HILLSBORO health PRIMARY CARE

New Patient Questionnaire

DEMOGRAPHICS

FIRST NAME_____MIDDLE NAME: _____LAST NAME: _____

DATE OF BIRTH: _____BIRTH SEX: _____PREFERRED SEX: _____

NAME YOU PREFER TO BE CALLED: _____SSN: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

EMPLOYER: _____ WORK PHONE: _____

OCCUPATION: _____ MARITAL STATUS: _____

EMPLOYMENT STATUS: (PLEASE CIRCLE) F/T ☐ P/T ☐ PRN ☐ UNEMPLOYED ☐

EMAIL ADDRESS: _____

RACE/ ETHNICITY: _____ PRACTICED RELGION: _____

PREFERRED PHARMACY: _____

NAME OF SPOUSE/PARENT/GUARDIAN: _____ PHONE #: _____

HOW DID YOU HEAR ABOUT US? _____

INSURANCE INFORMATION

NAME OF INSURED: _____ RELATIONSHIP TO PATIENT: _____

BIRTHDATE: _____ SSN: _____

NAME OF EMPLOYER: _____ TELEPHONE: _____

ADDRESS OF EMPLOYER: _____

INSURANCE CARRIER: _____

ADDRESS OF INSURANCE CARRIER: _____

GROUP NUMBER: _____ PLAN OR ID NUMBER: _____

Continued on next page →

Alcohol

How often do you have a drink containing alcohol?
☐ Never ☐ Monthly or less ☐ 2-4 times per month ☐ 2-3 times per week ☐ 4 or more times per week

How many standard drinks containing alcohol do you have on a typical day?
☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more

How often do you have 6 or more drinks on one occasion?
☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Caffeine

Do you consume any caffeine? ☐ No ☐ Yes: How often? How much?

Exercise

Do you exercise? ☐ No ☐ Yes: How often? How long?

Smoking

Do you smoke(electronic cigarettes included)? ☐ No ☐ Yes: How many cigarettes per day? _____
Start Date: _____ How many years total: _____
If you are a former smoker, please list quit date: _____

Drug Use

Do you use recreational drugs? This includes marijuana, cocaine, meth, etc. ☐ No ☐ Yes
How often are you using? _____
If you have a history, please list quit date: _____

Medical History

Medical Problem	Age of Onset	Medical Problem	Age of Onset

Family History

Relationship to you	Medical Problem	Age of Onset	Age Deceased

Continued on next page →

Immunization History

Type of Vaccination	Last Given	Type of Vaccination	Last Given
Influenza			
Pneumonia			
Shingles			

Medications

Name of Medication	Dose	Name of Medication	Dose
Place an X on the line if none: _____			

Allergies

Name	Type of Reaction	Name	Type of Reaction
Place an X on the line if no known allergies: _____			

Surgical History

Surgery/Procedure Type	Surgeon Name	Date

Have you ever had Staph Infection (MRSA)? Yes ☐ or No ☐
Do you object to blood transfusions? Yes ☐ or No ☐

Women's Health

Screening Type	Last Completed
Cervical Cancer Screening (Pap Smear)	
Breast Cancer Screening (Mammogram)	
Bone Density Scan (Dexa Scan)	

Men's Health

Screening Type	Last Completed
Prostate Cancer Screening	
Abdominal Aortic Aneurysm Screening	

Continued on next page →

Advanced Directives

Please select one of the following:		
☐ I do not have an advanced directive.		
☐ I have an advanced directive.		
☐ POA HEALTHCARE	☐ LIVING WILL	☐ DNR

If you selected one of the above listed advanced directives, please bring a copy with you to your first appointment.

Do you have any concerns? If yes, please describe below.

_____
_____
_____
_____
_____

Signatures

_____ _____
Signature of Patient(or parent/guardian if patient is a minor) Date

FOR OFFICE USE ONLY		
Accepted as a new patient:	YES	NO
Copies of advanced directives received:	YES	NO

Completed form may be returned in the following ways:

- **Mail:** Hillsboro Health Primary Care, 1220 E. Tremont Street, Suite A., Hillsboro, IL 62049
- **In Person:** Hillsboro Health Primary Care, 1220 E. Tremont Street, Suite A., Hillsboro, IL 62049
- **Fax:** 217-545-4350
- **Email:** ccmnurse@hhealth.us
    - *Note: Please allow a minimum of 2 business days for electronic submissions*

For Questions or concerns please call: 217-532-4351.

Medical Release Form

HILLSBORO health
PRIMARY CARE

Personal Information

Patient Name: _____ Date of Birth: ____/____/____

Previous Name Used: _____ SSN: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Phone: ( ) _____ Email: _____

Information Requested From

Organization Name: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Phone: ( ) _____ Fax: ( ) _____

Previous Primary Care Provider: _____

Information Requested

I am requesting the following records from the patient's medical record that were created between _____ and _____:

- ☐ Admission Form Records
- ☐ X-Ray Reports
- ☐ X-Ray Films
- ☐ Progress Notes- Physician
- ☐ Progress Notes- Nurses
- ☐ Other Please Specify: _____
- ☐ Discharge Summary
- ☐ History and Physical Examination
- ☐ Operative Reports
- ☐ Laboratory Reports
- ☐ Emergency Room Visit Notes
- ☐ Pathology Reports
- ☐ Physical Therapy
- ☐ Care Plans
- ☐ Psychiatric Notes

I wish to have the above requested records sent to:

Hillsboro Health Primary Care
1220 E. Tremont Street
Hillsboro, IL. 62049
Phone: 217-532-4351
Fax: 447-448-2960

- ☐ I wish to have the records copied and I will pick up at the facility.
- ☐ I wish to have the records sent electronically.
- ☐ I wish to have the records sent via mail to the address posted above.

Signature and Disclosures

I understand that this authorization includes disclosing information regarding mental health, developmental disability, sexually transmitted disease, alcohol and/or drug abuse services, and HIV/AIDS test results, including but not limited to examination, diagnosis, evaluation, treatment or rehabilitation.

Purpose of disclosure:

☐ Request of individual ☐ Healthcare treatment/services ☐ Other _____

Legal Authority for Request:

☐ I am the patient noted above.

☐ I am the parent of the minor patient noted above.

☐ I am the patient's legal guardian and have attached to this authorization a valid appointment of guardianship from a probate court.

☐ I am the patient's attorney-in-fact, and I have attached to this authorization a valid power of attorney or Durable Power of Attorney for Health Care (DPAHC) that grants me the power to request the patient's medical records. If a DPAHC is attached, then I also have included evidence that the patient's attending physician has determined that the patient has lost the capacity to make informed health care decisions.

Understanding & Agreements of Requestor:

1. This authorization is voluntary.
2. This authorization will expire. _____
(enter "N/A" if never until revoked in writing, or enter a date or event, such as "60 days from the date of my signature below", etc). If blank, "N/A" is assumed.
3. I understand that I may revoke this authorization at any time by notifying the facility in writing, but if I do so, it will not have any effect on any actions taken prior to receiving the revocation.
4. I agree to waive all claims against the facility related to the release of the requested information.
5. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by the facility if the recipient of the information is not a health plan, health care provider, health care clearinghouse, or a business associate that has a contract with the facility.
6. If I am the patient, I understand that the facility may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.
7. I understand that if I request that records be copied and sent to me that the facility will make a good faith effort to send those records to me in a reasonable amount of time, but no later than sixty (60) days from the facility's receipt of my request.
8. I understand that if I wish to have copies of records made, the facility may assess a handling fee and per page fee for copying the records according to the rates set forth by the State of IL Comptroller's Office, plus actual shipping costs.
9. If applicable, the facility will notify me of the total amount due for copying and handling of the requested records. I agree that the facility will only send the requested information once it has received payment in full for those costs.

_____ _____

Signature of Person Making Request Date

_____

Printed Name

TO BE COMPLETED BY HILLSBORO HEALTH PRIMARY CARE STAFF

☐ Photo Identification Verified ☐ Signature Verification

HILLSBORO health

Hillsboro Health

Patient Portal Consent Form

Patient's Name: _____ Date of Birth: _____

Email Address: _____

Authorized Representative's Name: _____ Relationship to Patient: _____

Authorized Representative's Email: _____

Important Information Regarding the Patient Portal

- Hillsboro Health offers a secure way for current patients to view a portion of the information kept in their electronic health record. This form provides documentation of your acceptance and agreement to participation conditions including any amended or superseding conditions that may occur.
- Do not use the Patient Portal in an emergency. Call 911 or go to the nearest emergency room.
- Parts of your medical record may not be kept on the Patient Portal
- You may be an authorized representative on your child's record only if your child is between zero and eleven years old.
    - This limitation does not affect any legal right you have to access your child's medical record by other means. For more information on how to obtain a copy of your child's medical record, please contact the Health Information Management Department.

Terms and Conditions

- I understand that as the Authorized Representative I will have the same access and privileges that the patient would have for the patient portal.
- I understand that this allows me, as the Authorized Representative, online access to the patient's personal health information and I will be able to view all areas of their health record that are available on the Patient Portal.
- I understand that additional information may be made available to me, as the Authorized Representative, through the Patient Portal as Hillsboro Health continues to implement this new feature.
- I understand that this authorization is valid until revoked by the patient, if able, or the appropriate legal representation. A written request is necessary to revoke or cancel an authorization of an Authorized Representative and/or patient access. The revocation will be applied within three business days of the received documentation.
- I understand that if I need to change my email address as the Authorized Representative, this must be completed in person at Hillsboro Health for privacy and security reasons.
- I understand that I, the Authorized Representative am responsible for protecting his or her password or other means of access to electronic communications and Hillsboro Health is not liable for any breaches of confidentially caused by the patient, an Authorized Representative, or any third party.

By signing below, you agree to the Terms and Conditions and acknowledge that you have read and understand them. You also understand that your enrollment is contingent on verification of your identity by a Hillsboro Health employee.

Patient/Legal Representation: _____ Date: _____

Verification of Identity for the patient requesting use of Hillsboro Health's Patient Portal was witnessed by the Hillsboro Health employee below.

Witness: _____ Date: _____

HILLSBORO health
PRIMARY CARE

Communication Release Form

Patient Name: _____ Date of Birth: _____

I hereby give permission to Hillsboro Health Primary Care, to notify me by telephone via call or text of the following: (check all that apply)

Appointment reminder, by text message.	☐ Yes	☐ No
Appointment reminder, either by personal or recorded message.	☐ Yes	☐ No
A message to call the office for results.	☐ Yes	☐ No

- Please note that your results will not be left by a recorded message.

I authorize Hillsboro Health Primary Care to share my protected health information with family members or others as designated by me below. This permission is NOT an authorization to release medical records, or a consent to treatment. This permission also authorizes Hillsboro Health Primary Care to communicate with the authorized persons by phone (including voice messages and text messages), in person, or by other means acceptable to Hillsboro Health.

Name	Relationship	Phone Number

In the event of an emergency, Hillsboro Health has my permission to contact the following:

Name	Relationship	Phone Number

Acknowledgement:

I understand this form is Intended to guard my privacy and IS NOT a release of general medical information. I fully understand and ACCEPT the terms of this consent.

_____ _____

Signature Date

_____

Relationship to Patient

_____ _____

Witness Date

HILLSBORO health PRIMARY CARE

Patient No-Show, Late, & Cancellation Signature Form

Description

"No Show" shall mean any patient who fails to arrive for a scheduled appointment. "Same Day Cancellation" shall mean any patient who cancels an appointment less than 24 hours before their scheduled appointment. "Late Arrival" shall mean any patient who arrives at the clinic 15 minutes after the expected arrival time for the scheduled appointment.

Policy

It is the policy of the practice to monitor and manage appointment no-shows, late cancellations, and late arrivals. The Hillsboro Health Primary Clinic's goal is to provide excellent care to each patient in a timely manner. If it is necessary to cancel an appointment, patients are required to call or leave a message at least 24 hours before their appointment time. Notification allows the practice to better utilize appointments for other patients in need of medical care.

Procedure

A patient is notified of the appointment "No-Show, Late, & Cancellation Policy" at the time of scheduling. This policy can and will be provided in writing to patients at their request.

New patients:

I. Appointments must be cancelled at least 24 hours prior to the scheduled appointment time.
II. In the event of a no-show, Hillsboro Health Primary Clinic the patient may be subject to dismissal from Hillsboro Health Primary Clinic. The patient's chart is reviewed, and dismissals are determined by a Healthcare Provider only, no exceptions, in accordance with Hillsboro Health Primary Care guidelines.

Established patients:

I. Appointments must be cancelled at least 24 hours prior to the scheduled appointment time.
II. In the event a patient arrives late as defined by "late arrival" to their appointment and cannot be seen by the provider on the same day, they will be rescheduled for a future clinic visit.
III. In the event a patient has incurred three (3) documented "no-shows", "same-day cancellations," and/or "late arrivals" the patient may be subject to dismissal from the Hillsboro Health Primary Clinic. The patient's chart is reviewed, and dismissals are determined by a Healthcare Provider only, no exceptions, in accordance with Hillsboro Health Primary Care guidelines.

(Patient Signature) (Date/Time)