NGUYEN
FAMILY PRACTICE

Date: _____

DEMOGRAPHICS

Last Name: _____ First Name: _____ Preferred Name: _____

Date of Birth: _____ Sex: _____ Email: _____

Address: _____ City: _____ State/Zip:_____

Home Phone: _____ Cell Phone: _____

Do you wish to receive appointment reminders via text and/or email? (Y) (N)

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widowed

Advance Directives: [ ] Living Will [ ] Power of Attorney [ ] Do No Resuscitate Order
[ ] Healthcare Surrogate [ ] Health Care Proxy

Emergency Contact: the provider and/or staff may speak to this contact, and share your medical information in the event you experience a medical emergency

Last Name: _____ First Name: _____ MI: ___ Relationship: _____

Address: _____ City: _____ State/Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

INSURANCE (if applicable)

Primary Insurance: _____ Policy #: _____

Group #: _____ Policy Holder Name (if not patient): _____

Date of Birth: _____ Relationship to patient: _____

Secondary Insurance: _____ Policy #: _____

Group #: _____

PHARMACY INFORMATION

Preferred Pharmacy: _____

REASON FOR VISIT

CHIEF COMPLAINT(S): What concern(s) would you like to discuss during your visit?

_____

MEDICAL HISTORY

Please list any other doctors that you see:

Name	Specialty and/or Office Name

Current or past medical conditions:

Condition	Condition	Condition	Condition
[ ] High Blood Pressure	[ ] Heart Disease	[ ] Gout	[ ] Gallstones
[ ] High Cholesterol	[ ] Peripheral Vascular Disease	[ ] Hernia	[ ] Kidney Stones
[ ] Diabetes	[ ] Anxiety	[ ] HIV/AIDS	[ ] Urinary Incontinence
[ ] COPD	[ ] Depression	[ ] Kidney disease	
[ ] Asthma	[ ] PTSD	[ ] Liver disease	
[ ] Stroke/TIA	[ ] Migraines	[ ] Blood clots	
[ ] Cancer	[ ] Arthritis	[ ] Anemia	

Surgeries you have had in the past starting with the most recent:

Year	Surgery	Reason

Hospitalization(s) you have had in the past starting with the most recent:

Year	Reason

SOCIAL HISTORY

Employment Status: [ ] Employed [ ] Unemployed [ ] Retired [ ] Student [ ] Other _____

Occupation: _____ Veteran: (Y) (N) Children: Boy(s) _____ Girl(s)_____

Illicit drugs: (Y) (N) Vape: (Y) (N) Marijuana: (Y) (N) Medical or Recreational

Tobacco: [ ] Current smoker: How long and how much? _____
[ ] Former smoker: How long ago did you quit?_____
[ ] Non-smoker

Alcohol Use: (Y) (N) Caffeine: (Y) (N) How much?_____

FAMILY HISTORY

Relationship	Age, if living	Age, at death	Cause of death
Father			
Mother			
Brother(s)			
Sister(s)			

Mark (x) if any of your blood relatives have had any of the following:

Disease	X	Relationship	Disease	X	Relationship
Heart disease			Diabetes		
Stroke/TIA			Kidney disease		
High cholesterol			Mental illness		
Hypertension			Cancer Type:		

DIAGNOSTIC SCREENING AND IMAGING

List any procedure you have had in the past starting with the most recent:

Procedure	Date	Procedure	Date
[ ] Chest X-Ray		[ ] Echocardiogram	
[ ] Other X-Ray		[ ] Electrocardiogram (ECG)	
[ ] Mammogram		[ ] Bone Density Scan	
[ ] Colonoscopy or Cologuard		[ ] Prostate Exam	
[ ] Endoscopy		[ ] Other:	

MEDICATIONS

List all medications, including all prescription AND non-prescription medications such as over-the-counter medications, vitamins, dietary supplements, herbs, and laxatives.

Medication Name **Dose** **How you take it** **How long you have been taking it**

_____

_____

_____

_____

_____

_____

_____

_____

ALLERGIES

List all allergies and the type of reaction.

Medication/Food/Substance/Product **Reaction**

_____

_____

IMMUNIZATIONS

Please enter the date of the last immunization:

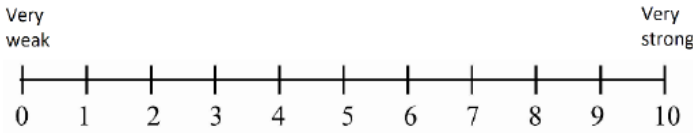
Immunization	Date	Immunization	Date
Influenza (Flu)		Tetanus Diphtheria (TD)	
Prevnar-13		Tetanus Pertussis (TDAP)	
Pneumovax-23		Zostavax (Shingles)	
COVID			

ADDITIONAL INFORMATION

How did you hear about Nguyen Family Practice?_____

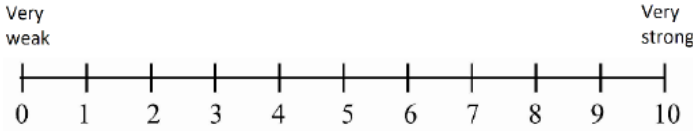
Would you be interested in body contouring or functional wellness? (Y) (N)

On a scale of 0-10, rate your core strength:



On a scale of 0-10, rate your quality of sleep:

On a scale of 0-10, rate your pelvic floor muscle strength:



On a scale of 0-10, rate your satisfaction with intimacy:

How many times per night do you wake up to use the bathroom? 0-1 2-4 4+

Have you accidentally leaked urine in the last month? *(e.g. laughing, jumping, sneezing)* (Y) (N)

How many times per week do you exercise? 0 1-3 4-6 6+

Would you like to increase your strength? (Y) (N)

Would you like to build muscle? (Y) (N)

Would you like to reduce fat? (Y) (N)

Would you like to increase your metabolism? (Y) (N)

CONSENT TO TREAT

By signing this consent form you are in agreement to the following:

· I give permission to Nguyen Family Practice to provide medical treatment.

· I allow Nguyen Family Practice to file my insurance benefits to pay for the care I receive.

· I have an understanding that Nguyen Family Practice will have to share my medical records with my insurance company.

· I am responsible for paying for my share of the costs. If my insurance does not pay or I do not have insurance, I must pay for the cost of these services.

· I understand that I have the right to refuse any medical procedure or treatment, and I have the right to discuss all of the risks/benefits/alternatives to all medical treatments with my provider.

· I acknowledge that healthcare services involve certain risks and benefits, which will be discussed with me as part of the informed consent process. I understand I have the right to ask questions about my care, seek a second opinion, or refuse treatment at any time

· If I participate in telehealth services, I consent to the use of electronic communication for my care, understanding the associated risks related to privacy and confidentiality.

By signing below, I acknowledge that I have read, understood, and agree to the terms outlined above.

X_____

Patient/Representative Signature Date:

Patient Name (Printed): _____

If signing on behalf of a minor or incapacitated individual:

Name of Legal Representative: _____

Relationship to Patient: _____

NO-SHOW POLICY

We require <u>24 hours notice</u> for any appointment cancellations.

There will be a $35 charge for each missed appointment without a minimum of 24 hour notice given. If a patient reaches 3 no shows, they will be required to prepay before being placed on the schedule. If you are more than 15 minutes late for your appointment, you have missed your appointment time slot and will need to reschedule and owe a no-show fee of $35.

Thank you for your cooperation.

I RECEIVED, HAVE READ & UNDERSTOOD NFP NO-SHOW & LATE POLICY:

X_____
Patient/Representative Signature Date:

CREDIT CARD AUTHORIZATION

Please sign below to authorize OR decline the option to securely store your credit card information on file. You may cancel this authorization at any time by contacting us.

I, _____, authorize Nguyen Family Practice to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

<u>Credit Card Information</u>

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX

Cardholder Name (as shown on card):_____

Card Number: _____

CVC:_____ Expiration Date (mm/yy): __/____

Billing zip: _____

X_____
Signature Date:

HIPAA PRIVACY PRACTICES & CONSENT

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services: *www.hhs.gov*

· Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

· The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

· You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

· You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

· Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

· We agree to provide patients with access to their records in accordance with state and federal laws.

· We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

· You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I,_____, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

X_____

Patient/Representative Signature Date: