PHYSICIAN CARE

Rashida Dossman, PA

Dear patient,

We would like to take this opportunity to thank you for choosing Huntsville Hospital Physician Care 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 (*huntsvillehospital.org/find-a-doctor/huntsville-hospital-physicians-offices*) 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 our office at the number on the left to schedule your new patient appointment prior to completing the New Patient Forms found on our website. We prefer that you mail, fax or drop off the completed forms prior to your appointment. If unable to do so, please bring the completed forms with you 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 provider 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 as soon as possible. We will be happy to reschedule a more convenient time for you.

Sincerely,

Leslianne Ralston
Practice Administrator
Huntsville Hospital Physician Care - Oakwood

1863 Sparkman Drive
Huntsville, AL 35816
o: (256) 265-0095
f: (256) 265-0098

PHYSICIAN CARE

PATIENT INFORMATION

Patient

Date: _____

Name: _____ Referred by: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Work phone: _____

DOB: _____ SSN: _____ Sex: ☐ M ☐ F

Email address: _____

Patient's occupation: _____ Employer: _____

Employer's address: _____ Employer phone: _____

Spouse's name: _____ Spouse's DOB: _____ Spouse's SSN: _____

Spouse's occupation: _____ Employer: _____

Employer's address: _____ Employer phone: _____

In case of emergency, notify: _____ Relationship: _____

City: _____ State: _____ Phone: _____

If patient is a minor, list person/s other than emergency contact above who have permission to bring child to office for treatment:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Insurance *(provide patient information unless patient is a minor, then provide guarantor's information)*

PRIMARY INSURANCE

Insurance name: _____ Relationship to patient: _____

Subscriber's name: _____ Copay amount: _____

Subscriber ID/Contract Policy #: _____ Group #: _____

Subscriber's SSN: _____ Subscriber's DOB: _____

Subscriber's Employer: _____ Employer's Phone: _____

SECONDARY INSURANCE

Insurance name: _____ Relationship to patient: _____

Subscriber's name: _____ Copay amount: _____

Subscriber ID/Contract Policy #: _____ Group #: _____

Subscriber's SSN: _____ Subscriber's DOB: _____

Subscriber's Employer: _____ Employer's Phone: _____

Person responsible for this account: _____ Phone: _____

I agree payment will be made at the time of service. I agree to pay all co0pays, 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 carries to release information to HH Physician Care concerning my illness, treatment and payments (including workmen's compensation) and I hereby assign to the physician all payments for medical services rendered to myself or my dependents if assignment applies.

_____ _____ _____

Signature Date Time

PHYSICIAN CARE

MEDICAL HISTORY WORK-UP SHEET

Date: _____ Appointment with: _____

Name: _____ Date of birth: _____ Age: _____

What other doctors/specialists do you see? Name/Specialty: _____

_____

Reason for visit: _____

Any new or worsening problems? If yes, please describe: _____

_____

PAST MEDICAL HISTORY *(Please check if you have any of the below.)*

- ☐ AIDS/HIV
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Anemia
- ☐ Anxiety
- ☐ Autoimmune Disease (Lupus)
- ☐ Biliary Cirrhosis
- ☐ Bipolar Disorder
- ☐ Blood Transfusion
- ☐ Brain Tumor
- ☐ Cirrhosis
- ☐ CVA/Stroke
- ☐ COPD (Lung Disease)
- ☐ Colon Cancer
- ☐ Coronary Heart Disease
- ☐ Crohn's Disease
- ☐ Chronic Kidney Disease
- ☐ Depression
- ☐ Diabetes - Type 1
- ☐ Diabetes - Type 2
- ☐ Diverticulitis
- ☐ DVT (Blood Clot in Legs)
- ☐ Eczema
- ☐ GI Bleed
- ☐ Gerd (Acid Reflux)
- ☐ Hemochromatosis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Goiter
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Infertility
- ☐ Insomnia
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Lung Cancer
- ☐ MI (Heart Attack)
- ☐ Migraine Headaches
- ☐ Neurological Disorder
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ PVD
- ☐ PUD (Stomach Ulcers)
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Thyroid Nodule
- ☐ Tuberculosis
- ☐ Valvular Heart Disease
- ☐ UTI - Recurrent
- ☐ Varicose Veins/Phlebitis
- ☐ Abnormal Pap Smear
- ☐ Breast Disease
- ☐ Breast Cancer
- ☐ Cervical Cancer
- ☐ Gestational Diabetes
- ☐ Rh Sensitized
- ☐ Sleep Apnea

Using a CPAP? Yes / No

Other_____

PAST SURGICAL HISTORY

- ☐ Amputation
- ☐ AV Fistula Creation
- ☐ AV Graft
- ☐ Aortic Valve Replacement
- ☐ Aortic Valve Replaced
- ☐ Appendectomy
- ☐ Both Legs Bypassed
- ☐ Back Surgery
- ☐ Bronchoscopy (Lung Scope)
- ☐ CABG (Heart Bypass)
- ☐ Carotid Endarterectomy
- ☐ Carpal Tunnel Right / Left
- ☐ Cataract Extraction
- ☐ Colon Resection
- ☐ Craniotomy
- ☐ Gastric Bypass
- ☐ Gallbladder Removed
- ☐ Hemorrhoidectomy
- ☐ Hip Replacement Right / Left
- ☐ Invasive Pain Procedure
- ☐ Kidney Transplant Right / Left
- ☐ Knee Arthroscopy Right / Left
- ☐ Knee Replacement Right / Left
- ☐ Kyphoplasty
- ☐ Mitral Valve Replaced
- ☐ Nephrectomy Right / Left
- ☐ Pacemaker Implanted
- ☐ Parathyroidectomy
- ☐ Pneumonectomy Right / Left
- ☐ PTCA (Angioplasty)
- ☐ Rotator Cuff Repair Right / Left
- ☐ Abdominal Hysterectomy
- ☐ Ovaries Removed Yes / No
- ☐ Prostate Surgery
- ☐ Shoulder Surgery Right / Left
- ☐ Sleep Apnea Surgery
- ☐ Thyroid Surgery
- ☐ Tonsil's Removed
- ☐ Vascular Surgery
- ☐ Breast Augmentation Right / Left
- ☐ Mastectomy Right / Left
- ☐ Lumpectomy Right / Left

Other_____

Patient name: _____ DOB _____

FAMILY HISTORY	Father	Mother	Brother	Sister	Children
High Blood Pressure	☐	☐	☐	☐	☐
Heart Artery Disease/Heart Attack	☐	☐	☐	☐	☐
Kidney Disease (Chronic)	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Thyroid Disorder	☐	☐	☐	☐	☐
Cancer (Type)	☐	☐	☐	☐	☐

SOCIAL HISTORY *(Check or circle appropriate)*

☐ Married ☐ Single ☐ Divorced ☐ Widowed

Work ☐ Part-Time ☐ Full-Time ☐ Retired ☐ Disabled Occupation:_____

Children: Yes / No Religious Affiliation _____

ALLERGIES OR MEDICATION REACTIONS ☐ **NO KNOWN DRUG ALLERGIES**

Allergic to: Reaction:

_____

_____

_____

RISK FACTORS *(Check or circle appropriate)*

☐ Current tobacco use Year started _____

Type of tobacco: Cigarettes / Cigars / Snuff / Vapor

☐ Former tobacco use Year quit _____

☐ Never smoked

Second hand smoke Yes / No

Do you wear a seat belt? Yes / No

Multiple sexual partners? Yes / No

Caffeine Use Yes / No

How many drinks per day _____

Alcohol use Yes / No

How many per day? _____ Type _____

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. *(Skip if you brought a list or bottles)*

Name	Dosage	How many times per day?	As Needed (PRN)

Pharmacy_____ Phone #_____ Location_____

Do we have permission to receive medication history on patient via electronic prescription? Yes / No

Signature of patient/guardian _____ Date _____

Patient name: _____ DOB _____

MEDICAL PROBLEMS Have you had any recent or persistent problems with the following?

General

- ☐ Weight Gain/Loss
- ☐ Fever/Chills/Fatigue
- ☐ Snoring
- ☐ Sleep Troubles
- ☐ Depression/Anxiety

Neuro

- ☐ Headache
- ☐ Head injury
- ☐ Blackouts/Dizzy
- ☐ Seizures/Tremors
- ☐ Memory Loss
- ☐ Numbness/Tingling
- ☐ Forgetfullness/ Confusion
- ☐ Abnormal Coordination

Urinary

- ☐ Frequency
- ☐ Trouble starting or stopping urine stream
- ☐ Blood In Urine
- ☐ Painful Urination
- ☐ Urinating at Night
- ☐ Urine Leakage
- ☐ Unable to Urinate

ENT

- ☐ Allergies
- ☐ Sinus Congestion
- ☐ Glasses/Contacts
- ☐ Blurred Vision
- ☐ Ringing
- ☐ Hoarseness
- ☐ Runny Nose
- ☐ Hearing Loss
- ☐ Trouble Swallowing
- ☐ Neck Lump
- ☐ Swollen Glands
- ☐ Earache

Skin

- ☐ Rashes
- ☐ Abnormal moles
- ☐ Changes in Hair/ Hair Loss
- ☐ Wounds that will not heal

Heart

- ☐ Chest Pain
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Ankle Swelling

Lungs

- ☐ Persistent Cough
- ☐ Cough Up Blood
- ☐ Shortness of Breath
- ☐ Wheezing

Women

- ☐ Irregular Periods
- ☐ Pelvic Pain
- ☐ Nipple Discharge
- ☐ Lumps In Breasts
- ☐ Frequent Sweats/ Hot Flashes
- ☐ Vaginal Discharge

Musculoskeletal

- ☐ Joint Pain
- ☐ Gout
- ☐ Varicose Veins
- ☐ Leg Swelling
- ☐ Back Pain
- ☐ Joint Stiffness
- ☐ Muscle Weakness
- ☐ Muscle Pain
- ☐ Muscle Cramps

Gastrointestinal

- ☐ Reflux/GERD
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloody/Black Stool
- ☐ Hemorrhoids
- ☐ Loss of Appetite
- ☐ Rectal Bleeding
- ☐ Abdominal Pain

Sexual

- ☐ Problems with sex
- ☐ Erectile Dysfunction
- ☐ Painful Intercourse
- ☐ Decreased Sexual Desire
- ☐ Blood in Semen

Endocrine

- ☐ Excessive Thirst
- ☐ Excessive Urination
- ☐ High Blood Sugars
- ☐ Heat Intolerance
- ☐ Cold Intolerance

Please enter the most recent date and results of the following:

	Date	**Results**	**Performed by (who/where)**
Colonoscopy	_____	_____	_____
Pap Smear	_____	_____	_____
Mammogram	_____	_____	_____
Bone Density Scan	_____	_____	_____
Menstural Period	_____	_____	_____
PSA (Prostate Sceen)	_____	_____	_____
Eye Exam	_____	_____	_____

When was your last vaccine on the following:

	Date	**Would you like one?**
Flu Vaccine	_____	Yes / No
Tetanus Vaccine	_____	Yes / No
Pneumonia Vaccine	_____	Yes / No
Shingles Vaccine	_____	Yes / No

PHYSICIAN CARE

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ SSN (opt):_____

Date of Birth: _____ Address:_____

Phone: _____ Date of Service: _____

Chart #: _____

Provider: _____

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

- Huntsville Hospital Physician Network is authorized to make the disclosure.
- The type and amount of information to be sued 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: _____

  Records release format:
  (choose one)
  - ☐ e-delivery (HealthPort connect)
  - ☐ CD
  - ☐ Paper
- I understand the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndroms (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
- This information may be disclosed to and used by the following individual or agency:

  Name: _____ Address: _____

  for the purpose of: _____
- I understand that I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Record Department. I understand the revocation will not apply to information already released in response to this authorization. I understand 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.
- Unless otherwise revoked, the authorization will expire on the following date, event or condition:

  _____

  If left blank, this authorization will expire six months from the date of signing.
- 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.
- I understand 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.
- I understand I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan or eligibility for benefits. HOWEVER, I understand that if I refuse to sign this form, under specific conditions the organization can refuse treatment enrollment in the health plan and/or eligibility for benefits.

_____ _____ _____
Signature Date Time

_____
Relationship to patient (if signed by legal representative)

_____ _____ _____
Signature of witness Date Time

OFFICE USE ONLY: Any portion of the record request found in paper chart? ☐ Yes ☐ No

PHYSICIAN CARE

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 _____

Signature _____ Date of Service _____

Patient Number: _____

Requested information for treatment, payment or operations:

- ☐ Discharge summary
- ☐ History and physical
- ☐ Operative note
- ☐ Pathology report
- ☐ Consultation report
- ☐ EKG report
- ☐ Nurses' notes
- ☐ Progress notes
- ☐ Physicians' orders
- ☐ Outpatient record
- ☐ Emergency dept record
- ☐ Laboratory results
- ☐ Imaging results
- ☐ Other: _____

_____

_____

_____

_____

Please send to:

Airport Road
Fax: (256) 265-0777

Bailey Cove
Fax: (256) 428-4912

Gateway Medical Clinic
Fax: (256) 817-9130

Hampton Cove
Fax: (256) 265-0357

Hazel Green (Adults)
Fax: (256) 428-4991

Hazel Green Pediatrics
Fax: (256) 828-0526

Huntsville
Fax: (256) 265-5986

Lowell Drive (both offices)
Fax: (256) 265-9875

Madison, Hwy 72
Fax: (256) 817-5647

Madison, Lanier Rd.
Fax: (256) 817-5971

Oakwood
Fax: (256) 265-0098

_____ _____

Signature Date

_____ _____

Relationship to patient Witness

ROI32A

PHYSICIAN CARE

PEDIATRIC MEDICAL HISTORY

Patient information

Name: _____ Date of birth: _____ Date: _____

Reason for visit: _____

Referred by: _____ Previous family physician: _____

IT IS THE RESPONSIBILITY OF THE PARENTS TO PROVIDE A COPY OF THE IMMUNIZATION RECORD.

Name/s and relationship/s of those living with the child:

_____

_____

Legal guardian of the child: _____

Please list the name/s of those who are authorized to bring the child in for medical exams, including immunizations:

_____

_____

Name/s and phone number/s of those we may discuss the patient's medical history with (phone and/or office visits):

_____

_____

The child's parents are: ☐ Married ☐ Divorced ☐ Separated ☐ Unmarried ☐ Widowed

Is there any legal reason why we cannot discuss the child's medical care with either parent?

_____

_____

Education/Development/Social

Does the child attend daycare? ☐ No ☐ Yes

What school does the child attend? _____ Grade: _____
(If homeschooled, please list)

Doe the child receive any special services such as physical therapy, speech therapy, occupational therapy or special education?

☐ No ☐ Yes: _____

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

☐ No ☐ Yes: _____

Does the child participate in organized sports or hobbies?

☐ No ☐ Yes: _____

Are there any smokers in the house? ☐ No ☐ Yes

Family history

Check any that the child has a family history of from the following:

- ☐ Diabetes
- ☐ High blood pressure
- ☐ Childhood heart disease
- ☐ Asthma
- ☐ Allergies
- ☐ Learning problems
- ☐ Seizures
- ☐ Sickle Cell Anemia
- ☐ Birth defects
- ☐ Sudden death
- ☐ Other pertinent family medical history:

_____

Medical history

Please list the child's medical problem and check all that apply.

☐ Asthma ☐ Allergic Rhinitis ☐ Attention Deficit Disorder (ADD) ☐ Migraines ☐ Seizures ☐ Heart Murmur

_____

Has the child ever been hospitalized? If so, when for what?

☐ No ☐ Yes: _____

Has the child ever had any surgeries? Check all that apply.

☐ None ☐ Appendectomy ☐ Tonsillectomy ☐ Adenoidectomy ☐ Tubes in ears ☐ Gall Bladder

☐ Orthopedic ☐ Other: _____

What medications does the child take?

_____

_____

Does the child have any medication allergies?

☐ No ☐ Yes, list: _____

Reaction:_____

What specific health concerns do you wish to address today?

_____

_____

_____

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

For teen girls

Have you started your period? ☐ No ☐ Yes, at age: _____ Are your period every month? ☐ No ☐ Yes

How long do they last? _____ Are they painful? ☐ No ☐ Yes

Have you ever been pregnant? ☐ No ☐ Yes

For teen boys and girls

Do you: smoke? ☐ No ☐ Yes Drink alcohol? ☐ No ☐ Yes Use illicit drugs? ☐ No ☐ Yes

Are you sexually active? ☐ No ☐ Yes - do you practice "safe" sex? ☐ No ☐ Yes

Have you ever had a child? ☐ No ☐ Yes

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 list everything the child has eaten or drunk in the last 24 hours:

_____

_____

_____

_____

_____

Name of person completing this form:_____ Relationship: _____