Dear patient,

We would like to take this opportunity to thank you for choosing Huntsville Hospital Physician care - Bailey Cove for your primary medical care and to welcome you to our office. We are pleased that you have chosen us to provide you with medical services.

Our website should help answer any questions about our office. We want you to know about our office services and what to expect at the time of your first visit.

Please call the office at (256) 428-4900 to schedule your new patient appointment prior to completing the New Patient Forms found on our website. We ask that you mail, fax or drop off the completed forms prior to your appointment. Bring your identification cards, insurance card and medication bottles, as well as your co-payments and/or deductibles the day of your visit.

We ask that all new patients arrive **30 minutes** prior to your appointment time, so you can be seen by the doctor at your scheduled time.

If you are unable to keep your appointment for any reason or if you are going to be **15 minutes** or more late, please call our office at (256) 428-4900 as soon as possible. We will be happy to reschedule a more convenient time for you.

Sincerely,

Sherri Telaga
Practice Administrator
Huntsville Hospital Physician Care - Bailey Cove
HH PHYSICIAN CARE

BAILEY COVE
9000 Bailey Cove Road
Huntsville, AL 35802
Phone: (256) 428-4900 Fax: (256) 428-4912

PATIENT INFORMATION

PLEASE PRINT

Patient’s Name ____________________________________________ Referred By ________________________________

LAST
FIRST
MI

Address ____________________________________________ City ________ State ________ Zip ________________

Home Phone_________________________ Work Phone_________________________ Cell Phone_________________________

SS# ___________ ___________ ___________ Sex M F D.O.B. ___________/_________/________

Email Address ____________________________________________

Patient’s Occupation ___________________________ Employer: ___________________________

Employer’s Address ____________________________________________ Employer’s Phone ( ) ___________

Spouse’s Name ___________________________ Spouse’s D.O.B. ___________/_________/________ Spouse’s SS # ___________

Spouse’s Occupation ___________________________ Spouse’s Employer ___________________________

Employer’s Address ____________________________________________ Employer’s Phone ( ) ___________

Notify in case of emergency ___________________________ Relationship ___________________________

City ___________________________ State ___________________________ Phone ( ) ___________

If patient is a minor, list persons other than responsible party above, who have permission to bring child to office for treatment:

Name ___________________________ Relationship ___________________________ Phone ___________________________

Name ___________________________ Relationship ___________________________ Phone ___________________________

Name ___________________________ Relationship ___________________________ Phone ___________________________

PRIMARY INSURANCE TO FILE

<table>
<thead>
<tr>
<th>Policy #</th>
<th>Group #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured’s Name</td>
<td>Relationship to Patient</td>
</tr>
<tr>
<td>Insured’s Social Security # or I.D. #</td>
<td>Insured’s Date of Birth</td>
</tr>
<tr>
<td>Insurance Company Name</td>
<td></td>
</tr>
</tbody>
</table>

SECONDARY INSURANCE TO FILE

<table>
<thead>
<tr>
<th>Policy #</th>
<th>Group #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured’s Name</td>
<td>Relationship to Patient</td>
</tr>
<tr>
<td>Insured’s Social Security # or I.D. #</td>
<td>Insured’s Date of Birth</td>
</tr>
<tr>
<td>Insurance Company Name</td>
<td></td>
</tr>
</tbody>
</table>

PERSON RESPONSIBLE FOR THIS ACCOUNT ___________________________ PHONE ( ) ___________

I agree that payment will be made at the time of service. I agree to pay all co-pays, non-covered or routine charges, deductibles and co-insurance amounts that apply. In the event this account is turned over to a collection agency for collection, I will be responsible for all collection fees, court costs and attorney’s fees. I authorize HH Physician Care to release information to insurance carriers and for insurance carriers to release information to HH Physician Care concerning my illness, treatment and payments (including workmen’s compensation) and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents if assignment applies.

Signature ___________________________ Date ___________ Time ___________
NAME: __________________________________________

WHAT OTHER DOCTORS/SPECIALIST DO YOU SEE:

DATE OF BIRTH: _________ NAME/SPECIALTY __________________________________

AGE: _________ ___________________________________________________

REASON FOR VISIT:

ANY NEW OR WORSENING PROBLEMS? IF YES, PLEASE DESCRIBE: __________________________________________

PLEASE CHECK IF YOU HAVE ANY OF THE BELOW:

PAST MEDICAL HISTORY:

[ ] ASTHMA [ ] CROHN'S DISEASE [ ] HEPATITIS A [ ] THYROID DISORDER
[ ] ATRIAL FIBRILLATION [ ] CHRONIC RENAL FAILURE [ ] HEPATITIS B [ ] TUBERCULOSIS
[ ] ANEMIA [ ] DEPRESSION [ ] HEPATITIS C [ ] VALVULAR HEART DISEASE
[ ] ANXIETY [ ] DIABETES - JUVENILE ONSET [ ] INFECTILITY [ ] UTI - RECURRENT
[ ] AUTOIMMUNE DISEASE (LUPUS) [ ] DIABETES - ADULT ONSET [ ] KIDNEY DISEASE [ ] VARICOSE VEINS/PHLEBITIS
[ ] BILIARY CIRRHOSIS [ ] DIVERTICULITIS [ ] KIDNEY STONES [ ] ABNORMAL PAP SMEAR
[ ] BLOOD TRANSFUSION [ ] DVT (BLOOD CLOT IN LEGS) [ ] LIVER DISEASE [ ] BREAST DISEASE
[ ] BRAIN TUMOR [ ] GI BLEED [ ] MI (HEART ATTACK) [ ] BREAST CANCER
[ ] CEREBROVASCULAR [ ] GERD (ACID REFLUX) [ ] NEUROLOGIC DISORDER [ ] CERVICAL CANCER
[ ] DISEASE (STROKE) [ ] HEMOCHROMATOSIS [ ] OSTEARTHRITIS [ ] GESTATIONAL DIABETES
[ ] CIRRHOSIS [ ] HIGH BLOOD PRESSURE [ ] OSTEOPOROSIS [ ] RH SENSITIZED
[ ] CVA/STROKE [ ] HIGH CHOLESTEROL [ ] PVD [ ] SLEEP APNEA
[ ] COPD (LUNG DISEASE) [ ] HYPOTHYROIDISM [ ] PUD (STOMACH ULCERS) [**USING CPAP YES/NO]
[ ] COLON CANCER [ ] HYPERTHYROIDISM [ ] RHEUMATOID ARTHRITIS
[ ] CORONARY HEART DISEASE [ ] GOITER [ ] SEIZURE DISORDER
[ ] OTHER __________________________________________________________________________________

PAST SURGICAL HISTORY:

[ ] AMPUTATION [ ] COLON RESECTION [ ] PACEMAKER IMPLANTED [ ] BREAST AUGMENTATION
[ ] AV FISTULA CREATION [ ] CRANIOTOMY [ ] PARATHYROIDECTOMY [ ] RIGHT/LEFT
[ ] AV GRAFT [ ] GASTRIC BYPASS [ ] PNEUMONECTOMY [ ] MASTECTOMY RIGHT/LEFT
[ ] AORTIC VALVE REPLACEMENT [ ] HEMORRHOIDECTOMY [ ] PTCA (ANGIOPLASTY) [ ] LUMPECTOMY RIGHT/LEFT
[ ] AORTIC VALVE REPLACED [ ] HIP REPLACEMENT [ ] ROTATOR CUFF REPAIR [ ] LUMPECTOMY
[ ] APPENDICOTMY [ ] INVASIVE PAIN PROCEDURE [ ] ABD. HYSTERECTOMY [ ] **OVARIES REMOVED YES/NO
[ ] BOTH LEGS BYPASSED [ ] KIDNEY TRANSPLANT [ ] HYSTERECTOMY/OVARIES [ ] PROSTATE SURGERY
[ ] BACK SURGERY [ ] KNEE ARTHROSCOPY [ ] **OVARIES REMOVED YES/NO [ ] SLEEP APNEA SURGERY
[ ] BRONCHOSCOPY (LUNG SCOPE) [ ] KNEE REPLACEMENT [ ] PROSTATE SURGERY [ ] THYROID SURGERY
[ ] CABG (HEART BYPASS) [ ] KYPHOLASTY [ ] SHOULDER SURGERY [ ] SLEEP APNEA SURGERY
[ ] CAROTID ENDARTERECTOMY [ ] LUMPECTOMY [ ] SLEEP APNEA SURGERY [ ] THYROID SURGERY
[ ] CARPAL TUNNEL [ ] MASTECTOMY [ ] SLEEP APNEA SURGERY [ ] THYROID SURGERY
[ ] CATARACT EXTRACTION [ ] MITRAL VALVE REPLACED [ ] TONSIL'S REMOVED [ ] VASCULAR SURGERY
[ ] GALLBLADDER REMOVED [ ] NEPHRECTOMY [ ] VASCULAR SURGERY
[ ] OTHER __________________________________________________________________________________
FAMILY HISTORY:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Father</th>
<th>Mother</th>
<th>Brother</th>
<th>Sister</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Blood Pressure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Artery Disease/Heart Attack</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Kidney Disease (Chronic)</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
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<tr>
<td>Stroke</td>
<td></td>
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<tr>
<td>Asthma</td>
<td></td>
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<tr>
<td>Arthritis</td>
<td></td>
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</tr>
<tr>
<td>Thyroid Disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer (Type)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

OTHER:______________________________________________________________________________________________

SOCIAL HISTORY: (CHECK OR CIRCLE APPROPRIATE)

- Married/Single/Divorced/Widowed
- Religious Affiliation

- Works Part-Time/Full-Time
- Occupation: _________________________
- Retired
- Disabled
- Children - Yes or No

ALLERGIES OR MEDICATION REACTIONS:

- Allergic To: _________________________
- Reaction: _________________________
- No Known Drug Allergies

RISK FACTORS: (CHECK OR CIRCLE APPROPRIATE)

- Current Tobacco Use
  - Year Started: ____________
  - Caffeine Use: Yes/No
  - Type of Tobacco: Cigarettes, Cigars, Snuff, Vapor
  - How Many Per Day: ________
  - Alcohol Use: Yes/No
  - Type: _______________________
  - How Many Drinks Per Day: ________
  - Former Tobacco Use
  - Year Quit: ____________
  - How Many Per Day: ________
  - Never Smoked
  - Type: _______________________
  - Second Hand Smoke: Yes/No
  - How Many Drinks Per Day: ________
  - Do You Wear Your Seat Belt? Yes/No
  - Exercise: Yes/No
  - Times Per Week: ________
  - Type: _______________________

CURRENT MEDICATIONS:

- Refer to List
- Refer to Bottles

Please include the dose and how often you take the medication (no need to list below if you brought a list or bottles)

- Name
- Dosage
- How Many Times Per Day
- As Needed (PRN)
**MEDICAL PROBLEMS:** HAVE YOU HAD ANY RECENT OR PERSISTENT PROBLEMS WITH THE FOLLOWING?

<table>
<thead>
<tr>
<th>General</th>
<th>Skin</th>
<th>Extremities</th>
<th>Neck</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ WEIGHT GAIN / LOSS</td>
<td>○ RASHES</td>
<td>○ JOINT PAIN</td>
<td>○ GOITER</td>
</tr>
<tr>
<td>○ DIABETES</td>
<td>○ NAIL / HAIR PROBLEMS</td>
<td>○ GOUT</td>
<td>○ SWOLLEN GLANDS</td>
</tr>
<tr>
<td>○ BACK PAIN</td>
<td>○ ABDOMINAL MOLES</td>
<td>○ VARICOSE VEINS</td>
<td>○ THYROID</td>
</tr>
<tr>
<td></td>
<td></td>
<td>○ LEG SWELLING</td>
<td></td>
</tr>
<tr>
<td><strong>Mouth:</strong></td>
<td><strong>Heart:</strong></td>
<td><strong>Gastrointestinal:</strong></td>
<td><strong>Urinary:</strong></td>
</tr>
<tr>
<td>○ DENTURES</td>
<td>○ CHEST PAIN</td>
<td>○ TROUBLE SWALLOWING</td>
<td>○ FREQUENCY</td>
</tr>
<tr>
<td>○ HOARSENESS</td>
<td>○ HYPERTENSION</td>
<td>○ REFLUX / GERD</td>
<td>○ TROUBLE STARTING OR STOPPING</td>
</tr>
<tr>
<td>○ GUMS</td>
<td>○ HIGH CHOLESTEROL</td>
<td>○ VOMITING</td>
<td>○ URINARY PAIN</td>
</tr>
<tr>
<td>LAST DENTAL EXAM:</td>
<td>○ CONGESTIVE HEART FAILURE</td>
<td>○ DIARRHEA</td>
<td>○ URINATE AT NIGHT</td>
</tr>
<tr>
<td></td>
<td>○ HEART MURMUR</td>
<td>○ CONSTIPATION</td>
<td>○ LEAKAGE</td>
</tr>
<tr>
<td></td>
<td>○ PALPITATIONS</td>
<td>○ BLOODY / BLACK STOOL</td>
<td>○ BLOOD IN URINE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>○ HEMORRHOIDS</td>
<td>○ KIDNEY STONES</td>
</tr>
<tr>
<td></td>
<td></td>
<td>○ HEPATITIS</td>
<td>○ INFECTIONS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>○ PROSTATE TROUBLE</td>
</tr>
<tr>
<td><strong>Neuro:</strong></td>
<td><strong>Lungs:</strong></td>
<td><strong>LAST COLONOSCOPY:</strong></td>
<td><strong>Sexual:</strong></td>
</tr>
<tr>
<td>○ HEADACHE</td>
<td>○ PERSISTANT COUGH</td>
<td></td>
<td>○ PROBLEMS WITH SEX</td>
</tr>
<tr>
<td>○ HEAD INJURY</td>
<td>○ COUGH UP BLOOD</td>
<td></td>
<td>○ MULTIPLE PARTNERS</td>
</tr>
<tr>
<td>○ BLACKOUTS / DIZZY</td>
<td>○ EMPHYSEMA / BRONCHITIS</td>
<td></td>
<td>○ HISTORY OF STD</td>
</tr>
<tr>
<td>○ SEIZURES / TREMORS</td>
<td>○ SHORTNESS OF BREATH</td>
<td></td>
<td>○ HIV</td>
</tr>
<tr>
<td>○ MEMORY LOSS</td>
<td>○ PNEUMONIA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>○ DEPRESSION / ANXIETY</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td><strong>ENT:</strong></td>
<td><strong>Women:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>○ ALLERGIES</td>
<td>○ IRREGULAR PERIODS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>○ SINUS TROUBLE</td>
<td>○ PELVIC PAIN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>○ HEARING LOSS</td>
<td>○ BIRTH CONTROL PILLS</td>
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<td></td>
</tr>
<tr>
<td>○ GLASSES / CONTACTS</td>
<td>○ NIPPLE DISCHARGE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>○ BLURRED VISION</td>
<td>○ LUMPS IN BREASTS</td>
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</tr>
<tr>
<td>○ RINGING</td>
<td>○ SELF BREAST EXAM</td>
<td></td>
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<tr>
<td>LAST EYE EXAM:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>EYE DOCTOR:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PLEASE ENTER THE MOST RECENT DATE AND RESULTS OF THE FOLLOWING:**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Date</th>
<th>Results</th>
<th>Performed by Who/Where</th>
</tr>
</thead>
<tbody>
<tr>
<td>COLONOSCOPY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PAP SMEAR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MAMMOGRAM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BONE DENSITY SCAN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MENSUTRAL PERIOD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSA (PROSTATE SCREEN)</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**WHEN WAS YOUR LAST VACCINE ON THE FOLLOWING:**

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Date</th>
<th>Would you like one?</th>
</tr>
</thead>
<tbody>
<tr>
<td>FLU VACCINE</td>
<td></td>
<td>Yes / No</td>
</tr>
<tr>
<td>TETANUS VACCINE</td>
<td></td>
<td>Yes / No</td>
</tr>
<tr>
<td>PNEUMONIA VACCINE</td>
<td></td>
<td>Yes / No</td>
</tr>
<tr>
<td>ZOSTAVAX</td>
<td></td>
<td>Yes / No</td>
</tr>
</tbody>
</table>
Huntsville Hospital Physician Care Bailey Cove

Medicare Secondary Payer Questionnaire

Patient Name: __________________________    Patient DOB: __________________

Patient DOS: __________________________

Part I

1. Are you receiving Black Lung Benefits?
   □ No
   □ Yes – (Date Benefits began: ____________________) Black Lung is Primary Only for
     Claims Related to Black Lung

2. Are the services to be paid by the government program such as research grant?
   □ No
   □ Yes – Government Program will be Primary

3. Has the Department of Veterans Affairs authorized and agreed to pay for care at this
   facility?
   □ No
   □ Yes – Department of Veterans Affairs is Primary

4. Was the illness or injury due to work related accident or condition?
   □ No – Go to Part II
   □ Yes – (Date of Injury/Illness: ________________) Worker’s Comp is
     Primary Go to Part III

Part II

1. Was illness or injury due to non-work related accident?
   □ No – Go to Part III
   □ Yes – (Date of Accident: ________________)

2. What type of accident caused the illness or injury?
   □ Automobile – Motor Vehicle Insurance is Primary
   □ Non-Automobile – Go to question 3

3. Was another party responsible for this accident?
   □ No – Go to Part III
   □ Yes – Liability Insurance Carrier is Primary

Part III

1. Are you entitled to Medicare based on:
   □ Age – 65 and over – Go to Part IV
   □ Disability – Go to Part V
   □ Dialysis (End Stage Renal Disease) – Go to Part VI
Patient Name: ________________________________           Patient DOB: ______________________

Patient DOS: ________________________________

Part IV – Age

1. Are you currently employed?
   □ No (Date of Retirement: ______________________)
   □ Never Worked
   □ Yes
       Employer Name: ________________________________
       Employer Address: ________________________________

2. Is your spouse currently employed?
   □ No (Date of Retirement: ______________________)
   □ Never Worked
   □ Yes
       Employer Name: ________________________________
       Employer Address: ________________________________

IF THE ANSWER TO BOTH QUESTIONS ABOVE ARE NO, MEDICARE IS PRIMARY. DO NOT PROCEED ANY FURTHER.

3. Do you have Group Health Plan coverage based on your own or a spouse’s current employment?
   □ No – Stop
   □ Yes – Go to Question 4

4. Does the employer that sponsors your Group Health Plan employ 20 or more employees?
   □ No – Stop
   □ Yes – Stop Group Health Plan is Primary

Part V – Disability

1. Are you currently employed?
   □ No (Date of Retirement: ______________________)
   □ Yes
       Employer Name: ________________________________
       Employer Address: ________________________________

2. Is a family member currently employed?
   □ No
   □ Yes
       Employer Name: ________________________________
       Employer Address: ________________________________

IF THE ANSWER TO BOTH QUESTIONS ABOVE ARE NO, MEDICARE IS PRIMARY. DO NOT PROCEED ANY FURTHER.

3. Do you have Group Health Plan coverage based on your own or family member’s current employment?
   □ No – Stop
   □ Yes – Go to Question 4

4. Does the employer that sponsors the Group Health Plan employ 100 or more employees?
   □ No – Stop Medicare is Primary
   □ Yes – Stop Group Health Plan is Primary
Part VI – Dialysis (End Stage Renal Disease)

1. Do you have Group Health Plan coverage?
   □ No – **Stop Medicare is Primary**
   □ Yes
     Employer Name: ________________________________
     Employer Address: ________________________________

2. Have you received a kidney transplant?
   □ No
   □ Yes (Date of Transplant: ______________________)

3. Have you received maintenance dialysis treatments?
   □ No
   □ Yes (Date Dialysis Began: _____________________)
     If you participated in a self dialysis training program provide date training started:

4. Are you within 30 month coordination period?
   □ No – **Stop Medicare is Primary**
   □ Yes

5. Are you entitled to Medicare on the basis of either End Stage Renal Disease and age or End Stage Renal Disease and Disability?
   □ No – **Stop Group Health Plan is Primary During the 30 Month Coordination Period**
   □ Yes

6. Was your initial entitlement to Medicare (including simultaneous entitlement) based on End Stage Renal Disease?
   □ No – **Initial entitlement based on age or disability**
   □ Yes – **Stop Group Health Plan Continues to Pay Primary During 30 Month Coordination Period**

7. Does the working aged or disability Medicare Secondary Payer apply (i.e. is the Group Health Plan primary based on age or disability entitlement)?
   □ No – **Medicare Continues to Pay Primary**
   □ Yes – **Group Health Plan Continues To Pay Primary During 30 Month Coordination Period**
Pediatric History Form

Name: ____________________________ DOB: __________________________ Date: __________________________
Reason for visit today: ________________________________________________________________
Referred by: ____________________________ Previous Family Physician: ____________________________

It is the responsibility of the parents to provide a copy of the immunization record.

With whom does the child live? (please provide names and relationship)

Who is the legal guardian of the child? __________________________________________________________________________________________
Who is authorized to bring the child in for medical exams including immunizations?

With whom can we discuss the patients medical history by phone or during office visits?

Are the parents married / divorced / separated / unmarried / widowed (circle one)
Is there any legal reason why we cannot discuss the child's medical care with either parent?

EDUCATION/DEVELOPMENT/SOCIAL
Does your child attend day care? __________________________________________________________________________________________
What school does the child attend and which grade? (If home-schooled, please list below)

Does the child receive any special services such as Physical Therapy, Speech Therapy, Occupational Therapy, or Special Education services? __________________________________________________________________________________________

Does the child have any behavioral, social or learning problems? __________________________________________________________________________________________

Does the child participate in any organized sports or hobbies? __________________________________________________________________________________________

Are there any smokers in the house? Yes / No

FAMILY HISTORY
Is there any family history of the following:
- Diabetes
- High Blood Pressure
- Childhood Heart Disease
- Asthma
- Allergies

Seizures
Sickle Cell Anemia
Birth Defects
Sudden Death

Please list any other pertinent Family Medical History:

MEDICAL HISTORY
Please list the child's medical problems. Circle all that apply.
Asthma Allergic Rhinitis Attention Deficit Disorder (ADD) Migraines Seizures Heart Murmur

Please continue on other side
Has the child ever been hospitalized? If so, for what and when?

Has the child ever had any surgeries? Circle all that apply.
- Appendectomy
- Tonsillectomy
- Adenoidectomy
- Tubes in ears
- Gall bladder
- Orthopedic

What medications does the child take?

Does the child have any medication allergies? If so, what is his/her reaction?

What specific health concerns do you wish to address today?

Do you have any concern about your safety or your child's safety? Yes / No

FOR TEEN GIRLS:
Have you started your period? If so, at what age? ______ Are your periods every month? ________________
How long do they last? __________________ Are they painful?

FOR TEEN BOYS AND GIRLS:
Do you smoke? __________ Drink alcohol? __________ Use illicit drugs? __________
Are you sexually active? ______ If so, do you practice "safe sex"? ________________
Have you ever been pregnant? __________ Had a child? ________________
What are your long term goals for the future? __________________
What talents do you have which give you joy and a sense of accomplishment? __________________

DIETARY HISTORY (all ages):
Please write down everything the child has eaten or drank in the last 24 hours.

Name of person completing this form and relationship ____________________________
PHYSICIAN CARE
BAILEY COVE

132 REQUEST FOR HEALTH INFORMATION FROM HOSPITALS OR OTHER PROVIDERS

Name of Organization/Person: ____________________________________________________________________________
Address_______________________________________________________________________________________________
Fax/Phone_____________________________________________________________________________________________

Huntsville Hospital Requests Information for the Following Patient:
Patient Name ___________________________________________________ SS# (Optional)________________________________________
Date of Birth __________________________________________
Address _________________________________________________________________________________________________
Phone _________________________________________________ Date of Service______________________________________
Signature:_________________________________________________________________________________________________

Requested information for treatment, payment, or operations:
☐ Discharge Summary ☐ Consultation Report ☐ Outpatient Record
☐ History and Physical ☐ EKG Report ☐ Emergency Dept Record
☐ Operative Note ☐ Nurses’ Notes ☐ Laboratory Results
☐ Pathology Report ☐ Progress Notes ☐ Imaging Results
☐ Operative Note ☐ Pathology Report ☐ Imaging Results
☐ Consultation Report ☐ EKG Report ☐ Other____________________

Patient Number

Please send to:
HH Physicians Care Bailey Cove
9000 Bailey Cove Road
Huntsville, AL 35802
Phone: (256) 428-4900 Fax: (256) 428-4912

Signature: ____________________________ Date: __________________________
Relationship to Patient: ____________________________
Witness: ____________________________
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name __________________________________________ SS Number (Optional) _______________________________________
Date of Birth __________________________________________ Address _________________________________________
Phone Number (_____) ___________________________ Date(s) of Service __________________

I authorize the use or disclosure of the above named individual’s health information as described below:

1. Huntsville Hospital Physician’s Network is authorized to make the disclosure.

2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)
   - All / Entire Record
   - Visit/Encounter Notes
   - Laboratory Results
   - X-Ray and Imaging Reports
   - Problem list
   - Medication List
   - Allergies List
   - EKG Report
   - Pathology Report
   - Consultation Report
   - Operative Report
   - Immunization Record
   - Drug and Alcohol Treatment
   - HIV/AIDS/STD Treatment
   - Registration Record
   - Other ________________________

3. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. This information may be disclosed to, and used by, the following individual or organization:
   Name: _______________________________________________________________________________________________
   Address: _____________________________________________________________________________________________

5. For the purpose of ________________________________________________________________________________________

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Record Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

7. Unless otherwise revoked, the authorization will expire on the following date, event, or condition:
   _______________________________________________________________________________________________________
   If I fail to specify an expiration date, event or condition, this authorization will expire in six months from the date of signing.

8. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

9. I understand that as the recipient, I am responsible for the security of these medical record copies and the health information contained therein, whether in paper format or on CD/DVD.

10. I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.
    Or
    I understand that if I refuse to sign this form, under specific conditions the organization can refuse:
    Treatment Enrollment in the health plan         Eligibility for benefits

SIGNATURE ___________________________ DATE ___________ TIME ___________  

IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT SIGNATURE OF WITNESS DATE ___________ TIME ___________  

*For Office Use Only*

Any portion of the record request found in paper chart? YES ____ NO ____ (Please circle one)
Huntsville Hospital Physician Care at Bailey Cove
9000 Bailey Cove Road • Huntsville, AL 35802
(256) 428-4900