PROHEALTH PARTNERS
HISTORY AND PHYSICAL

NAME _____ AGE _____ BIRTHDATE _____ TODAY'S DATE _____

DRUG ALLERGIES: _____

CURRENT MEDICATIONS: _____

FAMILY	LIVING		DECEASED		Have any blood relatives had	
	AGE	HEALTH	AGE	CAUSE	(Please Circle)	WHO
MOTHER					ASTHMA	
FATHER					CANCER	
BROTHERS					TB	
					DIABETES	
					HEART TROUBLE	
					HYPERTENSION	
SISTERS					STROKE	
					EPILEPSY	
					MENTAL ILLNESS:	

SOCIAL HISTORY:

Alcohol Intake ____Daily ____Weekly ____Occ. ____Never

Cigarettes ☐ Yes ☐ No ____Pack/Day ____Years Smoked

PAST MEDICAL HISTORY

	YES	NO	ONSET
HIGH BLOOD PRESSURE			
HEART DISEASE			
STROKE			
DIABETES			
EMPHYSEMA			
ASTHMA			
CANCER			
ARTHRITIS			
THYROID DISEASE			
ULCERS			
ALLERGIES OR HAYFEVER			
HEPATITIS			
EPILEPSY			
TUBERCULOSIS			

PAST SURGICAL HISTORY

	YES	NO	DATE
TONSILLECTOMY			
APPENDECTOMY			
HYSTERECTOMY			
GALL BLADDER REMOVAL			
HERNIA SURGERY			
BREAST SURGERY			
COLON SURGERY			
HEART SURGERY			
KIDNEY SURGERY			
BLADDER SURGERY			
SPINE SURGERY			
C-SECTION			
OTHER SURGERY			

SYSTEMS REVIEW

	YES	NO	ONSET
GENERAL			
WEIGHT LOSS			
WEIGHT GAIN			
POOR APPETITE			
FATIGUE			
EYES			
DOUBLE VISION			
CHANGE IN VISION			
EYE PAIN			
EARS			
HEARING DIFFICULTY			
RINGING			
EAR PAIN			
THROAT			
PAIN			
DIFF. SWALLOWING			
HOARSENESS			

	YES	NO	ONSET
CARDIO-RESPIRATORY			
CHEST PAINS			
SHORTNESS OF BREATH			
PALPITATIONS			
ANKLE SWELLING			
COUGH			
MUCOUS PRODUCTION			
COUGHING UP BLOOD			
GASTROINTESTINAL			
NAUSEA/VOMITING			
DIARRHEA/CONSTIPATION			
BLACK STOOLS			
BLOODY STOOLS			
VOMITING BLOOD			
GENITOURINARY			
BURNING ON URINATION			
URINARY FREQUENCY, DAY			

	YES	NO	ONSET
URINARY, FREQ. NIGHT			
BLOOD URINE			
NEUROLOGIC			
SEIZURES			
FAINTING			
NUMBNESS			
WEAKESS			
DIZZINESS			
GYNECOLOGICAL			
DATE OF LAST PERIOD			
ABNORM. VAGINAL BLEED.			
VAGINAL DISCHARGE			
BIRTH CONTROL			
NUMBER OF PREG.			
NUMBER OF ABORTIONS			

ProHeal Partners Patient Informat. a Sheet

PATIENT INFORMATION (*please print*)

First Name _____ Middle Initial _____ Last Name _____

Home Address _____ City _____ State _____ Zip Code _____

Billing Address (if different) _____

Home Phone _____ Work Phone _____ Cell Phone _____

Preferred Contact # _____ Email Address _____

Drivers License # _____ Date of Birth _____ Social Security # _____

Sex: __M __F Marital Status: □ S □ M □ D □ W □ Other _____ How did you hear about us? _____

Primary Care Physician _____ Primary Language _____

Race _____ Ethnicity (*circle one*) Hispanic or Latino Not Hispanic or Latino

Employer _____ Employer Phone _____ Occupation _____

Work Address _____

Emergency Contact _____ Relationship _____ Phone _____

GUARANTOR/PARENT/INSURED INFO [SEND BILL TO]:

Guardian Last Name (if applicable) _____ First _____ Initial _____

Date of Birth _____ Social Security # _____ Relationship _____

Employer _____ Address _____ Phone _____

INSURANCE INFORMATION

Primary Insurance _____

Policy Holder Name _____ DOB _____ Social Security # _____

Billing Address _____ City, State, Zip _____

Group or Policy # _____ Cert. or Member # _____ Local Union # _____

Co-pay Amount _____ Policy Effective Dates: From: _____ To: _____

Patient Relation to Policy Holder: □ Self □ Spouse □ Child □ Other: _____

Secondary Insurance _____

Policy Holder Name _____ DOB _____ Social Security # _____

Billing Address _____ City, State, Zip _____

Group or Policy # _____ Cert. or Member # _____ Local Union # _____

Co-pay Amount _____ Policy Effective Dates: From: _____ To: _____

Patient Relation to Policy Holder: □ Self □ Spouse □ Child □ Other: _____

PHARMACY INFORMATION

Pharmacy Name _____ Address _____ Phone _____

Second Pharmacy _____ Address _____ Phone _____

Signature (Patient or Parent of Minor): X _____ Date: X _____

FINANCIAL POLICY

AGREEMENT TO PAYMENT POLICY I acknowledge that I received a copy of PROHEALTH PARTNERS, INC., financial policy and agree to the terms of payment due.

AUTHORIZATION TO RELEASE INFORMATION I authorize release of my medical record information, pursuant to applicable federal and state laws, rules and regulations, to third party payers and other providers participating in my care, that agree to treat my information in a confidential manner in accordance with all applicable federal, state, and local laws. I further authorize any other individual or entity that has provided health care to me to release to PROHEALTH PARTNERS, INC., any and all of my medical records information, whether in printed or electronic form, needed to provide me with informed care. I may revoke my consent for the release of this information at any time, except to the extent that action has been taken in reliance on the consent.

ASSIGNMENT OF BENEFITS I hereby request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to PROHEALTH PARTNERS, INC., for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services.

GUARANTEE OF PAYMENT I agree to pay all applicable charges, which are not paid in full by my insurance. If amounts due to PROHEALTH PARTNERS, INC., are not paid according to this financial policy, the account shall be deemed delinquent. In the event that I default on payment of my account, I understand I am responsible for any and all cost incurred on the collection of my account, including court cost and reasonable attorney's fee. If the debt is assigned to a third party collection agency, I agree to be responsible for collection fees and interest due to amounts in default.

Patient's Signature Date

X _____ X _____

Responsible Party Relationship to Patient

_____

ELIGIBILITY GUARANTEE FORM

Member Name: _____

Health Plan. _____

Effective Date: _____

Medical Group/MD Name: _____

I hereby certify that I am eligible for coverage as of the date indicated above with the physician and/or medical group indicated.

I understand that my eligibility with my health plan as stated above cannot be verified at this time. I understand that if the above is not true or if I am not eligible under the terms of my employers/health plan agreement, I am liable for all charges for services rendered. Also, if the above is not true, I agree to pay in full for all services received within 30 days of receiving a bill from my physician or his/her authorized agent. I understand that failure to pay any amounts owed by me may result in my account being placed in collections.

X _____

Signature of Member/Guardian

_____

Office Personnel/Date

Attachment C

PF 5000

AUTHORIZATION TO COMMUNICATE PATIENT'S MEDICAL INFORMATION

COMMUNICATION WITH FAMILY & OTHERS INVOLVED IN YOUR CARE

(Signed original to be placed in the central medical record and copy to patient)

PATIENT IDENTIFICATION

Name: _____

Date of birth: _____

S.S. #: _____

Medical Record/Account#: _____

Office Name: _____

Address: _____

City/State/Zip: _____

Phone number: _____

Fax number: _____

Physician name: _____

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, indicate what kinds of information may be shared with each individual.

NAME:	RELATIONSHIP TO PATIENT	TYPE OF INFORMATION			
		ALL	Scheduling/ Appointment	Medical	Billing Insurance

Specific instructions or limitations: _____

_____

Validation code: _____ (Please give this to any individual who may be involved in coordinating your care or payment for care. They will be asked to give this code to our staff before we release information over the phone.)

We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. Please promptly notify your physician's office if you wish to alter the designations above.

Signature of Patient/Legal Representative: X _____ Date: X _____

Relationship to patient: _____