

# MINOR & JAMES MEDICAL



We ask that you take some time with this questionnaire so we can better help you. If any questions are difficult to answer please feel free to ask your doctor during your visit.

Today's Date \_\_\_\_\_  
Your Name \_\_\_\_\_ Next of Kin \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Female \_\_\_\_\_ Male \_\_\_\_\_ Marital Status \_\_\_\_\_  
Home Phone Number \_\_\_\_\_ Work Phone Number \_\_\_\_\_  
Occupation \_\_\_\_\_ Referred by \_\_\_\_\_

1. What **HEALTH PROBLEMS** do you want to talk about when you are seen in the clinic?  
\_\_\_\_\_
2. **ALLERGIES:** Are you allergic to or have you had a "bad reaction" to any medicines or other substances?  
No \_\_\_\_ If yes, list the medicines \_\_\_\_\_
3. What **PRESCRIPTION** medicines do you presently take? (List doses and frequency) \_\_\_\_\_  
\_\_\_\_\_
4. Do you take any **NON-PRESCRIPTION** medicines? For example: laxatives, vitamins, aspirin, antacids, or cold remedies?  
No \_\_\_\_ If yes, please list \_\_\_\_\_
5. **HOSPITALIZATIONS** or **SURGERIES:** (Type of illness / operation / place / year) \_\_\_\_\_
6. **VACCINATIONS:** (Include year if known) Measles \_\_\_\_\_ Mumps \_\_\_\_\_ Rubella \_\_\_\_\_ Tetanus \_\_\_\_\_  
Polio \_\_\_\_\_ Influenza \_\_\_\_\_ Hepatitis \_\_\_\_\_ Pneumonia \_\_\_\_\_

7. **YOUR HEALTH HISTORY:**  
Have you had any of the following?  
YES NO
- |       |       |  |
|-------|-------|--|
| _____ | _____ | Anemia                                   |
| _____ | _____ | Asthma                                   |
| _____ | _____ | Cancer, if yes, kind and date _____      |
| _____ | _____ | Emphysema                                |
| _____ | _____ | Heart disease                            |
| _____ | _____ | High blood pressure                      |
| _____ | _____ | Kidney stones                            |
| _____ | _____ | Liver disease, jaundice, hepatitis       |
| _____ | _____ | Migraine                                 |
| _____ | _____ | Serious injury or accident               |
| _____ | _____ | Sugar diabetes                           |
| _____ | _____ | Thyroid gland trouble                    |
| _____ | _____ | Tuberculosis or positive skin test to TB |
| _____ | _____ | Sexually transmitted disease             |
| _____ | _____ | Transfusions                             |

8. **WOMEN'S HEALTH HISTORY:**  
Number of pregnancies \_\_\_\_\_  
Age of first menstrual period \_\_\_\_\_  
Age of menopause \_\_\_\_\_  
Current types of contraception \_\_\_\_\_  
Have you been on the pill? \_\_\_\_\_ When? \_\_\_\_\_  
Have you been on estrogen replacement?  
Yes \_\_\_\_\_ No \_\_\_\_\_  
Calcium Intake? Yes \_\_\_\_\_ No \_\_\_\_\_  
Diet or Pills? Yes \_\_\_\_\_ No \_\_\_\_\_

9. **HABITS** (Please Circle)
- |                         |                                |            |                    |               |
|-------------------------|--------------------------------|------------|--------------------|---------------|
| Tobacco:                | Cigarettes                     | Pipe       | Cigar              | Chew          |
|                         | Number of years _____          |            | Daily amount _____ |               |
| Caffeine:               | Number of cups/day _____       | Type _____ |                    |               |
| Alcohol:                | None                           | Beer       | Wine               | Other Liquors |
|                         | Amount per week _____          |            |                    |               |
|                         | Hours of sleep per night _____ |            |                    |               |
|                         | Number of meals per day _____  |            |                    |               |
| Do you use other drugs? | Yes _____                      | No _____   |                    |               |
| Exercise?               | Yes _____                      | No _____   |                    |               |
| Use Seatbelts?          | Yes _____                      | No _____   |                    |               |
| Use Bicycle helmets?    | Yes _____                      | No _____   |                    |               |
| Smoke Detectors?        | Yes _____                      | No _____   |                    |               |

PLEASE CONTINUE ON THE OTHER SIDE OF SHEET.  
**ADULT HEALTH QUESTIONNAIRE**

10. **SYMPTOMS:** Please mark (X) in the appropriate box indicating if you now have these symptoms by either Yes or No

Yes	No	<b><u>CONSTITUTIONAL</u></b>
<input type="checkbox"/>	<input type="checkbox"/>	Unexplained Fever
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

Yes	No	<b><u>HEAD, EYES, EARS, NOSE, THROAT</u></b>
<input type="checkbox"/>	<input type="checkbox"/>	Severe Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Ear or Hearing Trouble
<input type="checkbox"/>	<input type="checkbox"/>	Vision Changes
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

Yes	No	<b><u>RESPIRATORY/LUNGS</u></b>
<input type="checkbox"/>	<input type="checkbox"/>	Daily Cough
<input type="checkbox"/>	<input type="checkbox"/>	Wheezing
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

Yes	No	<b><u>HEART</u></b>
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain
<input type="checkbox"/>	<input type="checkbox"/>	Heart Palpitations (skipped beats)
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

Yes	No	<b><u>VASCULAR</u></b>
<input type="checkbox"/>	<input type="checkbox"/>	Leg Vein Trouble
<input type="checkbox"/>	<input type="checkbox"/>	Clotting Problems
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

Yes	No	<b><u>STOMACH/INTESTINAL</u></b>
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Nausea or Vomiting
<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

Yes	No	<b><u>URINARY</u></b>
<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine
<input type="checkbox"/>	<input type="checkbox"/>	Unusual Discharge
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

Yes	No	<b><u>GYNECOLOGY</u></b>
<input type="checkbox"/>	<input type="checkbox"/>	Changes in Menstrual Flow
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Cramping
<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Discharge
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

Yes	No	<b><u>METABOLIC/ENDOCRINE</u></b>
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Hunger
<input type="checkbox"/>	<input type="checkbox"/>	Cold or Heat Intolerance
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

Yes	No	<b><u>NERVOUS SYSTEM</u></b>
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Nervousness
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

Yes	No	<b><u>DERMATOLOGY/SKIN</u></b>
<input type="checkbox"/>	<input type="checkbox"/>	Rashes
<input type="checkbox"/>	<input type="checkbox"/>	Itching
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

Yes	No	<b><u>BONES/JOINTS/MUSCLES</u></b>
<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain or Swelling
<input type="checkbox"/>	<input type="checkbox"/>	Muscle Weakness
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

Yes	No	<b><u>BLOOD</u></b>
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bruising
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

Yes	No	<b><u>IMMUNOLOGY</u></b>
<input type="checkbox"/>	<input type="checkbox"/>	Food Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Environmental Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

11. WHICH OF YOUR BLOOD RELATIVES HAD ANY OF THE FOLLOWING DISEASES:

Early coronary heart disease \_\_\_\_\_

Diabetes \_\_\_\_\_

High blood pressure \_\_\_\_\_

Mental or emotional disease \_\_\_\_\_

Tuberculosis \_\_\_\_\_

Alcohol or substance abuse \_\_\_\_\_

Cancer:

Breast \_\_\_\_\_ Ovary \_\_\_\_\_

Colon \_\_\_\_\_ Prostate \_\_\_\_\_

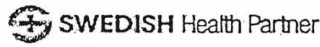
12. CHILDREN

Number of children \_\_\_\_\_

Health Status \_\_\_\_\_

**PATIENT REGISTRATION  
FORM**

**MINOR & JAMES  
MEDICAL**



(PATIENT LABEL HERE)

**Patient Information**

Last Name				First Name				MI	Alias or Maiden Name		
Date of Birth	Sex	Marital Status	Race	Social Security Number				Employer Name			
Street Address						Apt. #	City		State	Zip	
Home Phone				Work Phone				Cell Phone			
Email Address				Emergency Contact Name & Relationship				Emergency Contact Phone #			

**Responsible Party Information**

Last Name				First Name				MI	Alias or Maiden Name		
Date of Birth	Sex	Marital Status	Race	Social Security Number				Relationship to the patient			
Street Address						Apt. #	City		State	Zip	
Home Phone				Work Phone				Cell Phone			
Email Address				Employer Name				Occupation			

**Insurance Information**

<b>Primary Insurance</b>												
Insurance Company Name				Group Number				Subscriber ID Number			Copay	
Subscribers Name				Social Security Number				Date of Birth		Relationship to the patient		
Subscribers Employer Name				Subscribers Home Phone				Subscribers Work Phone				
<b>Secondary Insurance</b>												
Insurance Company Name				Group Number				Subscriber ID Number			Copay	
Subscribers Name				Social Security Number				Date of Birth		Relationship to the patient		
Subscribers Employer Name				Subscribers Home Phone				Subscribers Work Phone				

**CONSENT TO CARE:**

I consent to the plan of care proposed by the providers in this clinic. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse this plan of care. I will ask for any information I want to have about my medical care and will make my wishes known. \_\_\_\_\_ (Initial)

**NOTIFICATION OF RELEASE FOR PAYMENT:**

I understand that Minor and James Medical will disclose any diagnosis and pertinent information to the extent required to assure payment from insurance companies and any liable third party payers. I understand that this disclosure, unless expressly limited by me in writing, will extend to all aspects of treatment including testing and/or treatment for HIV/AIDS, sexually transmitted diseases, substance abuse, or mental health conditions. \_\_\_\_\_ (Initial)

**FINANCIAL AGREEMENT:**

I understand co-payments are due at the time of service. I assign payment from my insurance directly to Minor and James Medical. I understand I am financially responsible to Minor and James Medical for the charges not paid by insurance and that those charges are due within 30 days of invoice. I understand that in addition to the bill from my provider, I may also receive separate bills from the laboratory, radiology and other specialized services. \_\_\_\_\_ (Initial)

- Data entered into NextGen
- Insurance Card Scanned
- Drivers license/picture ID scanned

**Patient Signature:** \_\_\_\_\_

**Parent or Guardian:** \_\_\_\_\_

**Date:** \_\_\_\_\_

# MINOR & JAMES MEDICAL



## Acknowledgement of Receipt of Minor & James Medical, PLLC Notice of Privacy Practices

Pursuant to the requirements found in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the following is offered for your information. It is this office's policy to ask you to read and sign this form to acknowledge receipt of our Notice of Privacy Practices. If you have any questions, please ask for the Privacy Official in this office.

I, (print) \_\_\_\_\_, currently residing in (city) \_\_\_\_\_, do hereby acknowledge receipt of the Minor & James Medical PLLC, Notice of Privacy Practices.

I understand that Provider has reserved the right to change its privacy practices as described in the Notice. In the event of any change in Providers privacy practices, Provider will revise the Notice. I understand that I can obtain a copy of the revised Notice by writing to Provider.

I understand that if I chose not to sign this acknowledgement Provider is still authorized to disclose individually identifiable health information for the purpose of providing treatment, billing, or health care operations.

I understand that I have the right to request a restriction on Provider's use or disclosure of any or all Protected Health Information to any or all locations, entities, or persons. I further understand that Provider is not obligated to agree to my request. However, if Provider does agree to my request, the agreement will become binding.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship, if other than patient: \_\_\_\_\_

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For Clinic Purposes Only:

1. Form must be on yellow paper.
2. File in the advanced directive section of medical record.

# MINOR & JAMES MEDICAL



## Authorization to Leave Personal Health Information by Alternate Means

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Address: \_\_\_\_\_  
\_\_\_\_\_

(Please check all that apply)

- May leave detailed message on voicemail at home #: (\_\_\_\_) \_\_\_\_\_
- May leave detailed message on voicemail at work #: (\_\_\_\_) \_\_\_\_\_
- May leave information with spouse (name): \_\_\_\_\_
- May leave information with other family member: \_\_\_\_\_
- May leave detailed message on cellular phone #: (\_\_\_\_) \_\_\_\_\_
- May leave detailed message at a different location #: (\_\_\_\_) \_\_\_\_\_

With my signature below I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change one or more of the telephone numbers listed above.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

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For Clinic Purposes Only:

1. Form must be on yellow paper.
2. File in the advanced directive section of medical record.
3. For patient authorized revocation use the *Revocation of Authorization for Minor & James to Use or Disclose Health Care Information* form (MJ/0294).

