

PATIENT INFORMATION

Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____ Social Security # _____

City, State & Zip _____

Home Phone # _____ Work# _____ Cell # _____

Employer: _____ Address: _____

(PLEASE CIRCLE AS APPLIES) SEX: FEMALE MALE SINGLE MARRIED DIVORCED WIDOWED OTHER

Name of Primary Care Physician: _____ Phone # _____

Pharmacy Name: _____ Phone# _____

Reason for being seen today: _____

HOW DID YOU HEAR OF US: ___ Billboard ___ US1 ___ Hazen Website ___ Internet Search ___ Other ___

Who referred you: _____

****MEDICAL HISTORY****

LIST ALL MEDICATION'S: (include over the counter) _____

DO YOU HAVE A LATEX ALLERGY? ___ YES ___ NO/ PENICILLIN ALLERGY? ___ YES ___ NO

PLEASE LIST ANY OTHER ALLERGIES: _____

LIST ALL PREVIOUS SURGERIES AND DATES: _____

DO YOU SMOKE? ___ YES ___ NO HOW MUCH? _____ HOW LONG? _____

PLEASE CIRCLE ALL THAT APPLY: HEADACHES DIZZINESS HYPOGLYCEMIA THYROID EMPHYSEMA
ASTHMA HEART ATTACK STROKE DIABETES HIV HEPATITIS HIGH/LOW BLOOD PRESSURE
OTHER _____

If patient is a minor (under 18) do we have permission to treat the child? Please circle YES NO

Authorized Signature: _____ Today's Date _____

Relationship to child: _____

*****CONSENT FOR PHOTOGRAPHY*****

It is a routine part of Dr. Jill Hazen's practice to take pre-operative, intra-operative and post-operative photographs.

Signature of Patient and /or Legal Guardian _____ Date: _____

Patient Authorization for Disclosure of Protected Health Information

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 controls how the Protected Health Information of our patients can be discussed and with whom. This form authorizes me and my staff to discuss your information with those you have listed below and in what specific manner.

Individuals to whom your health information may be disclosed (check all that apply)

- Spouse, Name _____
- Parent, Name _____
- Parent, Name _____
- Child, Name _____
- Other, Name _____

Can a message be left on an answering machine?

- Home Work Cell

What kinds of information can be disclosed?

- All at the doctor's discretion
- Medical History
- Diagnosis
- Surgical Information
- Treatment
- Billing/Insurance Information
- Only return a call message
- Other _____

The Patient has the right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization. This authorization will remain in effect unless otherwise revoked by the patient. Release of the Patient Health Information covered by this authorization will be disclosed solely for the purpose of keeping designation family members informed of your healthcare condition.

Patient Name: _____

Date of Birth: _____

Patient Signature/Date _____