Bonne Terre Healthcare Clinic

11 S. Division St. Suite A • Bonne Terre, MO 63628
Tel (573)723-1100 • Fax (573)723-1130
www.bthealthcareclinic.com

New Patient Information Form

Name: _____

Name you prefer to be called: _____ Gender: Male Female

Date of birth: _____ SSN: _____

Current physical address (Must be where you live):

_____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____

May we leave a message at this number: Yes No

Alternate Phone: _____

May we leave a message at this number: Yes No

Consent to call: Yes No

Medication History Authority: Yes No

Demographics

Circle correct response:

Language: English Spanish Other: _____

Race: Caucasian African American Hispanic/Latino Asian Other: _____

Ethnicity: Not Hispanic or Latino Hispanic or Latino

Marital status: Single Married Widowed Divorced Separated Partner

Sexual orientation: Heterosexual Homosexual Bisexual Choose not to disclose

Gender identity: Male Female Transgender Non-Gender Choose not to disclose

Emergency Contact Information

Name: _____ Relationship: _____

Current address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____

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Insurance Information

Name of INSURED: _____
Last First Middle Initial

Address of Insured: _____

Insured Social Security Number (Required): _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____

Insured Date of Birth: _____

Patient Relationship to Insured: Self Spouse Child Other

Cell Phone: _____

Primary Insurance: _____ Policy #: _____

Group #: _____ Effective Date: _____

Secondary Insurance: _____ Effective Date: _____

Group #: _____ Effective Date: _____

General Information

Circle correct response:

How did you hear about this clinic?

Referral Insurance Company Website Family / Friend Current Patient

If referred from another doctor or organization, please complete below:

Referring entity: _____

Referring provider: _____

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If yes, please list and identify their specialty.

What brings you to the clinic? Describe briefly your current symptoms / problems.

Preferred Pharmacy

Pharmacy: _____

City: _____ State: _____ Zip Code: _____

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Release / Disclosures

I, _____ authorize medical treatment by Bonne Terre Healthcare Clinic, LLC.

I acknowledge full financial responsibility for services rendered by Bonne Terre Healthcare Clinic LLC. I understand that payment is due at the time of service unless a payment plan has been created and agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.

I further understand and agree that in case I do not show up or call at least 24 hours before an appointment to cancel or reschedule, I will be charged a fee according to Bonne Terre Healthcare Clinic LLC policies. I understand that this fee is not covered by my insurance and will be billed directly to me as it is my sole responsibility. This fee must be paid prior to being seen for subsequent services.

Disclosure: Additional office policies have been reviewed and agreed to in writing on this same date.

_____

Printed name of patient

_____ _____

Signature of patient Date

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Patient History Form

Date: _____

Name: _____
Last First Middle Initial

DOB: _____ Gender: Male Female

Circle appropriate response.

How did you hear about this clinic?

Referral Insurance Company Website Family / Friend Current Patient

If referred from another doctor or organization, please complete below:

Referring entity: _____

Referring provider: _____

What brings you to the clinic? Describe briefly your present symptoms / problems.

Drug Allergies:

No Yes If yes, List allergies:

Current Medications

Name of drug	Dose (include strength & # of pills per day)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

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Family History

	IF LIVING		IF DECEASED	
	Age(s)	Health & Psych	Age(s)	Cause
Father				
Mother				
Siblings				
Children				

EXTENDED FAMILY PSYCHIATRIC PROBLEMS
Maternal relatives:

Paternal relatives:

Social History

Education and Occupation

Highest level of education:
☐ 9th ☐ 10th ☐ 11th
☐ GED ☐ High School
☐ Some College ☐ College Graduate ☐ Advanced Degree

Are you currently working? ☐ Yes ☐ No

If yes, what is your occupation? _____

Do you receive disability or SSI? ☐ Yes ☐ No

If yes, what disability & how long? _____

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Activities of Daily Living

Circle appropriate response:

Are you able to care for yourself? Yes No

Are you blind or have difficulty seeing? Yes No

Are you deaf or do you have serious difficulty hearing? Yes No

Do you have difficulty concentrating, remembering or making decisions? Yes No

Do you have difficulty walking or climbing stairs? Yes No

Do you have difficulty dressing or bathing? Yes No

Do you have difficulty doing errands alone? Yes No

Are you able to walk? Without restrictions With assistive device

Do you have transportation difficulties? Yes No

Substance Use

Circle appropriate response:

Do you or have you ever smoked?

Never smoker Former smoker Current every day smoker

Have you ever used any other forms of tobacco or nicotine? Yes No

If yes, do you vape? Yes No If yes, do you use smokeless tobacco? Yes No

What is your level of alcohol consumption?

None Occasional Moderate Heavy

What is your level of caffeine consumption?

None Occasional Moderate Heavy

Do you use any illicit or recreational drugs? Yes No

List drugs: _____

_____

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Advanced Directive
Circle appropriate response:
Do you have an advanced directive? Yes No
Is blood transfusion acceptable in an emergency? Yes No

Home and Environment
Circle appropriate response:
Have there been any changes to your family or social situation? Yes No
What type of childcare do you use? N/A Parents Day Care
Do you have any pets? Yes No
Do you have smoke and carbon monoxide detectors in your home? Yes No
Are you passively exposed to smoke? Yes No
Are there guns present in your home? Yes No Decline to Answer
What is the fluoride status of home? Fluoridated Non-Fluoridated Unknown
Do you use insect repellent? Yes No
Do you use sunscreen routinely? Yes No

Lifestyle
Circle appropriate response:
Do you feel stressed (tense, restlessness, nervous, or anxious or unable to sleep at night? Not at all Only a little To some extent Rather much Very much
Do you participate in social media? Yes No
Do you wear a helmet when biking? Yes No
Do you use your seat belt or car seat routinely? Yes No

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Marriage and Sexuality

Circle appropriate response:

Marital status: Single Married Widowed Divorced Separated Partner

Are you sexually active? Yes No

How many biological or adopted children do you have? 1 2 3 4 5 6 7

How many stepchildren do you have? 1 2 3 4 5 6 7

Diet and Exercise

Circle appropriate response:

What type of diet are you following? Regular Vegetarian Vegan Gluten Free Carbohydrate Cardiac Diabetic

What is your current exercise level? None Occasional Moderate Heavy

How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days? 1 2 3 4 5 6 7

What types of sporting activities do you participate in? _____

Gender Identity and LGBTQ Identity

Circle appropriate response:

Gender identity: Male Female Transgender Non-Gender Choose not to disclose

Assigned sex at birth? Male Female

Surgical History

1. _____
2. _____
3. _____
4. _____

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Past Medical History					
	ADD/ADHD		Constipation		Mental Illness
	AIDS/HIV		Coronary Artery Disease		Muscle, Joint or Bone Pain
	Abuse/ Domestic		Chronic Ear Infections		Obesity
	Allergies/ Hay fever		Congestive Heart Failure		OCD
	Alzheimer's Disease		Constipation		Opioid Dependence
	Amnesia		Depression		Osteoporosis
	Anemia		Developmental Disorder		Parkinson's Disease
	Anesthesia Complications		Difficulty swallowing		Post-Partum Depression
	Anxiety Disorder		Diverticulitis		PTSD
	Arthritis		Ear or Hearing Problems		Pre-Eclampsia
	Asperger's Disorder		Eating Disorder		Psychiatric Hospitalizations
	Asthma		Eczema / Psoriasis		Psychiatric Conditions
	Autism Spectrum Disorder		Endometriosis		Psychosis
	Bedwetting		Fibromyalgia		Pulmonary Emboli
	Bipolar Disorder/ Mood Swings		GERD/ Acid Reflux		Schizophrenia
	Birth Defect		GI Problems / Stomach Ulcer		Seizures / Epilepsy
	Bladder or Kidney Problems		Gout		Skin Problems
	Blood Diseases		Headaches		Stroke/ CVA
	Blood Transfusion		Heart Attack		Thrombophilia
	Brain Injury		Heart Problems		Thyroid
	Breast Cancer		High Cholesterol		Tourette's Syndrome
	Breast Problem		Hypertension		Trichotillomania
	COPD / Emphysema		Hyperthyroidism		Tuberculosis
	Cancer		Hypothyroidism		Type I Diabetes
	Cardiovascular Disease		Illicit Drug Use		Type II Diabetes
	Cerebral Palsy		Infertility/ PCOS		Varicosities
	Chicken Pox		Insomnia		Vision/ Eye Problems
	Chronic Bronchitis		Irritable Bowel Syndrome		
	Chronic Ear Infections		Kidney Disease		
	Congestive Heart Failure		Kidney Stones		
	Crohn's Disease		MRSA Exposure		

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Past Medical History

Do you now or have you ever had:

- ☐ Heart murmur
- ☐ Pneumonia
- ☐ Hepatitis A B C
- ☐ Goiter
- ☐ Cancer (type) _____
- ☐ Leukemia
- ☐ Rheumatic fever
- ☐ Cataracts
- ☐ HIV/AIDS

Other medical conditions (please list):

_____

In the past month, have you had any of the following problems?

☐ Weight gain _____#'s	☐ Difficulty in swallowing	☐ Constipation
☐ Weight loss _____#'s	☐ Pain in jaw	☐ Diarrhea
☐ Fatigue	☐ Chest pain	☐ Blood in stool
☐ Weakness	☐ Heart palpitations	☐ Rash
☐ Fever	☐ Shortness of breath	☐ Nodules/ skin bumps
☐ Night sweats	☐ Fainting	☐ Hair loss
☐ Joint Pain	☐ Swollen legs or feet	☐ Jaundice
☐ Muscle weakness	☐ Cough	☐ Color changes hands/ feet
☐ Joint swelling	☐ Headache	☐ Anemia
Where? _____	☐ Dizziness	☐ Clots
☐ Ringing in ears	☐ Memory loss	☐ Bleeding between periods
☐ Loss of hearing	☐ Numbness or tingling	☐ Frequent or painful urination
☐ Eye pain	☐ Heartburn	☐ Abnormal pap smear
☐ Loss of vision	☐ Nausea	☐ Irregular periods
☐ Double or blurred vision	☐ Stomach pain	☐ Bleeding between periods
☐ Frequent sore throats	☐ Vomiting	☐ PMS

Other medical conditions (please list):

_____

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Personal History
Were there problems with your birth? (specify)
Where were you born and raised?

Psychiatric History

What have you been diagnosed with in the past?

☐ Anxiety ☐ Depression ☐ PTSD
☐ Schizophrenia ☐ Bipolar Disorder ☐ Schizoaffective Disorder
☐ Personality Disorder ☐ Panic Disorder ☐ ADD / ADHD
☐ Other: _____
_____

Psychiatric hospitalizations (include where, when & for what reason).

1. _____
_____
2. _____
_____
3. _____
_____
4. _____
_____

Greater than 5

TOO MANY TO COUNT

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Previous drug / alcohol treatment programs:
1. _____ _____ 2. _____ _____ 3. _____ _____ 4. _____ _____ Greater than 5 TOO MANY TO COUNT

Substance Abuse					
Drug Category (circle each substance used)	Age when you first used this drug:	How much & how often did you use this drug?	How many years did you use this drug?	When did you last use this drug?	Do you currently use this drug?
Alcohol					☐ Yes ☐ No
Cannabis MJ, hashish, hash oil					☐ Yes ☐ No
Stimulants Cocaine, crack					☐ Yes ☐ No
Stimulants Methamphetamine, speed, ice, crank					☐ Yes ☐ No
Amphetamines/Other Stimulants Ritalin, Benzedrine, Dexedrine					☐ Yes ☐ No
Benzodiazepines/Tranquilizers Valium, Librium, Halcion, Xanax, roofies					☐ Yes ☐ No

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Drug Category (circle each substance used)	Age when you first used this drug:	How much & how often did you use this drug?	How many years did you use this drug?	When did you last use this drug?	Do you currently use this drug?
Sedatives/Hypnotics/Barbiturates Amytal, Seconal, Dalmane, Quaalude, Phenobarbital					☐ Yes ☐ No
Heroin					☐ Yes ☐ No
Street or Illicit Methadone					☐ Yes ☐ No
Other Opioids Tylenol #2 & #3, 282's, 292's, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid					☐ Yes ☐ No
Hallucinogens					☐ Yes ☐ No
Inhalants Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room					☐ Yes ☐ No
Other Specify: _____ _____ _____					☐ Yes ☐ No

Legal History

Have you ever had any legal problems? (specify)

☐ Jail
☐ Probation
☐ Prison
☐ Parole
☐ Charges pending

Religion?

☐ Yes ☐ No

If yes, what denomination?

Violence History

☐ Emotional
☐ Physical
☐ Sexual
☐ Domestic

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WOMENS REPRODUCTIVE HISTORY
Age of first period: _____ # of pregnancies: _____ # of miscarriages: _____ # of abortions: _____ Have you reached menopause: ☐ Yes ☐ No At what age? _____ Do you have regular periods? ☐ Yes ☐ No

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AUTHORIZATION TO **RELEASE** INFORMATION

_____
Persons(s) and/or Organization

_____
Address Phone Number

_____
City, State, Zip Fax Number

Patient Name: _____

Date of Birth: _____

Social Security #: _____

I hereby authorize Bonne Terre Healthcare Clinic LLC to receive behavioral health medical records, medical records, reports, labs or x-rays pertaining to me and to release and/or receive full information regarding my condition including etiology, diagnosis or prognosis.

I also authorize Bonne Terre Healthcare Clinic LLC to receive any medical records, reports or any information pertaining to previous treatments of alcohol abuse and/or treatment of substance abuse, any psychiatric records or reports, and any information regarding treatment for HIV/AIDS or STD's. This authorization will remain valid for the course of treatment unless otherwise stated. A photographic copy of this authorization shall be valid as the original. It is understood that the person authorizing the release and/or to receive this specific information has the right to inspect and copy the information to be disclosed and that this information will not be re-disclosed without proper authorization.

_____
Printed name of patient

_____ _____
Signature of patient Date

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Consent for **Mental Health** Evaluation and/or Treatment
Adult Version

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1. **Consent to Evaluate/Treat:** I voluntarily consent that I will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or course of treatment and chronic care management, as may be applicable, by staff from Bonne Terre Healthcare Clinic LLC (hereinafter "Provider"). I have received complete and accurate information concerning each of the following areas:
    a. The benefits of the proposed evaluation, treatment, and/or chronic care management (as applicable);
    b. Alternative treatment modes and services;
    c. The manner in which treatment/chronic care management will be administered;
    d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable); and
    e. Probable consequences of not receiving treatment/chronic care management.

    The evaluation or treatment will be conducted by, a psychiatric nurse practitioner, a psychiatrist, a licensed therapist or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of Missouri Law for Psychological, Psychiatric, Nursing, Social Work, Professional Counseling, or Marriage and Family Counseling. A chronic care management will be conducted by a psychiatric nurse practitioner in collaboration with a psychiatrist.

2. **Potential Benefits of Evaluation/Treatment/Chronic Care Management:** Evaluation and treatment may be administered by way of psychological interviews, psychological assessment or testing, psychotherapy, and/or medication management. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning so that appropriate recommendations and treatments may be offered. Uses of this evaluation or course of treatment may include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Chronic care management will be beneficial to me if I have two or more chronic conditions expected to last at least 12 months and this type of intervention may prevent exacerbation/decompensation of these conditions, or my overall functional decline. Possible benefits to treatment/chronic care management include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.

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3. **Medical Insurance and Financial Responsibility:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments, deductibles and any fees associated with missed appointments. I hereby authorize Provider or their designee to file a claim with my insurance company for the services rendered during the term of treatment and use the term "signature on file" as my signature. I authorize the medical insurance company to pay directly to Provider for the services rendered. I request payment of authorized Medicare benefits or Medigap benefits to be made on my behalf directly to the Provider, for any services that were furnished to me by the Provider or their designee. I authorize the holder of medical information about treatments and other services provided to me to release any information needed to determine these benefits to the health care financing administration, Medigap insurer, or their agents.

4. **Confidentiality, Harm, and Inquiry:** Information from my evaluation and/or treatment is contained in a confidential medical record at Provider's offices, and I consent to the disclosure of same for use by Provider staff for the purpose of continuity of my care. Information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

5. **Right to Withdraw Consent:** This authorization will be perpetual unless I give written instructions to revoke it, which I may do at any time.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions of my service provider about the above information at any time.

_____ _____

Signature of client **Date**

_____ _____

Signature of witness **Date**

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Consent for **Medical** Evaluation and/or Treatment

I, _____, voluntarily request to receive medical treatment
(Printed patient name)

from Bonne Terre Healthcare Clinic LLC. I understand that this consent is for any of the services or programs which are provided by Bonne Terre Healthcare Clinic LLC. I consent to the administration of treatment deemed necessary by my provider(s) who attend to me, their associates, employees of BTHC and other healthcare professionals responsible for my care. I understand that care may consist of a physical exam, medical assessment, nursing and counseling/social work assessments, laboratory tests, treatment planning, individual and group treatments, discharge planning, care coordination, as well as prescribing and administration of medications.

The purpose of my participation in treatment has been described to me. I understand that the specific care proposed for me, including the benefits and risks, may be further discussed with me by my provider or counseling staff. I agree to attend and participate in all scheduled treatment activities as described in my treatment/services plan. I understand that I have the right to ask for clarification of services and interventions and to decline the services and interventions at any time. I acknowledge that no guarantees have been made to me as to the effect of treatment or prognosis of my condition.

I understand that in the event of an emergency, I may be transferred to a hospital or emergency medical facility better equipped than BTHC to provide emergency and/or comprehensive medical care.

_____ _____

Signature of client or guardian **Date**

_____ _____

Signature of witness **Date**