Chart #_____

Date: _____

NEW PATIENT INFORMATION

GENERAL INFORMATION

Name: _____
(Last) (First) (Middle)

Responsible Party: _____
(Last) (First) (Middle)

Address: _____
(Street) (City) (State) (Zip Code)

Birthdate: __ __ / __ __ / __ __ __ __ Social Security Number (SSN): _____-_____-_____

Age: _____

Sex:
____Male
____Female

Marital Status:
____Divorced
____Legally Separated
____Married
____Single
____Widowed

Race: (please check one)
____ African American
____ Asian
____ Hispanic or Latino
____ Pacific Islander
____ White
____ Other

Ethnicity: (please check one)
____ Hispanic or Latino
____ Not Hispanic or Latino

Employer: _____Phone Number: _____

Who Referred you to Healthways? _____

CONTACT INFORMATION

Home Phone: (___) _____-_____ would you like a text or email reminder? Y/N

Work Phone: (___) _____-_____ Signature: _____

Cell Phone: (___) _____-_____

Email Address: _____

CIRCLE ALL ALLERGIES:

Ace Inhibitors	Animal Hair	Antihistamines	Bee Sting
Cat Hair	Cephalosporin	Dog Hair	Egg/Poultry
Environmental Allergy	Fish Product Derivatives	Gluten Protein	Influenza Virus Vaccines
Lactose	Latex	Levodopa	Macrolides
Milk Products	Mumps vaccine	Niacin	NSAIDS
Peanut	Penicillin	Pollen	Quinolones
Ragweed	Salicylates	Shellfish	St. John's Ward
Sulfa (Sulfonamide Antibiotics)	Tetanus Toxoid	Tetracycline	Tricyclic Compounds
Vitamin C	Watermelon		

Other: _____

Please list all Medications and any Supplements you are taking:

Name of Medication or supplement and Dosage:

_____

_____

_____

_____

Social History:

Do you smoke? Yes No

Have you ever smoked? Yes No

Cigarettes Cigars Chew Tobacco Dipping Tobacco

How many per day? _____ How many Years? _____ Last used? _____

Do you drink alcohol? Yes No

Beer Wine Hard Alcohol

How much per day? _____ Years Used _____ Last used _____

Do you Drink Caffeine? Yes No

How much each day?_____

Do you use illicit drugs? Yes No

Have you ever used illicit drugs? Yes No

Do you Exercise? Yes No

If yes how often?_____

Any Family History of the following cancers:

If Yes who and what age when diagnosed if known:

Y / N Breast Cancer:

Y / N Uterine Cancer:_____

Y /N Ovarian Cancer: _____

Y / N Colorectal Cancer:_____

Females Only:

Last Menstrual cycle: _____

Menopausal Status: _____

Gravida - # of Pregnancies: _____

Para # of birth after 20 weeks: _____

# of Miscarriages or Abortions:_____

Please Indicate If Maternal Grandma (MGM), Maternal Grandpa (MGF), Paternal Grandma (PGM),

Paternal Grandpa (PGF), Mother (M), Father (F), Brother (B), Sister (S) Also if Alive (A) Deceased (D) :

Anemia			Anxiety			Arthritis			Asthma		
BPH			Back Problem			Breast Ca			CAD		
CHF			COPD			Cancer			Cholesterol High		
Dementia			Depression			Dermatitis			Diabetes		
Epilepsy			GERD			Glaucoma			Gout		
HIV			Headache			Hepatitis			Hypertension		
MI			Migraine			Pneumonia			Renal Stone		
Stroke			TB			Thyroid Disease			Ulcer (GI)		

CIRCLE ALL PAST MEDICAL HISTORY CONDITIONS:

Anemia	Anxiety	Arthritis	Asthma
BPH	Back Problem	Breast Cancer	CAD
CHF	COPD	Cancer	Cholesterol High
Dementia	Depression	Dermatitis	Diabetes
Epilepsy	GERD	Glaucoma	Gout
HIV	Headache	Hepatitis	Hypertension
MI	Migraine	Pneumonia	Renal Stone
Stroke	TB	Thyroid Disease	Ulcer (GI)

Other: _____

CIRCLE ALL SURGERIES:

AAA Repair	Aortic Aneurysm	Appendectomy	Breast Augment
Breast Reduction	CABG	Carotid Endarterectomy	Cataract Extract
Cesarean Section	Cholecystectomy	Colectomy	Duodenal Ulcer
ESWL	Ectopic Pregnancy	Fracture	Gall Bladder
Gastric Banding	Heart Valve	Hernia Abdominal	Hip Fracture
Hip Surgery	Hysterectomy	Intestinal By-Pass	Knee Arthroscopy
Knee Surgery	LS Spine Surgery	Lasik	Mastectomy
Oophorectomy Uni	PTCA	PVD Procedure	Pacemaker
Prior Surgeries	Prostate Biopsy	Prostatectomy Retro	Should. Arthroscopy
Shoulder Surgery	Synovectomy (Nasal)	Splenectomy	TURP
Thyroidectomy	Tonsillectomy	Tubal Ligation	Vasectomy

Healthways Medication History Authorization

I, _____(Print patient Name), authorize Healthways PLLC to access my medication history; if available through Healthfusion software to be added to my Healthways electronic record.

Patient or Guardian Signature:_____

Date:_____

Privacy Policy

The following page is the last page of the Healthways patient privacy policy. Please sign and date the bottom of the form. If you would like to receive the full copy of this privacy policy, the receptionists will be happy to print you a copy. The full copy of the privacy policy is located in the waiting room, as well as on our website.

Thank you.

We may deny your request for an amendment if it is not in writing or does not include a reason for wanting the amendment. We also may deny your request if the information: a) was not created by us, unless the person or entity that created the information is no longer available to amend the information, b) is not part of the information maintained by the Practice, c) is not information that you would be permitted to inspect and copy or d) is accurate and complete.

If your request is granted the Practice will make the appropriate changes and inform you and others, as needed or required. If we deny your request, we will explain the denial in writing to you and explain any further steps you may wish to take.

Right to an Accounting of Disclosures – You have the right to request an accounting of disclosures. This is a list of certain disclosures we have made regarding your PHI. To request an accounting of disclosures, you must write to the Practice's Privacy Officer. Your request must state a time period for the disclosures. The time period may be for up to six years prior to the date on which you request the list, but may not include disclosures made before April 14, 2003.

There is no charge for the first list we provide to you in any 12-month period. For additional lists, we may charge you for the cost of providing the list. If there will be a charge, we will notify you of the cost in advance. You may withdraw or change your request to avoid or reduce the fee.

Certain types of disclosures are not included in such an accounting. These include disclosures made for treatment, payment or healthcare operations; disclosures made to you or for our facility directory; disclosures made with your authorization; disclosures for national security or intelligence purposes or to correctional institutions or law enforcement officials in some circumstances.

Right to a Paper Copy of this Notice – You have the right to receive a paper copy of this Notice of Privacy Practices, even if you have agreed to receive this Notice electronically. You may request a paper copy of this Notice at any time.

Right to File a Complaint – You have the right to complain to the Practice or to the United States Secretary of Health and Human Services (as provided by the Privacy Rule) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. To file a complaint with the United States Secretary of Health and Human Services, you may write to: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, DC 20201. All complaints must be in writing.

To obtain more information about your privacy rights or if you have questions about your privacy rights you may contact the Practice's Privacy Officer as follows:

Name: **Troy Wollmann**

Address: **1033 Basin Ave., Bismarck, ND 58504**

Telephone No.: **701-223-6613**

We encourage your feedback and we will not retaliate against you in any way for the filing of a complaint. The Practice reserves the right to change this Notice and make the revised Notice effective for all health information that we had at the time, and any information we create or receive in the future. We will distribute any revised Notice to you prior to implementation.

I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Patient: _____ Date: _____