authorization, I must do so in writting and present it to Avicenna Clinic. Unless otherwise revoked, this authorization will expire two (2) years from the date signed.

Patient Signature:_____ Date:_____

ATTENTION

ALL REFILLS FOR PRESCRIPTIONS MUST BE ADDRESSED AT TIME OF OFFICE VISIT WITH PROVIDER

Please be advised, we do not respond to pharmacies calling or faxing refill requests for you. It is the patient's responsibility to make sure that all prescription refills are addressed at time of your appointment.

In emergency situations, refills by phone may be honored. In the event that emergency situation arises, please understand that it can take up to 72 hours for refills to be completed. If it is not an emergency then you may be required to make an appointment.

Print Name:_____

Signature:_____

Date:_____

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Dear Patient:

Recently the U.S. Government established new rule concerning the use and protection of medical and health information. This initiative was part of the Health Insurance Portability and Accountabillity Act (HIPPA) of 1996. The rules are intended to provide standard privacy protection of your medical information. Avicenna Clinic regards the privacy of our patients as a central part of our mission to serve the needs of the patient first. The Notice of Privacy Practices provides you with information explaining how we use your medical information.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that Avicenna Clinic has provided me a copy of its Notice of Privacy Practices. I understand this acknowledgment means only I have received the notice and in no way affects the care I receive.

Patient's Printed Name:_____

Patient's Signature:_____

Relationship to Patient:_____

Date:_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include surgeries, follow-up care, administering medication, etc.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your medical health plan for your medical services.
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities. Auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care who assist in taking care of you. We will use and disclose your protected health information when we are required to do so by federal, state or local law. We may disclose your protected health information to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your protected health information if requested by a law enforcement official for any circumstance required by law. We may release your protected health information to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directions to perform their jobs. We may release protected health information to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your protected health information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your protected health information if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your protected health information to federal officials for intelligence and national security activities authorized by law. We may disclose protected health information to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose protected health information to correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement official. Disclosure for these purposes would be necessary: (a) for the Institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your protected health information for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect and copy your protected health information.
- The right to request an amendment to your protected health information.
- The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:
Name Office Manager
Address 901 W 23rd St., N-5
Panama City, FL 32405
Phone 850-769-1566

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)