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**
- ☐ **Diagnosis**
- ☐ **Treatment**
- ☐ **Only return a call message**
- ☐ **Medical History**
- ☐ **Surgical Information**
- ☐ **Billing/Insurance Information**
- ☐ **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_____