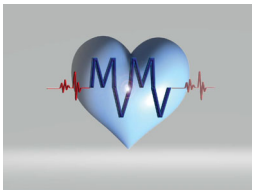

MVMV
My Virtual Medical Visit

New Patient Paperwork

Name *(Last, First, M.I.):* ☐ M ☐ F		**Today's Date:**
Patient Nickname *(if applicable)*		
Email Address:		**DOB:**
Primary Phone:	**Cell Phone:**	
Emergency Contact Information: **Name:** _____ **Phone:** _____	**Race:** ☐ American Indian/Alaska Native ☐ Asian ☐ African American ☐ Caucasian ☐ Nat Hawaiian/Pacific Islander ☐ Unknown ☐ Decline to Answer	
Address:	**City:** **State:**	**Zip:**
Previous or Current Primary Care Physician:	**Date of last physical exam:**	

PERSONAL HEALTH HISTORY

Please list any other physicians that contribute to your health care:

NAME & CONTACT NUMBER	SPECIALITY	DATE OF LAST VISIT

CURRENT MEDICAL PROBLEMS
Please list any concerns or problems you would like to address with your physician

MEDICAL HISTORY

Current and past medical diagnoses (check all that apply)

☐ Hypertension	☐ Kidney stones	☐ HIV / AIDS	☐ Insomnia	☐ Hypogonadism (low testosterone)
☐ Diabetes	☐ Enlarged prostate	☐ Hepatitis C	☐ Depression	☐ Bladder Cancer
☐ High cholesterol	☐ Urinary incontinence	☐ Cirrhosis	☐ Osteoporosis	☐ Kidney Cancer
☐ Heart disease	☐ Chronic pain	☐ Stomach ulcer	☐ Osteopenia	☐ Prostate Cancer
☐ Heart attack	☐ Arthritis, degenerative	☐ GERD / reflux	☐ Blood Clots(legs/lung)	☐ Cancer (Specify)
☐ Abnormal heart valve	☐ Arthritis, rheumatoid	☐ Irritable bowel disease	☐ Crohn's Disease	☐ Cancer (Specify)
☐ Heart failure	☐ Arthritis, gout	☐ Seizures	☐ Ulcerative Colitis	☐ Cancer (Specify)
☐ Stroke	☐ COPD	☐ Migraine headaches	☐ UTI	☐ Other (Specify)
☐ Kidney Disease	☐ Asthma	☐ Sleep apnea	☐ Erectile Dysfunction	☐ Other (Specify)
☐ Thyroid Problems	☐ Glaucoma	☐ Anxiety	☐ Pregnant #_____times	☐ Congestive Heart Failure

Exposure to: ☐ Asbestos ☐ Chemicals ☐ Ionizing Radiation

IMMUNIZATIONS & DATES - If checked, please provide date(s)

☐ Influenza	☐ Hepatitis B	☐ MMR *Measles, Mumps, Rubella*
☐ Pneumonia	☐ Shingles / Zoster	☐ Tdap *Tetanus, diphtheria, pertussis*
COVID -19: 1st Dose Date: Lot: Mfr:	COVID -19: 2nd Dose Date: Lot: Mfr:	COVID -19: Booster Date: Lot: Mfr:

HEALTH SCREENING TESTS

Mammogram	☐ Normal ☐ Abnormal	Date:	Provider:
Colonoscopy	☐ Normal ☐ Abnormal	Date:	Provider:
Fecal occult blood	☐ Normal ☐ Abnormal	Date:	Provider:
Pap smear	☐ Normal ☐ Abnormal	Date:	Provider:
Bone density (DEXA)	☐ Normal ☐ Abnormal	Date:	Provider:
Prostate specific antigen (PSA)	☐ Normal ☐ Abnormal	Date:	Provider:
Lipid profile (cholesterol)	☐ Normal ☐ Abnormal	Date:	Provider:
Electrocardiogram (EKG)	☐ Normal ☐ Abnormal	Date:	Provider:
Cardiac stress test	☐ Normal ☐ Abnormal	Date:	Provider:

PAST HOSPITALIZATIONS

Reason	Year	Hospital

SURGICAL HISTORY

Operation	Year	Surgeon

ALLERGIES

Name the Drug	Reaction You Had

MEDICATIONS

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

***Provide Your Local Pharmacy Name & Phone:**

Name the Drug	Strength	Frequency Taken

SOCIAL HISTORY

Place of Birth:

Occupation:

Travel outside of USA: ☐ No ☐ Yes

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Alcohol	Do you drink alcohol?	☐ Yes	☐ No
	If yes, what kind?		
	How many drinks per week?		
	Are you concerned about the amount you drink?	☐ Yes	☐ No
Tobacco	Do you use tobacco?	☐ Yes	☐ No
	☐ Cigarettes – pks./day ☐ Chew - #/day ☐ Pipe - #/day ☐ Cigars - #/day		
	☐ # of years ☐ Or year quit		
Sex	How many sexual partners have you had in the past six months?		
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness or other sexual transmitted diseases?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
Depression	In the past two weeks have you felt down, depressed or hopeless?	☐ Yes	☐ No
	In the past two weeks have you felt little interest or pleasure in doing things?	☐ Yes	☐ No
Exercise	☐ Sedentary (No exercise)		
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Domestic Violence	Over the last 12 months, has anyone close to you hurt, hit or threatened you?	☐ Yes	☐ No
Drugs	Do you currently use recreational or illicit /illegal drugs?	☐ Yes	☐ No
	List all Illicit / Illegal and recreational drugs used in the last 30 days		

FAMILY HISTORY				
RELATIVE	**AGE (CURRENT OR DEATH)**	**HEART ATTACK OR STROKE**	**CANCER**	**OTHER HEALTH PROBLEMS**
Mother		☐ No ☐ Yes at age _____	☐ No ☐ Yes (type) _____	
Father		☐ No ☐ Yes at age _____	☐ No ☐ Yes (type) _____	
Sibling		☐ No ☐ Yes at age _____	☐ No ☐ Yes (type) _____	
Sibling		☐ No ☐ Yes at age _____	☐ No ☐ Yes (type) _____	
Sibling		☐ No ☐ Yes at age _____	☐ No ☐ Yes (type) _____	
Grandmother *Maternal*		☐ No ☐ Yes at age _____	☐ No ☐ Yes (type) _____	
Grandfather *Maternal*		☐ No ☐ Yes at age _____	☐ No ☐ Yes (type) _____	
Grandmother *Paternal*		☐ No ☐ Yes at age _____	☐ No ☐ Yes (type) _____	
Grandfather *Paternal*		☐ No ☐ Yes at age _____	☐ No ☐ Yes (type) _____	

$25 CANCELLATION FEE POLICY

If you are unable to keep your scheduled doctor's appointment, we require a 24-hour notice (1-full business day) so that we may accommodate the needs of another patient. In the event of a failed provider appointment, the patient is charged a $25 fee.

Patient Initials_____

PRESCRIPTION REFILL POLICY

I understand my doctor's refill policy:

1. Refills must be requested at least 24 - 48 hours ahead if I am not seeing the doctor.
2. Refills ARE NOT given at night or on weekends.
3. Refills are provided by my doctor only. I will not ask other physicians for refills.
4. Refills ARE NOT given for lost, stolen, spilled, misplaced or "used up early" medications. NO EMERCENCY REFILLS.
5. Some insurances may take 7-10 days for prior authorization to be complete.

Patient Initials_____

AUTHORIZATION FOR DISCLOSURE OF PATIENT HEALTH INFORMATION (HIPPA CONSENT)

I authorize My Virtual Medical Visit to disclose my health care and billing information to those that I designate. I further provide authorization for these individuals to pick up prescriptions and/or medications on my behalf.

Patient Initials_____

I designate the following individuals for disclosure of patient health information as described above for my health care, billing and medications/prescriptions.

Patient Initials_____

Name_____ Relationship _____ Phone _____

Name_____ Relationship _____ Phone _____

Name_____ Relationship _____ Phone _____

NOTICE OF PRIVACY PRACTICES

I have the right to review the "Notice of Practices", prior to signing this consent and agree with these privacy policies.

Patient Initials_____

FINANCIAL / PRIVACY POLICY

I hereby authorize My Virtual Medical Visit to release any medical information required during the course of examination and treatment to my insurance company. I agree to pay for services incurred after the patient has been charged for the office visit, such as labs, medical supplies, etc. I agree to pay my bill in full for services rendered by My Virtual Medical Visit.

Patient Initials_____

I **do / do not (circle one)** authorize the release of information specific to laboratory tests of HIV infection (Human Immunodeficiency Virus, the causative agent of AIDS) or the diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions.

Patient Initials_____

Signature of Patient or Legal Guardian:_____ Date:_____

Medical Records Request

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

First Name_____ Last Name _____

Date of Birth_____ Social Security #_____

I hereby authorize_____(list name of healthcare facility/provider) to disclose the following specific information from my health record.

Release/Disclose to:
My Virtual Medical Visit
1723 Hammond St., Suite #2
Hermon, ME, 04401

INFORMATION TO BE DISCLOSED (PLEASE INITIAL ALL THAT APPLY)

Entire Health Record _____ Lab Results _____ Radiology/Imaging Reports _____ Operative Report _____

Mammogram Report _____ Physician Consults _____ History/Physical _____ Other _____

This authorization below may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION:

I,_____(patient name or legal guardian), authorize the release of information, including, if applicable, specific laboratory tests of HIV infection (Human Immunodeficiency Virus, the causative agent of AIDS) or the diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions, all medical records or other information regarding my treatment, hospitalization including psychological or psychiatric impairment, drug abuse and/or alcoholism or sickle cell anemia.

Patient Initials_____

REASON FOR DISCLOSURE (PLEASE INITIAL ALL THAT APPLY)

Continued Care _____ Insurance Claim _____ Legal Purposes _____

Personal Use _____ Other _____

I understand if I do not authorize the release of my entire health record, only a limited health record is provided per patient request.

I understand I may revoke this authorization in writing at any time, except to the extent that action has already been taken; forms are available. My Virtual Medical Visit is hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.

I understand it *may take 7 to 10 business days* for this request to be processed. I further understand that I am entitled to a copy of the authorization.

Signature of Patient:_____ Date:_____

Signature of Representative:_____ Date:_____

Witness:_____ Date: _____

Communications Consent Form

Consent to Phone, Email or Text Usage for Appointment Reminders and Other Healthcare Communications: Patients in our practice may be contacted via phone, email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, to provide general health reminders and practice news/information.

TEXT MESSAGE

_____(Patient Initials) I consent to receive text message reminders from My Virtual Medical Visit Medical Specialists on my cell phone.

- Cell Phone Number: The cell phone number that I authorize to receive text message reminders for my appointment is **(_____)_____.**
- *The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).*

_____(Patient Initials) I decline to receive text messages from Woodlands Medical Specialists.

EMAIL MESSAGE

_____(Patient Initials) I consent to receive email reminders from My Virtual Medical Visit.

- The email that I authorize to receive email reminders for my appointment is_____.

_____(Patient Initials) I decline to receive email reminders from My Virtual Medical Visit.

PHONE MESSAGE

_____(Patient Initials) I consent to receive phone call reminders from My Virtual Medical Visit.

- Phone Number: The phone number that I authorize to receive phone call reminders for my appointment is **(_____)_____.**
- I do___, I do not_____, give permission to leave relevant medical information on my answering machine or voice mail.
- I do___, I do not_____, want relevant medical information shared with the person who may answer the telephone. The name(s) of the individuals(s) with whom you may leave pertinent information are:

Name_____ Contact Number **(_____)** _____

Name_____ Contact Number **(_____)** _____

_____(Patient Initials) I decline to receive phone call reminders from My Virtual Medical Visit.

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach & messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, missed appointment, overdue wellness visit, or any other reasonable healthcare related communication. I also authorize my healthcare provider to disclose to such third parties limited protected health information regarding healthcare events, unpaid balances, missed appointments, and to leave a reminder message on my voice mail or answering system if I am unavailable at the number provided by me.

Patient Printed Name_____ Date of Birth _____

Patient Signature _____ Today's Date_____

My Virtual Medical Visit_____ Today's Date_____