PATIENT REGISTRATION FORM

PATIENT INFORMATION (PLEASE PRINT)

Patient's Legal Name: (Last)__________ (First)__________ (Middle)__________

Preferred Full Name (If different from above): __________ Date of Birth (MM/DD/YYYY): __________

Address: __________

City: __________ State: __________ Zip: __________

Phone (Home): __________ (Cellular): __________ (Work): __________

Email Address: __________

Gender Identity:

__ Male __ Female __ Transgender Male to Female __Transgender Female to Male __ Choose not to disclose

__ Additional category not listed: __________

Race:

__ Black/African American __ White/Caucasian __ Asian __ American Indian __ Hawaiian/Pacific Islander __ Hispanic

__ Choose not to disclose __ Other not listed: __________

Preferred Language:

__ English __ Spanish __ American Sign Language __ Japanese __ Mandarin __ Korean __ Arabic __ Swahili __ Russian

__ Hindi __ Gujarati __ Pashto __ Dari __ Farsi __ Urdu __ Vietnamese __ Haitian Creole __ Bosnian/Croatian/Serbian

__ Albanian __ Burmese __ Tagalong __ Portuguese __ Cambodian

__ Other not listed: __________

Patient Social Security Number: __________

RESPONSIBLE PARTY INFORMATION (IF NOT SELF) (Information used for patient balance statements)

Responsible Party: __ Guarantor __ Self

Check here if address/telephone is the same as patient __

Responsible party name: (Last) __________ (First) __________ (Middle) __________

Date of Birth (MM/DD/YYYY): __________

Gender Identity:

__ Male __ Female __ Transgender Male to Female __Transgender Female to Male

__ Additional category not listed: __________

Responsible Party Social Security Number: __________

Address: __________

City: __________ State: __________ Zip: __________

Phone (Home): __________ (Cellular): __________ (Work): __________

INSURANCE INFORMATION: Please provide your insurance card(s) (primary, secondary, etc.) to the front desk at check in.

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: (Last) ____________________ (First) ____________________ (Middle) ____________

Emergency contact relationship to patient: ______________________________ Check here if guardian: __ Guardian

Address: ____

City: ____________________ State: ____________________ Zip: ______________

Phone (Home): ____________________ (Cellular): ____________________ (Work): ____________

Do you have a living will? __ Yes __ No

Medical Power of Attorney? __ Yes __ No

Advance Directive? __ Yes __ No

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT:

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that:

1. You intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended
2. You consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other healthcare providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative: ______________________________ Date: ______________

Printed name of patient or personal representative: ______________________________

Relationship to patient: ______________________________

PATIENT NAME: ____________________

DATE OF BIRTH (MM/DD/YYYY): ____________________

PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

FINANCIAL AGREEMENT

- I acknowledge, that as a courtesy, Mission Family Practice may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges that have not been paid in full including, but not limited to any co-payment, co-insurance, and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

THIRD PARTY COLLECTION

- I acknowledge that Mission Family Practice may use the services of a third-party business associate or affiliated entity as an extended business office for medical account billing and servicing

ASSIGNMENT OF BENEFITS

- I hereby assign to Mission Family Practice/Jeffrey J. Globus, MD any insurance or other third-party benefits available for health care services provided to me.
- I understand that Mission Family Practice has the right to refuse or accept assignment of such benefits.
- I understand that if these benefits are not assigned to Mission Family Practice, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon request.

MEDICARE PATIENT CERTIFICATION AND ASSIGNMENT OF BENEFITS

- I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") of the Social Security Act is correct.
- I request payment of authorized benefits to be made on my behalf to Mission Family Practice by the Medicare. We do not participate in Medicaid/Medical program.

CONSENT TO TELEPHONE CALLS FOR FINANCIAL COMMUNICATIONS

- I agree that, in order for Mission Family Practice or Extended Business Office Servicers and collection agents to service my account or to collect any amounts I may owe, I expressly agree and consent that Mission Family Practice or Billingt Company Servicers and collection agents may contact me by any telephone number that has been provided, or obtained from the telehone number(s) that we have on file, without limitation, regarding services rendered, or my related financial obligations. Methods of contact may include using pre-recorded or artificial voice messages and/or use of an automatic dialing device, as applicable.

A PHOTOCOPY OF THIS CONSENT SHALL BE CONSIDERED AS VALID AS THE ORIGINAL.

Patient/Patient Representative Signature: ____________________ Date (MM/DD/YYYY): ____________

If you are not the patient, please identify your relationship to the patient below by placing a circle around the choices below:

Spouse Guarantor

Parent Healthcare Power of Attorney

Legal Guardian Other (please specify): ____________________

PATIENT HIPPA ACKNOWLEDGEMENT AND CONSENT FORM

Mission Family Practice			
Patient Last Name (Printed)	Patient First Name (Printed)	Middle Initial	Date of Birth (MM/DD/YYYY)

NOTICE OF PRIVACY PRACTICE/CLINIC

__ (Patient/Representative Initials) I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have any questions or any complaints. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

DISCLOSURES TO FRIENDS AND/OR FAMILY MEMBERS

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHO MAY BE CONTACTED? (LIST BELOW)

I give permission for my Protected Health Information to be disclosed for the purpose of communicating results, findings, and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1.			
2.			
3.			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification MUST be written.

COMMUNICATIONS ABOUT MY HEALTHCARE

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

CONSENT FOR PHOTOGRAPHING OR OTHER RECORDING FOR SECURITY AND/OR HEALTH CARE OPERATIONS

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes, and/or the practice's/clinic's health care operation purposes (example: quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

CONSENT TO EMAIL, CELLULAR TELEPHONE, OR TEXT USAGE FOR APPOINTMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS

If at any time I provide an email address or cellular phone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided for you. I agree that I may be contacted at any number that has been obtained or forwarded from that number. These instructions may include, but are not limited to: pre-procedure instructions, educational information, prescription information, post-procedure instructions, follow-up instructions, communications to family or designated representatives regarding my treatment or condition, and reminder messages regarding appointments for medical care.

Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

NOTE: This location uses an Electronic Medical Record that will update all of your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated locations that share an Electronic Health Record in which you have a relationship.

PATIENT HIPPA ACKNOWLEDGEMENT AND CONSENT FORM CONTINUED

Mission Family Practice			
Patient Last Name (Printed)	Patient First Name (Printed)	Middle Initial	Date of Birth (MM/DD/YYYY)

RELEASE OF INFORMATION

I hereby permit this practice/clinic and the physicians or other healthcare professionals involved in my inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service at other affiliated providers may be made available to subsequent affiliated providers to coordinate care and for the purpose of continuity of care. Health care information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare , I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment, and discharge summaries.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and /or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records, decreasing the time needed to access my information, aggregating and comparing my information for quality improvement purposes, and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological or psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions, and/or infectious diseases including, but not limited to: blood borne diseases, such as HIV and AIDS.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Patient or Representative's Signature: ______________________________ Date: ____________________

EMAIL &TEXT POLICY & CONSENT:

Jeffrey J. Globus, MD and associates cannot guarantee the security and confidentiality of an email /Text transmission. Employers and on-line services have the right to access and archive e-mail transmitted through their systems. If your email is a family address, other family members may see your messages, therefore, please be aware that you email at your own risks, as well as any texts. Because of the many internet and email factors beyond our control, we cannot be responsible for misaddressed, misdelivered or interrupted email/text. Your health care provider is not liable for breaches in confidentiality by yourself or a third party.

Email/Texting is best suited for routine matters and simple questions. You should not send us email for urgent or emergency situations or matters requiring immediate response. Your provider will attempt to read and respond promptly, therefore, the staff may call or email you his/her response. Time sensitive issues should be taken care of by telephone.

Please do not use email/text for communications regarding sensitive health information, such as sexually transmitted diseases, AIDS/HIV, mental health or substance abuse.

All emails between you and your provider and staff regarding diagnosis or treatment will be printed and made a part of your health information.

Your provider may forward your email to other staff members as necessary for response. However, you email will not be forwarded outside the office without your authorization.

You are responsible for protecting your password and other means of access to email

I understand and agree to the following:

The email address provided is accurate and I accept responsibility for messages sent to or from this email address

Communication over the internet or using unencrypted email/text may not be secure and there is no assurance of confidentiality of information communicated via unencrypted email / or text.

I have the right at any time to revoke this authorization at any time. May submit request in writing.

I agree to hold Mission Family Practice and individuals associated with Mission Family Practice harmless from any and all claims and liabilities arising from or related to this request to communicate via unencrypted email/text.

Patient Name:____Date of Birth:________________

Patient email address:____

If the patient listed above is a minor or unable to sign, and you are the parent or legal guardian who will use email to communicated about this patient, please sign and completed below:

Print Name:______________________________ Relationship to Patient:______________Date:

Notice to Patients About Open Payments Database

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided below. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs medical devices, and biologics to physicians and teaching hospitals to be made available to the public.

The Open Payments Database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

The purpose of the program is to provide the public with a more transparent health care system.

Patient Name (Printed) ______________________________

Signature: ______________________________ Date: ________

Patient's Name: ______________________________ Date of Birth: ____________________

MEDICATIONS

Medication Name (please include all prescriptions, vitamins and OTC medications)	Dose (ex: 25 mg)	Frequency (ex: 2 times daily)

Please use the back of this form to list any additional medications that you are taking.

ALLERGIES/CONTRAINDICATIONS

____ No Known Drug Allergies

Name	Reaction

Please use the back of this form to list any additional medication, food, or drug allergies that you may have.

MEDICAL HISTORY

	Yes	No		Yes	No		Yes	No
Allergies (seasonal)			Depression			Lupus		
Anemia			Diabetes Mellitus			Myocardial Infarction		
Anxiety			Diverticulitis			Nerve/Muscle Disease		
Arthritis			Diverticulosis			Osteoporosis		
Asthma			Emphysema			Parkinson's Disease		
Anorexia			GERD			PCOS		
Bulimia			Glaucoma			Seizures		
Blood Transfusion			Gastritis			Shortness of Breath		
Cancer			Gallstones			Sickle Cell Anemia		
Cataracts			Heart Murmur			Stroke		
Chest Pain			HIV/AIDS			Scoliosis		
CHF			Hypertension			Substance Abuse		
Clotting Disorder			High Cholesterol			Thyroid Disease		
COPD			Kidney Stones			Tuberculosis		
Cardiomegaly			Kidney/Renal Disease			Ulcers (peptic)		

Other Medical History Not Listed Above: ______________________________

____

SURGICAL HISTORY

	Yes	No		Yes	No		Yes	No
Aneurysm Repair			Cosmetic Surgery			Joint Replacement		
Appendectomy			Eye Surgery			Intestine Surgery		
Brain Surgery			Fracture Surgery			Spine Surgery		
CABG			Hernia Repair			Tubal Ligation		
Cholecystectomy			Hysterectomy			Value Replacement		
Cataract Removal			Oophorectomy			Prostate Surgery		
Colon/Bowel Surgery			Orchiectomy			Transplant		

Other Surgical History Not Listed: ______________________________

Name: ______________________________ Date of Birth: ______________________

FAMILY MEDICAL HISTORY

Relationship	Living?		Alcohol Abuse	Arthritis	Asthma	Autoimmune Disease	Cancer	COPD	Depression	Diabetes	Drug Abuse	Heart Disease	High Cholesterol	Hypertension	Kidney Disease	Learning Disability	Mental Illness	Stroke	Vision Loss	Other/Comments
Mother	☐ Y ☐ N																			
Father	☐ Y ☐ N																			
Sister 1	☐ Y ☐ N																			
Sister 2	☐ Y ☐ N																			
Sister 3	☐ Y ☐ N																			
Brother 1	☐ Y ☐ N																			
Brother 2	☐ Y ☐ N																			
Brother 3	☐ Y ☐ N																			
Daughter 1	☐ Y ☐ N																			
Daughter 2	☐ Y ☐ N																			
Daughter 3	☐ Y ☐ N																			
Son 1	☐ Y ☐ N																			
Son 2	☐ Y ☐ N																			
Son 3	☐ Y ☐ N																			
Mat GM	☐ Y ☐ N																			
Mat GF	☐ Y ☐ N																			
Pat GM	☐ Y ☐ N																			
Pat GF	☐ Y ☐ N																			

__ Adopted

__ Family History Unknown

Other Family History: ______________________________

____

____

____

NAME OF PHARMACY , ADDRESS AND PHONE NUMBER:______________________________

Patient's Name: ______________________________ Date of Birth: ____________________

ALCOHOL SCREEN

Do you drink alcohol? __ Yes __ No

Are you ready to quit? __ Yes __ No

Have you ever had more than 4 drinks in a day? __ Yes __ No

How many times in the past 12 months? __ 0 __ 1 __ 2 __ 3 __ 4 __ 5+

Drinks per week?

	Glasses of wine
	Cans of beer
	Shots of liquor
	Cocktails

SOCIAL HISTORY

Are you sexually active? __ Yes __No __ Not Currently

Partners: __ Male __ Female __ Both

Do you use birth control/protection? __ Yes __ No X

If so, which types?

Abstinence	Coitus Interruptus (the pull out method)	Female Condom	Male Condom
Diaphragm	Implant	Injection	Inserts
IUD	Oral Contraceptive Pill	Patch	Post-Menopausal
Spermicide	Sponge	Surgical Intervention	None
Last Menstrual Period (LMP): ____________ C-sections______#	# of pregnancies:______ # of abortions:________	# births:____	# miscarriages:_______ menopause? If so, year:_______

Drug Use? __ Yes __ No

Use/Week? ____ times per week

Types used:

☑

	Amphetamines		Amyl Nitrate		Anabolic Steroids		Barbiturates		Benzodiazepines
	Crack Cocaine		Cocaine		Codeine		Fentanyl		Gamma Hydroxybutyrate
	Hashish		Heroin		Hydrocodone		Hydromorphone		Ketamine
	LSD		Marijuana		Ecstasy/Molly		Mescaline		Flakka/Gravel
	Methamphetamine		Methaqualone		Methylphenidate		Morphine		Nitrous Oxide
	Opium		Oxycodone		PCP		Psilocybin Mushrooms		Solvent Inhalants
	Other:								

Patient's Name: ______________________________ Date of Birth: ____________________

SOCIAL HISTORY CONTINUED

Tobacco Use? __ Yes __ No Vape Use? __ Yes __ No

If so? Are you ready to quit? __ Yes __ No USE SNUFF ? __YES __NO CHEWING TOBACCO? __YES __NO

Check One:

__ Current Smoker # Packs per day: ____

__ Former Smoker Quit Date: ____________ #Packs per day: ____

__ Current Smokeless Tobacco Use

__ Former Smokeless Tobacco use Quit Date: ____________

Comments: ____

SOCIOECONOMIC HISTORY

Occupation: ______________________________________ ____ Retired

Employer: ______________________________________ ____ Unemployed

Check One: ____ Single ____ Engaged ____ Married ____ Divorced ____ Widow ____ Widower

Spouse/Significant Other/Life Partner's Name: ______________________________

How Many Children? ____________________

Who Do You Live With? ____________________

HEALTH MAINTENANCE

Please document the date of last completion and the result if appropriate for the following:

Screening	Date Completed	Results/Comments
Pap Smear/ Pelvic Exam		Normal or Abnormal
Mammogram		Normal or Abnormal
Colonoscopy		Normal or Abnormal
DEXA/Bone Density Scan		Normal or Abnormal
PSA (prostate)		Normal or Abnormal
Eye Exam		Normal or Abnormal
Diabetic Foot Exam		Normal or Abnormal

MENINGOCCUS VACCINES

COVID 19 VACCINE /BOOSTERS		
FLU VACCINE		
TB test--PPD OR QUANTIFERON TB BLOOD		
PNEUMONIA VACCINE		Which PCV ---13,15,20, or PPSV 23(CIRCLE)
SHINGLES VACCINE (SHINGRIX &/OR ZOSTAVAX (CIRCLE)		
HEPATITIS B		
VARICELLA (CHICKENPOX)		
MEASLES,MUMPS,RUBELLA (MMR)		
TETANUS DIPHTHERIA (TD)		
TETANUS,DIPHTHERIA,PERTUSSIS (Tdap)		
HEPATITIS A VACCINE		
GARDASIL (HPV)		
ABDOMINAL AORTIC ANEURYSM SCREENING		NORMAL OR ABNORMAL
LOW DOSE CT OF CHEST		NORMAL OR ABNORMAL

PLEASE INDICATE IF YOU DO OR DO NOT NEED HELP PERFORMING THESE ROUTINE TASKS

FEEDING YOURSELF	☐ YES	☐ NO	IF YES, WHO HELPS?________
GETTING FROM BED TO CHAIR	☐ YES	☐ NO	IF YES, WHO HELPS?________
GETTING TO THE TOILET	☐ YES	☐ NO	IF YES, WHO HELPS?________
GETTING DRESSED	☐ YES	☐ NO	IF YES, WHO HELPS?________
BATHING OR SHOWERING	☐ YES	☐ NO	IF YES, WHO HELPS?________
USING THE TELEPHONE	☐ YES	☐ NO	IF YES, WHO HELPS?________
TAKING YOUR MEDICINES	☐ YES	☐ NO	IF YES, WHO HELPS?________
PREPARING MEALS	☐ YES	☐ NO	IF YES, WHO HELPS?________
SHOPPING FOR GROCERIES	☐ YES	☐ NO	IF YES, WHO HELPS?________
DRIVING	☐ YES	☐ NO	IF YES, WHO HELPS?________
CLIMBING A FLIGHT OF STAIRS	☐ YES	☐ NO	IF YES, WHO HELPS?________
MANAGING MONEY (TRACKING EXPENSES/PAYING BILLS)	☐ YES	☐ NO	IF YES, WHO HELPS?________
WALKING ACROSS THE ROOM (WITH A CANE/WALKER)	☐ YES	☐ NO	IF YES, WHO HELPS?________
MODERATELY STRENUOUS HOUSEWORK (LAUNDRY)	☐ YES	☐ NO	IF YES, WHO HELPS?________
SHOPPING FOR PERSONAL ITEMS (TOILETRIES/MEDICINES)	☐ YES	☐ NO	IF YES, WHO HELPS?________

CHECK YES, NO, OR SOMETIMES FOR EACH QUESTION

DO YOU FIND IT DIFFICULT TO FOLLOW A CONVERSATION IN A CROWDED ROOM?	☐ YES	☐ NO	☐ SOMETIMES
DO YOU FEEL THAT PEOPLE ARE MUMBLING OR NOT SPEAKING CLEARLY?	☐ YES	☐ NO	☐ SOMETIMES
DO YOU EXPERIENCE DIFFICULTY FOLLOWING DIALOGUE IN A THEATER?	☐ YES	☐ NO	☐ SOMETIMES
DO YOU FIND YOURSELF ASKING PEOPLE TO SPEAK UP OR REPEAT THEMSELVES?	☐ YES	☐ NO	☐ SOMETIMES
DO YOU HAVE ANY VISION DIFFICULTIES (GLASSES/CONTACTS)	☐ YES	☐ NO	☐ SOMETIMES
DO YOU HAVE TROUBLE WITH YOUR MEMORY?	☐ YES	☐ NO	☐ SOMETIMES
DO YOU FEEL SAFE IN YOUR LIVING ENVIRONMENT?	☐ YES	☐ NO	☐ SOMETIMES
DO YOU EXPERIENCE RINGING/NOISES IN YOUR EARS?	☐ YES	☐ NO	☐ SOMETIMES
DO YOU HAVE SOMEONE AVAILABLE TO HELP YOU IF NEEDED?	☐ YES	☐ NO	☐ SOMETIMES
HAVE YOU FALLEN IN THE PAST YEAR?	☐ YES	☐ NO	☐ SOMETIMES
HAVE YOU FALLEN 2 OR MORE TIMES IN THE PAST YEAR?	☐ YES	☐ NO	☐ SOMETIMES
ARE YOU AFRAID OF FALLING?	☐ YES	☐ NO	☐ SOMETIMES
DO YOU SOMETIMES HAVE DIFFICLTY GETTING TO THE RESTROOM "IN TIME"?	☐ YES	☐ NO	☐ SOMETIMES
DO YOU SOMETIMES HAVE URINARY ACCIDENTS WHEN SNEEZING OR COUGHING?	☐ YES	☐ NO	☐ SOMETIMES
DO YOU HAVE IN BOWEL INCONTINENCE?	☐ YES	☐ NO	☐ SOMETIMES
DO YOU FEEL LITTLE INTEREST/PLEASURE IN DOING THINGS?	☐ YES	☐ NO	☐ SOMETIMES
DO YOU FEEL DOWN, DEPRESSED OR HOPELESS?	☐ YES	☐ NO	☐ SOMETIMES
DO YOU HAVE CHRONIC PAIN?	☐ YES	☐ NO	☐ SOMETIMES
HOW MUCH BODY PAIN DO YOU HAVE ON A SCALE OF 0-10 (0 NO PAIN, 10 SEVERE PAIN) PLEASE CIRCLE NUMBER.	0 1 2 3 4 5 6 7 8 9 10		

DO YOU HAVE AN ADVANCED DIRECTIVE (LIVING WILL)? ☐ YES ☐ NO

______________________________   ____/____/____

AUTHORIZED SIGNATURE   DATE