Blueze Wellness

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www.bluezewellness.com

2020

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

Who can we Thank for referring you to Blueze Wellness?____

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	**SECONDARY INSURANCE COVERAGE**
Name of Policy Holder__________________________	Name of Policy Holder__________________________
Patient Relationship to Policy Holder ________________________	Patient Relationship to Policy Holder ________________________
Insurance Company____________________________	Insurance Company____________________________
Policy Holder's Date of Birth_____________________	Policy Holder's Date of Birth_____________________
Policy Holder's SS#_____________________________	Policy Holder's SS#_____________________________

CONSENT TO TREAT **2020**

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

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

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.

Please mark appropriate section below:

____ No Restrictions ____ Restrictions: (Please list your requested restrictions)

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

____ May share my protected health and financial information with:

Name: ________________________________ **Relationship:** ____________________

Name: ________________________________ **Relationship:** ____________________

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 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
- 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.

Personal Past Medical History

	Condition	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

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

Past Surgical History

	Procedure	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