Blueze Wellness

2412 E Washington St, Ste 4B ● Bloomington, IL 61704
309-585-2116 ● Fax: 309-585-2152
www.bluezewellness.com

2021

PATIENT INFORMATION Date Completed_____

Preferred Pharmacy_____ Pharmacy Location _____

Preferred Hospital or Surgical Facility _____

Name_____
Last Name First Name (Full Name) M.I. Preferred Name Maiden Name

Address_____
Street City and State Zip Code

Home_____Work_____ Cell _____

Preferred Phone: ☐HM ☐WK ☐CELL Emergency Contact:_____ Emergency Phone:_____

Birth Date_____ Age _____ Marital Status __S __M __W __D

Race: ___American Indian / Alaskan Native ___Asian ___Black / African American

___Natural Hawaiian / Pacific Islander___White ___ Other Race ___ Unknown ___ Decline

Ethnicity: ___Hispanic or Latino ___Not Hispanic or Latino ___Unknown ___Decline

Preferred Method of Communication for Appointment and Yearly Reminders: ___Phone ___E-mail ___Text

E-mail: _____

Employed by: _____ Occupation: _____

Spouse's Name:_____

Spouse's Employer: _____ Spouse's Work Phone:_____

How did you hear about us? ___Friend ___Family Member ___Co-Worker ___Radio ___Web Site ___ Print Ad

___ Publication / Article ___Health Fair ___Doctor / ER ___Seize the Deal ___Yellow Pages

Doctor Referral:_____

If patient is a minor, please complete this section:

Guarantor Name: _____
Last Name First Name M.I.

Address _____
Street City and State Zip Code

Guarantor Birth Date _____ Home Phone Number _____

Work Phone Number _____ Relationship to Patient_____

PRIMARY INSURANCE COVERAGE

Name of Policy Holder_____

Patient Relationship to Policy Holder _____

Insurance Company_____

Policy Holder's Date of Birth_____

Policy Holder's SS#_____

SECONDARY INSURANCE COVERAGE

Name of Policy Holder_____

Patient Relationship to Policy Holder _____

Insurance Company_____

Policy Holder's Date of Birth_____

Policy Holder's SS#_____

CONSENT TO TREAT

I hereby authorize employees and agents; including physicians, physician assistants and nurse practitioners; of this medical office to render routine medical care to the patient indicated on this form, obtain medication history, and to fulfill the orders of the physicians; including consultants, associates and assistants of the physician's choice.

Initials

HIPAA AUTHORIZATION

Blueze LLC may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless the facility has obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA privacy regulations or state law. Disclosures of your protected health information for the purposes are described in our Privacy Notice and may be made in writing, orally, or by facsimile.

If there is anyone you would allow us to share information with, please list the names, relationships and phone numbers of those people below.

____ May share my protected health and financial information with:

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

Please mark whether we can share all information with the people listed above or list what you do not want shared:

____ No Restrictions

____ Restrictions: (Please list your requested restrictions) _____

For further explanation or for a copy of our HIPAA Privacy Notice please see the front desk staff or visit our website. This release is effective until revoked by patient with written signature.

Initials

FINANCIAL AGREEMENT

- It is your responsibility to inform our office of any address, telephone number or insurance changes. You may be responsible for additional charges if your primary insurance is terminated during your medical care.
- Your account is to be kept current - accordingly, all self-pay or insurance co-payments, co-insurances, and deductibles will be collected at the time of service. Payable by cash, check, or credit/debit card.
- If you do not have your payment(s), your appointment may be rescheduled.
- You may be asked to schedule another appointment for issues other than the reason for your original appointment.
- A returned check will result in a $50 service charge ***and*** all future payments being required in the form of cash or credit card.
- There is a $75 No Call/No Show fee if you do not give notice of needing to cancel your appointment.
- Refunds will be issued within 4-6 weeks from the date requested, if there are no pending insurance claims.
- If your account is assigned to a collection agency, you will be responsible for any costs incurred in collection of said balance, which will include collection agency fees of 30% , court costs and attorney fees and will not be able to schedule further appointments.

We will submit your insurance claims. However, we must emphasize that as medical providers, our relationship is with you not your insurance company. We attempt to verify your benefits. Please be advised this is only an estimate of your coverage based on the information given to us at the time of the inquiry.

- Not all services are a covered benefit with all insurance plans
- It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance policy.
- You are responsible for any non-covered charges not payable by your insurance policy.
- Although filing your insurance claims is a courtesy extended to you, all charges are always your responsibility.
- We realize that temporary financial problems may affect timely payment. We urge you to contact us promptly for assistance.

I authorize Blueze, LLC to release to my insurance carrier and its agents any information needed to determine the benefits payable under their coverage. I authorize my insurance company and its carriers to disclose any information requested regarding claims for medical benefits. A copy of this authorization may be used in place of the original. I request that payment of authorized medical benefits be made on my behalf to Blueze, LLC for services furnished to me.

Initials

Your signature below indicates that you understand and agree to the above.

Signature of Patient: _____ Date: _____

Signature of Parent/Legal Guardian: _____ Date: _____

We look forward to providing you with the highest quality care and trust. We hope you will find us friendly and helpful.

Updated 1/5/2021 ah

Personal Past Medical History

	Date
Abnormal PAP Smear	
Abnormal Uterine Bleeding	
Anemia	
Anxiety	
Arthritis	
Asthma	
Bleeding Disorder	
Cancer:	
Chickenpox	
Chlamydia	
Deep Vein Thrombosis (DVT)	
Depression	
DES Exposure	
Diabetes	
Eating Disorder:	
Endometriosis	
Epilepsy	
Esophageal Reflux (GERD)	
Fatigue	
Fibrocystic Changes of the Breast	
Fibroids, Uterine	
Gastrointestinal Disorder:	
Genital Warts	
Headache	
Heart Attack / Disease	
Hematuria (Blood in urine)	
Hepatitis	
Herpes Simplex, Genital	
High Blood Pressure	
High Cholesterol	
Human Immunodeficiency Virus (HIV)	
Human Papilloma Virus (HPV)	
Incontinence of Urine	
Infertility, Female	
Irregular Periods	
Irritable Bowel Syndrome	
Kidney Disease:	
Liver Disease	
NONE	
Osteoporosis	
Other STDs:	
Ovarian Cyst	
Pelvic Inflammatory Disease	
Pelvic Mass	
Pelvic Pain	
Polycystic Ovaries	
Postmenopausal Bleeding	
Premenstrual Tension Syndrome (PMS)	
Previous Blood Transfusion	
Psychiatric Problems	
Recent Rash or viral illness	
Respiratory Disorder	
Sexual Dysfunction	
Sickle Cell Anemia	
Stroke	
Thyroid Disorder	
Tuberculosis (TB)	
Urinary Tract Infection	
Uterine Prolapse	
Other:	
Other:	

Health Maintenance

	Date
Last Mammogram	
Last Exam and/or pap	
Last Cholesterol Check	
Last Bone Density	
Last Colonoscopy	

Past Surgical History

	Date
Abdominal Hysterectomy	
Ablation	
Appendectomy (Appendix)	
Back Surgery	
Bladder Surgery	
Breast Surgery	
Cervical Procedure	
Cesarean Section	
Cholecystectomy (Gall Bladder)	
Cryosurgery	
Dilation and Curettage (D & C)	
Ectopic Pregnancy	
Hysteroscopy (Exploration of the Uterus)	
Knee Surgery	
Laparoscopy (Exploration of the Abdomen)	
Lumpectomy (Breast)	
NONE	
Other	
Ovarian Surgery	
Thyroidectomy	
Tubal Ligation / Essure	
Vaginal Hysterectomy	

Allergy List

NO KNOWN ALLERGIES

Allergic to:	Reaction:

Family Medical History

M=Maternal
P=Paternal

Disease Name	Relative	Age onset	
Alzheimer's			M A P A
Blood Disorder			M A P A
Breast Cancer			M A P A
Cervical Cancer			M A P A
Colon Cancer			M A P A
Diabetes			M A P A
Heart Disease			M A P A
High Blood Pressure			M A P A
High Cholesterol			M A P A
Mental Illness / Depression			M A P A
NONE			
Osteoporosis			M A P A
Other			M A P A
Ovarian Cancer			M A P A
Stroke			M A P A
Thyroid Disorder			M A P A
Tuberculosis			M A P A
Uterine Cancer			M A P A

Date Completed:

Patient Name:

DOB:

Height: **Weight:**

Date Completed:

Medication List

Current Medication	Indication	Dosage	Prescribing Doctor

Genetic History

	Disease Name	Relation
	Canavan Disease	
	Congenital Heart Defect	
	Cystic Fibrosis	
	Down Syndrome	
	Hemophilia	
	Huntington Chorea	
	Mental Retardation/Autism	
	Metabolic Disorder (PKU, Diabetes)	
	Muscular Dystrophy	
	Neural Tube Defect/Spina Bifida	
	NONE	
	Other Inherited Genetic or Chromosomal D/O	
	Other:	
	Sickle Cell Anemia	
	Tay-Sachs Disease	
	Thalassemia	

Reproductive History (Menstrual)

Age at 1st Period			
Cycle Interval Days			
Menses Duration Days			
Flow	Light	Medium	Heavy
Last Menstrual Period			
Menopause Status	Pre	Peri	Post
Age Menopause			

Method of Birth Control:

Cervical Cap	Condoms	Depo Provera
Diaphragm	IUD	OCPs (BC pills)
OTC (foam, jelly, etc)	Other	***NONE***
Rhythm Method	Sterilization	Tubal Ligation
Vasectomy	Withdrawal	

Clots	No	Yes
Breakthrough Bleeding	No	Yes
On Hormone Replacement Therapy (HRT)	No	Yes

Reproductive History (Pregnancy)

Pregnancy Summary (including miscarriages, ectopic, abortion)

Total Pregnancy	Full Term	Premature	Abortion Induced	Miscarriage	Ectopics	Multiple	Living

Pregnancy Details (Anesthesia types: Epidural, General, IV Meds, Local, None Spinal)

Date	GA (weeks)	Hrs Labor	Birth WT	Sex	Delivery Type	Anesthesia	Early Labor	Complications

Social History

Have you ever been sexually active? No Yes Are you currently sexually active? No Yes

Marital Status: Bisexual Dating Divorced Engaged Lesbian Married Not-dating Single Widowed

Education Level: High School Some College/AA Degree College Graduate Degree Post Other:

Occupation:

Exercise: Sedentary Active but no formal Minimal (1 per week) Moderate (1-3 per week) Heavy (4 or more per week)

Substance Use:				Name/type	amount	age started	age stop	other information
Tobacco	*Never*	*Current*	*Former*					
Alcohol	*Never*	*Current*	*Former*					
Caffeine	*Never*	*Current*	*Former*					
Prescription ABUSE	*Never*	*Current*	*Former*					
Other	*Never*	*Current*	*Former*					
Illegal Drugs	*Never*	*Current*	*Former*					

Have you engaged in abusive behavior towards others? No Yes

Have you been emotional / physically / sexually abused or threatened by anyone? No Yes

Do you wear your seat belt? No Yes

Updated 5/7/19 AH