TAYLOR REGIONAL HOSPITAL MEDICAL OFFICES

DATE: _____

PATIENT INFORMATION

Name: _____ Birthdate: ____/____/_____
Last First Middle

Social Security #: _____ Sex: M____ F____ Home Phone: _____

Single ____ Married ____ Legally Separated ____ Divorced ____ Life Partner ____ Widowed ____ Unknown ____

Address: _____ Cell Phone: _____

City: _____ State: _____ Zip: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Patient Employer: _____ Work Phone: _____

Employer Address: _____ State: _____ Zip: _____

GUARANTOR INFORMATION

Person Responsible for Account: _____
Last First Middle

Relationship to Patient: _____ Birthdate: ____/____/_____ SSN: _____

Address (if different from patients): _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

PRIMARY INSURANCE INFORMATION

Primary Insurance: _____ Subscribers Name: _____

Subscribers DOB: ____/____/_____ Subscribers Relationship to Patient: _____

Effective Dates: _____

SECONDARY INSURANCE INFORMATION

Is patient covered by additional insurance? ____Yes ____No Secondary Insurance: _____

Subscribers Name: _____ Subscribers Relationship to Patient: _____

Subscribers DOB: ____/____/_____ Effective Dates: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____ Home Phone: _____

Relationship to Patient: _____ Cell Phone: _____

TAYLOR REGIONAL HOSPITAL MEDICAL OFFICES

DATE: _____ PATIENT NAME:_____ DOB: _____ MRN: _____

CONSENT FOR TREATMENT

I, the patient or authorized representative, consent to any examination, evaluation and treatment regarding any illness, injury or other health concern affecting me at the time I present to any of Taylor Regional Hospital's Medical Offices for care. These services may include, but are not limited to, laboratory procedures, x-ray examinations, and medical or surgical treatment/procedures.

I have read and understand this agreement. I am the patient, the parent of a minor child, or the legally authorized representative of the patient, and am authorized to act on behalf of the patient and to sign this agreement.

HIPPA

I acknowledge that I have received a copy of the Notice of Privacy Practices (effective April 14, 2003), which explains how my protected health information may be used and disclosed for treatment, payment and health care operations.

SIGNATURE ON FILE

I authorize any holder of medical or other information about me to release to the social security administration and CMS or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801 – 3812 provides penalties for withholding information). Regulations pertaining to Medicare assignment benefits also apply.

I authorize the release of any medical or other information necessary to process claims. I also request payment of government benefits either to myself or to the party who accepts assignment.

FINANCIAL POLICY

By signing below, I agree that I have read and fully understand the financial policy set forth by Taylor Regional Hospital's Medical Offices and I agree to the terms of this financial policy. I also understand and agree that the terms of this policy may be amended by the practices at any time without prior authorization to the patient.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO AUTHORIZED REPRESENTATIVES

I give Taylor Regional Hospital and its staff permission to disclose the minimum necessary protected health information to the following designated authorized representative during my visit.

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____

I understand that when requesting disclosure of protected health information, the above name individual(s) must identify me (the patient) by full name, and have knowledge of my birthdate as verification of my identity.

I understand this Authorization can be revoked at any time. Such revocation must be in writing to the Taylor Regional Hospital Privacy Office 1700 Old Lebanon Road Campbellsville KY 42718.

Do we have permission to leave information on your answering machine when you are not home? Yes ____ No _____

☐ **I have reviewed the Consent for Treatment, HIPPA, Signature on File, Financial Policy and Authorization to Release Protected Health Information sections.**

_____ _____ _____

RESPONSIBLE PARTY SIGNATURE RELATIONSHIP DATE

CONSENT TO PRESCRIPTION AND USE OF CONTROLLED SUBSTANCES

I, _____ **[Insert name of patient]** hereby acknowledge that my medical provider recommends the use of certain controlled substances in the treatment of my medical condition. I understand that the prescription and use of controlled substances is subject to Kentucky law and regulations.

1. I hereby consent to the prescription and use of controlled substances in the treatment of my medical condition, as prescribed by my medical provider.

2. I have been provided information by my medical provider including the following:

   A. how to safely and properly dispose of unused controlled substances;
   B. proper use of the controlled substances;
   C. the effect of use of controlled substances during pregnancy (if appropriate);
   D. the potential for overdose and appropriate response to overdose; and,
   E. the impact of controlled substances on driving and work safety.

3. It has been explained to me that controlled substances used to treat an acute medical complaint are for time-limited use and that I should discontinue the use of controlled substances, under the direction of my medical provider, when the condition requiring the use of controlled substances has been resolved.

4. I consent to my prescribing medical provider discussing all diagnostic and treatment details with my other healthcare providers, pharmacists, other professionals who provide my healthcare, and with my family regarding my use of controlled substances. The family members with whom my medical provider may discuss my use of controlled substances are listed here:

_____

_____

_____

I understand I may revoke this consent or change the approved family members by notifying my medical provider.

5. I understand that if the responsible legal authorities have questions concerning my treatment, as might occur, for example, if I were obtaining controlled substances at several pharmacies, <u>all confidentiality is waived,</u> and I authorize that these authorities may be given full access to my medical records related to my treatment, including controlled substances administration and use.

6. State law requires my medical provider to query and report information to KASPER, the Kentucky database of prescriptions of controlled substances. I understand that my medical provider will query KASPER as part of my care and to confirm my prescriptions and that the KASPER report or information from the KASPER report may be included in my medical record.

7. The risks and potential benefits of the prescribed controlled substances, including, but not limited to, psychological addiction, physical dependence, and withdrawal, have been explained to me and all of my questions have been answered to my satisfaction. These risks and benefits are described in the information attached to this form and made a part of my medical record.

I, the undersigned patient or his/her legally authorized representative, attest that the foregoing was discussed with me, and that I have read, fully understand, and consent to the terms of this Consent.

Patient (or Legally Authorized Representative): _____ _____
Date/Time

Legally Authorized Representative Relationship to Patient: _____

Signature of Witness: _____ _____
Date/Time

TAYLOR REGIONAL PHYSICIANS FOR WOMEN

Patient Name: _____ DOB: _____

Pharmacy:(city and location) _____

Current Medications

_____

_____

_____

_____

_____

Allergies

_____

_____

_____

_____

_____

Gyecological History:

Last Menstrual Period: _____

Age at first period: _____

Age at menopause: _____

Gravida: (# of times pregnant) _____

Para: (# of live births) _____

# of Miscarriages: _____

Genitourinary infection:

Chlamydia HPV Trichomonas

Gonorrhea PID Other GU history

Herpes

# of Abortions: _____

Gynecologic: (circle all that apply)

Abnormal Pap PID Dyspareunia

Chronic Pelvic Pain Polycystic ovarian synd Sexual dysfunction

Endometriosis Recurrent vaginal infxn Other gyn history

Last Pap Smear: _____

Last Mammogram: _____

Family History:(circle all that apply)

Family disease history: Heart disease, TB (tuberculosis), Stroke, DVT (diverticulitis), HTN (hypertension), Thyroid disease, Hepatitis

Family Cancer History: Breast, Colon, Ovarian, Other

Family Genetic History: Cystic Fibrosis, TAY-SACHS, Sickle Cell, Down Syndrome, Hemophilia

REQUIRED:

Immunizations up to date: Yes No

Tetanus immunization: tetanus up to date, tetanus N/A, Other

Level of education: Grade school, College, High School, Post-Graduate, Other

Past Surgical History: (circle all that apply)

Gynecologic:	LEEP	Cesarean delivery	Hysterectomy	Oophorectomy	Tubal ligation	Other gyn surgery
Breast:	Breast biopsy	Lumpectomy	Mastectomy,bilateral	Mastectomy,left	Mastectomy,right	Other breast surgery

HEENT:	Cataract extraction	Tonsillectomy	Other ear surgery
	Dental surgery	Other head surgery	Other nasal surgery
	Laryngectomy	Other eye surgery	Other throat surgery
Endocrine:	Parathyroidectomy	Thyroid surgery	Other endocrine surg
Respiratory:	Bronchoscopy	Lobectomy	Other chest surgery
Cardiovascular:	Angiogram	Carotid endarterectomy	Pacemaker
	Angioplasty	Coronary stent	Valve replacement
	CABG surgery	Heart transplant	Other cardiac surgery
Gastrointestinal:	Appendectomy	Colectomy,total	Splenectomy
	Gall bladder removal	Gastric bypass	Other GI surgery
	Colectomy,subtotal	Hernia repair	

Genitourinary:	Bladder surgery	Nephrectomy	Kidney stone extraction	Other GU surgery
Musculoskeletal:	Joint replacement	Other musculoskeletal		
Integumentary:	Skin cancer removal	Other integumentary		
Neurologic:	Craniotomy	Spinal surgery	Other neurologic surg	

Social History: (circle all that apply)

Tobacco Use:	Current every day smoker	Never Smoker	Unknown
	Current some day smoker	Smokeless tobacco user	
	Former smoker		
Alcohol Intake:	None	2+ drinks per day	Other
	0-2 drinks per day		
Substance Use:	None	Hallucinogens	Club/designer drugs
	Marijuana	Tranquilizers/sedatives	Inhalants
	Cocaine/crack	Opiates	Injection drugs
	Amphetamines	Painkillers	Other

Past Medical History: (circle all that apply)

HEENT:	Cataracts	Recurrent ear infections	Meniere's	Glaucoma	Recurrent sinusitis	Other HEENT history
Endocrine:	Diabetes mellitus	Hyperthyroidism	Graves disease	Hypothyroidism	Other endocrine history	
Respiratory:	Allergies/hay fever	COPD	Sleep apnea	Asthma	CPAP use	Other respiratory history

Cardiovascular:	Abdominal aortic aneurysm	Deep venous thrombosis	Hypertension
	Angina	Heart failure	Heart attack
	Atrial fibrillation	Heart valve disease	Peripheral vascular disease
	Cardiac arrhythmias	Hyperlipidemia	Other cardiovascular history
	Coronary artery disease		
Gastrointestinal:	Colitis	Liver disease	Peptic ulcer disease
	GERD	Pancreatitis	Other GI history
	Irritable bowel syndrome		
Musculoskeletal:	Fibromyalgia	Osteoarthritis	Rheumatoid arthritis
	Fractures	Osteoporosis	Other musculoskeletal
	Gout		
Hematology/Oncology:	Anemia	GU cancer	Oral cancer
	Blood cancer	Kidney cancer	Ovarian cancer
	Brain cancer	Leukemia	Skin cancer
	Breast cancer	Liver cancer	Stomach cancer
	Cervical cancer	Lung cancer	Thrombocytopenia
	Coagulopathy	Lymphoma	Thyroid cancer
	Colorectal cancer	Musculoskeletal cancer	Uterine cancer
	Endocrine cancer	Myeloma	Other cancer history
	Eye cancer	Neurologic cancer	Other hematologic history
	GI cancer		
Infectious disease:	AIDS	MRSA	Rubella
	Chickenpox	Mumps	Syphilis
	Hepatitis	Polio	Tuberculosis
	HIV	Positive PPD	Vanc-resistant enterococc
	Measles	Rheumatic fever	Other infectious disease history
Integumentary:	Acne	Psoriasis	Eczema	Other integumentary

Neurologic:	ADHD	Multiple sclerosis	Seizures
	Autism	Parkinson disease	Stroke
	Dementia	Peripheral neuropathy	Trans ischemic attack
	Developmental delay	Restless leg syndrome	Other neurologic history
	Headaches		

TAYLOR REGIONAL PHYSICIANS FOR WOMEN

Previous Pregnancies

Date of Delivery	GA Weeks at Delivery	Length of Labor	Birth Weight	Type of Delivery (Vaginal or Csection)	Anesthesia (Yes/No)	Place of Delivery	Infant Mortality (Yes/No)	Treatment of Preterm Labor (Yes/No)

LAST MENSTRUAL CYCLE: _____

Comments (Include any complications during pregnancy or delivery):

_____

_____