DATE: _____

Patient Information

NAME_____
Last First Middle Initial

NAME YOU WOULD LIKE TO BE ADDRESSED BY IN THE OFFICE_____

DATE OF BIRTH _____-_____-_____ AGE: _____ SOCIAL SECURITY #_____-_____-_____

ADDRESS_____ CITY_____ STATE_____ZIP_____

PHONE: Home_____ Work_____ Cell_____

FAX: _____ Physical or follow up reminders to: Cell ☐ Email ☐ Home phone ☐

E-MAIL _____

RACE _____ ETHNIC GROUP_____ LANGUAGE SPOKEN_____

MARITAL STATUS: Single ☐ Married ☐ Divorced ☐ Widowed ☐ SEX: Male ☐ Female ☐

EMPLOYER NAME_____ POSITION _____

SPOUSE'S NAME_____ SPOUSE'S WORK PHONE_____

PHARMACIES USED _____ PH# _____ Fax# _____

_____ PH# _____ Fax#_____

MAIL ORDER _____ PH# _____ Fax#_____
PHARMACY *(if applicable)*

Major Medical Coverage
(For Care Rendered Outside Office)

INSURANCE COMPANY NAME:_____ID #_____

*****If HMO Policy, Please make sure you update your PCP selection to reflect Dr. Robin. This may result in lab or referral bills.*****

POLICY HOLDER NAME_____DATE OF BIRTH_____

RELATIONSHIP TO PATIENT: Self ☐ Spouse ☐ Child ☐ Other _____

Emergency Contact

NAME_____ RELATIONSHIP_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

PHONE: Home _____ Work _____ Cell _____

OFFICE USE ONLY

HINT ACCT_____ DR. **ROBIN**_____ CONTRACT_____

START DATE_____ ATHENA _____

Patient Information Form **DATE:**_____ **Name:**_____

Please list any conditions or chronic illnesses you have (Such as high blood pressure, diabetes, pregnancy, glaucoma, prostate problems, etc.)

_____
_____
_____

☐ **None**

What **major surgeries** have you had and the dates of the surgery and the doctor performing surgery (if known)

_____
_____
_____

☐ **None**

Please list all the **medicines** being taken that were **prescribed by a doctor or dentist** (Include what you take for chronic conditions, birth control, etc.)

_____
_____
_____
_____

☐ **None**

Please list **medicines** you sometimes take that were bought **without a prescription**. (Such as aspirin, antacids, sleep medicine, allergy, cold medicine, vitamins, etc.)

_____
_____
_____
_____

☐ **None**

PLEASE LIST ALLERGIES TO MEDICINES

_____
_____
_____

☐ **None**

Please list all individuals that live with you and their age

_____
_____
_____
_____

Family History of**:**

	YES	NO	(Family Member)
Breast Cancer -	☐	☐	
Colon Cancer **-**	☐	☐	
Prostate Cancer -	☐	☐	
Heart Disease -	☐	☐	
Diabetes-	☐	☐	
Hypertension**-**	☐	☐	

☐ **None**

Do you smoke?

☐ **Yes** ☐ **No** ☐ **Used To ***

If yes, how much? _____

***If used to**, how much? _____

How long did you smoke? _____

When did you quit? _____

Do you drink alcoholic beverages?

☐ **Often** ☐ **Sometimes** ☐ **No**

How many drinks a week?_____

Any history of drug abuse?

☐ **Yes** ☐ **No**

Do you exercise?

☐ **Yes** ☐ **No**

If yes, how many times per week? _____

Do you drink caffeinated drinks?

☐ **Yes** ☐ **No**

If yes, how many drinks per week?_____

Are you sexually active?

☐ **Yes** ☐ **No**

Application
Sidney T. Robin, M.D.

This application applies to the following patients:	Age:	Cardio Program $80/month
1. _____	_____	Yes ____ No ____
2. _____	_____	Yes ____ No ____
3. _____	_____	Yes ____ No ____
4. _____	_____	Yes ____ No ____

I agree to pay the annual fee as follows and understand that they will increase without notice as age changes.

Monthly amounts are based off of the patients age.

Age 50+	$120/month
Age 40-49	$90/month
Age 18-39	$80/month
Age 2-17	$70/month

***Student rate: Member plus a full time student will get a $30.00 a month discount off of the dependents rate up to 25 years old.

Option 1: Please bill my credit card as follows:

☐ VISA ☐ Mastercard

☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly

Name on card: _____ CVC Code:_____

Card Number: _____ Expires: _____

Responsible Party Name and Address (if different): _____

Authorized Signature: _____

Option 2: Please automatically deduct fee(s) from my checking account:

☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly

(Please attach a voided check with the application)

Name of Bank: _____

Name on Account: _____

Bank/Routing #: _____ Account #: _____

Authorized Signature: _____

*All fees paid in advance will be held in trust and released to Sidney T. Robin, M.D. On the 24th of each month for services provided during that month. Patients may leave Sidney T. Robin, M.D. at any time after six months and receive a refund of all fees held in trust that have not been earned as of that date. Unless other written arrangements are made, charges commence with the month during which this completed application is received and **continue until a written notice is received.***

Signature: _____ Date: _____

Office Use Only: Hint_____ Athena_____Chart_____Med Rec Req_____Date_____

PATIENT RECORD OF DISCLOSURE

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ **Home Telephone _____**

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call back number only

☐ **Written Communication**

- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address

☐ **Work Telephone _____**

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ **E- Mail _____**

- ☐ O.K. to leave detailed information
- ☐ Leave call back-back number only

For information regarding my <u>financial</u> account, please contact me at the following phone numbers:

Weekday:_____Weekend:_____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Persons to whom personal health information may be released

1._____ relationship _____

2._____ relationship _____

3. _____ relationship _____

4. _____ relationship _____

5. _____ relationship _____

_____ _____

Patient Signature Date

_____ _____

Print Name Birthdate

SIDNEY T. ROBIN, M.D.

FAMILY PRACTICE

AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, do hereby authorize _____ to release information from the medical record of:

_____ _____ _____-_____-_____
Patient Name Date of Birth Social Security No.

From: _____

_____

_____

To: Sidney T. Robin, M.D.
Family Practice
631 W. 38th St., Ste. 1
Austin, TX 78705
Ph: 512.459.4177
Fax: 512.420.0974

Information to be released: *(Reports may include information on drug/alcohol/ psychological/communicable disease treatment).*

- ☐ History & Physical
- ☐ Laboratory
- ☐ X-Rays
- ☐ HIV/AIDS
- ☐ Other: _____
- ☐ Consultation
- ☐ EKG
- ☐ Progress Notes
- ☐ All Medical Records

Dates of Treatment: _____

Reason for Release of Information:

- ☐ Application for Insurance Coverage
- ☐ Workers' Compensation
- ☐ Change of Physician
- ☐ Other: _____

(Article 4495b, Section 5.08(j) Texas Revised Civil Statutes requires that an authorization for release of medical records include "the reason or purposes for the release".)

I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it and that, in any event, this authorization expires automatically ninety (90) days from the date of signature.

_____ _____
Signature Date

_____ _____
Legal Witness Relationship to Patient *(state reason patient is unable to sign)*

SIDNEY T. ROBIN, M.D.

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Sidney T. Robin, M.D
Privacy Officer
631 West 38th Street, Suite 1
Austin, Texas 78705

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a baby sitter take their child to the pediatrician's

office for treatment of a cold. In this example, the baby sitter may have access to this child's medical information.

8. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

8. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

9. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

10. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

11. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Sidney T. Robin, M.D 631 West 38th Street, Suite 1, Austin, Texas 78705 specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to Sidney T. Robin, M.D 631 West 38th Street, Suite 1, Austin, Texas 78705. Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Sidney T. Robin, M.D. 631 West 38th Street, Suite 1, Austin, Texas 78705 in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Sidney T. Robin, M.D. 631 West 38th Street, Suite 1, Austin, Texas 78705. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you

must submit your request in writing Sidney T. Robin, M.D 631 West 38th Street, Suite 1, Austin, Texas 78705. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a Paper Copy of This Notice**. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact: Sidney T. Robin, M.D 631 West 38th Street Suite 1, Austin, Texas 78705.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Sidney T. Robin, M.D. 631 West 38th Street, Suite 1, Austin, Texas 78705. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact

SIDNEY T. ROBIN, M.D.
512-459-4177
631 West 38th Street, Suite 1
Austin, Texas 78705

SIDNEY T. ROBIN, M.D

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM.

I, _____, have received a copy of Sidney T.
Patient Name
Robin, M.D.'s Notice of Privacy Practices.

_____ _____
Signature of Patient Date

austin concierge medicine

SIDNEY T. ROBIN, M.D.
FAMILY PRACTICE

Interval History

Today's Date:_____

NAME: _____ _____ _____ **DATE OF BIRTH**: _____
Last First Initial

Do you have now or have you had since your last complete physical exam: (Check "Yes" or "No" for each problem. **Please explain any "Yes" answers**.)

YES NO

☐ ☐ Any medical problems, serious injuries, illness, hospitalizations, surgeries (operations)?_____
_____

☐ ☐ Any new medications? _____
☐ ☐ Any diet changes? _____
☐ ☐ A change in exercise pattern? _____
☐ ☐ A change in smoking habit? _____
☐ ☐ Other lifestyle changes? _____
☐ ☐ A change in job status? _____
☐ ☐ Increased drug/alcohol use? _____
☐ ☐ New family problems? _____
☐ ☐ Other new stresses in your life? _____

When was your last:
Physical Exam?_____ Eye Exam? _____
Blood Pressure Check? _____ Rectal exam?_____
Cholesterol Check? _____ Chest x-ray? _____
Electrocardiogram (EKG) ? _____

Recent Immunizations:
Td/Tdap?_____ Pneumonia_____
Influenza?_____ Zostavax (Shingles)?_____
Hepatitis B?_____ Hepatitis A?_____

Please describe your current health: _____

WOMEN ONLY
When was your last: Pelvic examination? _____Pap Smear? _____
Breast examination? _____Mammogram? _____
Current birth control method? _____

PLEASE SEE OTHER SIDE

MEDICATION RECORD

MEDICATION NAME	STRENGTH	DOSAGE	START DATE	END DATE	PRESCRIBING DR	REACTION/SIDE EFFECTS

austin concierge medicine

SIDNEY T. ROBIN, M.D.
FAMILY PRACTICE

Date:_____

ADULT DATABASE

Name: _____ **Sex**: ____ **Date of Birth**: _____ **Age**:_____
Last First Initial

Past Medical History

	YES	NO		YES	NO
Heart Disease	☐	☐	Diabetes	☐	☐
Kidney Disease	☐	☐	Thyroid or Glandular	☐	☐
Asthma & Lung	☐	☐	Cancer	☐	☐
Liver, Hepatitis	☐	☐	Back or Spine Disorder	☐	☐
Gastrointestinal	☐	☐	Rheumatic Fever	☐	☐
Peptic Ulcer	☐	☐	Stroke	☐	☐
Head Injury, Seizures	☐	☐	Migraines	☐	☐
Psychiatric Disorder	☐	☐	Colon Disorder	☐	☐
High Blood Pressure	☐	☐	HIV or AIDS	☐	☐

List ALL Hospitalizations & Surgeries (with dates)

TYPE	YEAR	TYPE	YEAR
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies:

MEDICATION	REACTION
_____	_____
_____	_____
_____	_____
_____	_____

Immunizations (with dates):

Tetanus, Diphtheria (Td): _____ **Tetanus, Diphtheria, Pertussis (Tdap):** _____
Zostavax (shingles): _____ **Pneumovax (pneumonia):** _____
Hepatitis A: _____ **Hepatitis B:** _____

PLEASE COMPLETE OTHER SIDE

GYN (Women Only) Pregnancies _____ Full Term _____ Premature _____ Still Born _____ Abortion/Miscarriage _____

Age Menses Began _____ Hysterectomy Yes ☐ No ☐ Last Menstrual Period_____

SOCIAL HISTORY:

Tobacco use? Yes ☐ No ☐ / If yes, what type? _____ How Much Per Day?_____ For How Long? _____

If used to, how much? _____ How long? _____ When did you quit? _____

Do you drink alcoholic beverages? Yes ☐ No ☐ How many drinks a week? _____

Highest Level of Education? _____ Occupation? _____

Exposure to toxic chemical, work related injuries or stresses? _____ Military Service? _____

Foreign Travel (Where?) _____

Do you wear seat belts? Yes ☐ No ☐ Exercise Type & Schedule?_____

Hobbies? _____

FAMILY HISTORY:

PARENTS	**HEALTH STATUS:**	**IF DECEASED - CAUSE OF DEATH**	**AGE**
Father	GOOD FAIR POOR	_____	_____
Mother	GOOD FAIR POOR	_____	_____
SIBLINGS			
_____	GOOD FAIR POOR	_____	_____
_____	GOOD FAIR POOR	_____	_____
_____	GOOD FAIR POOR	_____	_____
_____	GOOD FAIR POOR	_____	_____
CHILDREN: MALE/FEMALE			
____	GOOD FAIR POOR	_____	_____
____	GOOD FAIR POOR	_____	_____
____	GOOD FAIR POOR	_____	_____

Please list any family members with the following diagnoses (please specify *paternal*/*maternal*):

Cancer: _____
Heart Disease: _____
Diabetes: _____
High Blood Pressure: _____
Stroke: _____
Rheumatoid Arthritis: _____
Gout: _____
Glaucoma: _____
Migraines: _____
Asthma/Lung Disease: _____
Colon Disease: _____ Peptic Ulcer: _____
Alcohol/Drug Abuse: _____ Hereditary Disorder: _____
Mental Illness: _____ Blood Disease: _____
Epilepsy: _____ Kidney Disease: _____
Sickle Cell Anemia: _____ Tuberculosis: _____

The above is complete and true to the best of my knowledge. I, the undersigned, voluntarily consent and grant permission to the physician to perform tests, treatments and procedures as indicated for myself or the above named minor for as long as I am a patient of the physician.

_____ _____ _____ _____

Patient's Signature Date Reviewed by Date

SUBMIT