APPOINTMENT AND WALK-IN POLICY

We welcome both **APPOINTMENTS** and **WALK-INS**, however, **APPOINTMENTS** will be taken back and seen at their appointment time, which may cause a **LONGER WAIT TIME** for patients who choose to walk in rather than making an appointment.

THANK YOU FOR ALLOWING US TO PARTICIPATE IN YOUR HEALTH CARE, AND YOUR PATIENCE, AND KINDNESS TOWARDS OUR STAFF!!

Eva Family Health Clinic

4208 Eva Road
Eva, AL 35621
Suite B

Phone: 256-735-4154
Fax: 256-735-4054

PATIENT'S PERSONAL INFORMATION

General

Last Name:______________________ First:__________________ M.I.:_____

Home Address: ______________________ Apt.: _____ City: ____________________
Number *Street*

State: ________ Zip: ___________ Home Telephone: (____)___________ Cell Phone: (____)__________

Date of Birth: ______/______/______ Age: _______ Sex: ________ Birthplace:______________
MM *DD* *YYYY* *M/F* *State (Country, if not US)*

Social Security Number: _____-_____-________ Driver's License Number: ________________

Email Address: __________________________@______________.com

Marital Status (Circle): Single Married Domestic Partner Divorced/Widowed Spouse's Name: ________________

Previous Physician *(if applicable)*: __________________________ Phone: (_____)______________

Employment

Employer: ________________________________ Occupation:____________________
Specific Job Title

Employer Address: __________________________ City: ______________________
Number *Street*

State: ________ Zip: ___________ Telephone: (______)______________

Primary Insurance

Insurance Company Name: ______________ Group Number: ______________ Policy Number______________

Address: __________________________ City: ____________ State: __________ Zip: __________
Number *Street*

Insured's Date of Birth: ______/______/______ Insured's Name: ____________________
MM *DD* *YYYY*

Insured's Social Security Number: _____-_____-________ Relationship to Insured: __________________

Secondary Insurance

Insurance Company Name: ______________ Group Number: ______________ Policy Number______________

Address: __________________________ City: ____________ State: __________ Zip: __________
Number *Street*

Insured's Date of Birth: ______/______/______ Insured's Name: ____________________
MM *DD* *YYYY*

Insured's Social Security Number: _____-_____-________ Relationship to Insured: __________________

Emergency Contact

Name: ______________________ Relationship:______________ Phone: (_______)______________

Authorization

I understand that this office will submit claims to the listed insurance company, but that I am ultimately responsible for this account. I also authorize the release of any medical information necessary to process my claim.

____

Signature *Date*

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INFORMATION FOR YOUR DOCTOR

General

Last Name:____________________ First:____________________ M.I.:_____

Date of Birth: ______/______/______ Age: _______ Sex: _______

What is the main reason for visiting us today? ____________________

How did you hear about us? *Doctor* *Friend* *Family Member* *Internet* *Other*__________

By whom were you referred? *(if applicable)* ____________________

Medical History

List **all medical problems:**____________________

____

____

List **all medications** you are taking: ____________________

____

____

List **all herbal, naturopathic, and homeopathic medications/supplements** you are taking: __________

____

List **all drug allergies** (include name of medication and reaction): ____________________

____

When was your last physical examination? ____________________

Have you ever been admitted to the hospital? _______ If so, please list the reason(s) and the date(s):__________

____

For women: When was your last mammogram? ______________ Pap smear? __________

Social History

What is your marital status? (Circle): Single Married Domestic Partner Divorced/Widowed Spouse's Name:__________

Do you have any children? __________ (*Y/N*) If so, how many? _____ (#) Boys _____ (#) Girls

If your parents are not living, what was the cause of death(s)? ____________________

Do you drink alcohol? Never Rarely Socially Daily

How often do you exercise? Never A few times a month Once a week More than once a week

Do you use tobacco products? Yes No If yes, which products? __________ How many times per day?____

Is there any other information that you feel necessary to tell us? ____________________

____

Authorization

I hereby authorize whatever services are deemed necessary during my appointment. I agree to assume financial responsibility for ALL services provided.

____

Signature *Date*

MEDICAL HISTORY

Patient Name ______________________ Nickname ______________ Age______

Name of Physician/and their specialty ______________________

Most recent physical examination ______________ Purpose ______________

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:

	YES	NO
1. hospitalization for illness or injury	☐	☐
2. an allergic reaction to ☐ aspirin, ibuprofen, acetaminophen, codeine ☐ penicillin ☐ erythromycin ☐ tetracycline ☐ sulfa ☐ local anesthetic ☐ fluoride ☐ metals (nickel, gold, silver, ________) ☐ latex ☐ other ________		
3. heart problems, or cardiac stent within the last six months	☐	☐
4. history of infective endocarditis	☐	☐
5. artificial heart valve, repaired heart defect (PFO)	☐	☐
6. pacemaker or implantable defibrillator	☐	☐
7. artificial prosthesis (heart valve or joints)	☐	☐
8. rheumatic or scarlet fever	☐	☐
9. high or low blood pressure	☐	☐
10. a stroke (taking blood thinners)	☐	☐
11. anemia or other blood disorder	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5)	☐	☐
13. emphysema, shortness of breath, sarcoidosis	☐	☐
14. tuberculosis, measles, chicken pox	☐	☐
15. asthma	☐	☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17. kidney disease	☐	☐
18. liver disease	☐	☐
19. jaundice	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency	☐	☐
21. hormone deficiency	☐	☐
22. high cholesterol or taking statin drugs	☐	☐
23. diabetes (HbA1c = ______)	☐	☐
24. stomach or duodenal ulcer	☐	☐
25. digestive disorders (i.e. celiac disease, gastric reflux)	☐	☐
26. osteoporosis/osteopenia (i.e. taking bisphosphonates)	☐	☐
27. arthritis, rheumatoid arthritis, lupus	☐	☐
28. glaucoma	☐	☐
29. contact lenses	☐	☐
30. head or neck injuries	☐	☐
31. epilepsy, convulsions (seizures)	☐	☐
32. neurologic disorders (ADD/ADHD, prion disease)	☐	☐
33. viral infections and cold sores	☐	☐
34. any lumps or swelling in the mouth	☐	☐
35. hives, skin rash, hay fever	☐	☐
36. STI / STD	☐	☐
37. hepatitis (type ___)	☐	☐
38. HIV / AIDS	☐	☐
39. tumor, abnormal growth	☐	☐
40. radiation therapy	☐	☐
41. chemotherapy, immunosuppressive	☐	☐
42. emotional problems	☐	☐
43. psychiatric treatment	☐	☐
44. antidepressant medication	☐	☐
45. alcohol / street drug use	☐	☐

ARE YOU:

	YES	NO
46. presently being treated for any other illness	☐	☐
47. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea)	☐	☐
48. taking medication for weight management (i.e. fen-phen)	☐	☐
49. taking dietary supplements	☐	☐
50. often exhausted or fatigued	☐	☐
51. experiencing frequent headaches	☐	☐
52. a smoker, smoked previously or use smokeless tobacco	☐	☐
53. considered a touchy person	☐	☐
54. often unhappy or depressed	☐	☐
55. FEMALE - taking birth control pills	☐	☐
56. FEMALE - pregnant	☐	☐
57. MALE - prostate disorders	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ______________________ Date ______________

Doctor's Signature ______________________ Date ______________

Medical Release Form

Patient Name____ Date of Birth________/__________/__________

SSN_______________________________ Address_________________________________ City___________________

State __________ Zip Code _________________ Email ____

INFORMATION REQUESTED FROM

Name____

Address_______________________________________ City____________________ State______________ Zip_______

Phone (   )______________________ Fax (   )______________________Email_____________________________

SEND INFORMATION TO

Name: Eva Family Health Clinic   Send By ______Mail   ________Fax   ________Secure Email

Address: 4208 Eva Road, Suite B   City: Eva   State: AL   Zip Code: 35621

Phone: 256-735-4154   Fax: 256-735-4054   Email: evafamilyhealthclinic@outlook.com

I, ____(name), herby grant permission for you to release confidential health information about me, by releasing a copy of my medical record or a summary or narrative of my protected health information to the physician / person / facility / entity.

____   ______________________________

Printed Name   Date

____   ______________________________

Signature   Date

Eva Family Health Clinic

4208 Eva Road
Eva, AL 35621
Suite B
Phone: 256-735-4154
Fax: 256-735-4054

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOUR CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

I. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your PHI may be used and disclosed by your CRNP, our office staff, and others outside of our office that are involved in your health care and treatment, for the purpose of providing health services to you, to pay your health care bills, to support the operation of the medical practice, and any other use required by law.

Treatment:

We will use and disclose your PHI to provide, coordinate, or manage your physical or mental health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a third-party provider to whom you have been referred to ensure that the provider has the necessary information to diagnose or treat you.

Payment:

Your PHI will be used, as needed, to obtain payment for your medical health care services.

For example, obtaining approval for services that may require that your relevant PHI be disclosed to the health plan to obtain approval for treatment.

Healthcare Operations:

We may use or disclose, as needed, your PHI to support the business activities of your medical practice. These activities may include, but are not limited to, quality assurance activities, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization. These situations include as Required by Law, Public Health issues (as required by law), Abuse or Neglect, Legal Proceedings, Law Enforcement, Danger to Self or Others, Under the Law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other permitted and required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your medical team has taken an action in reliance on this use or disclose indicated in the authorization.

I have received a copy of the Privacy Policy for Eva Family Health Clinic.

Sign: ____

Print: ____

Date: __________________