Saline Health System
Saline Clinics

NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name:____
Last First Middle

Date of Birth:______________ Patient Sex:______________

Social Security Number:______________________________

Mailing Address:____________________________________

City:_______________________ State:______ Zip:_________

Driver's License Number: _____________________________

Driver's License State:__________ Expiration:_____________

Home Phone:____

Mobile Phone:_______________________________________

Can we send you text messages? Yes No

Work Phone:____

Email Address:_______________________________________

Preferred Contact Method: ☐ Home ☐ Cell ☐Work ☐ Email

PCP Name:____

PCP Phone:____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated

☐ Widowed ☐ Partner

Language: ____

Race:__________________ Ethnicity:____________________

HOW DID YOU HEAR ABOUT US?

☐ Friend/Family Name:_______________________________

☐ Physician Name:___________________________________

☐Hospital ☐Billboard ☐TV ☐Radio ☐Social Media ☐Internet

☐ Other:____

PHARMACY INFORMATION:

Name:____

Address:____

City:_____________________ State:______ Zip:___________

Phone:____

INSURANCE INFORMATION:

Insurance Carrier:_____________________________________

Claims Mailing Address:_______________________________

City:_______________________ State:______ Zip:_________

Group Number:_______________________________________

Member Number:_____________________________________

Policy Holder Information:

Name:____

Social Security Number:_______________________________

Date of Birth:____________ Relation:___________________

EMERGENCY CONTACT INFORMATION:

Name:____

Phone:____________________ Relation:_________________

EMPLOYMENT:

Employer Name:______________________________________

☐Full Time ☐Part Time ☐Retired ☐Disabled ☐Not Employed

IF PATIENT IS A MINOR:

Guarantor Name:_____________________________________

Date of Birth:___________ Relation:____________________

Mailing Address:_____________________________________

City:_______________________ State:______ Zip:_________

Home Phone:____

Cell Phone:____

ASSIGNMENT OF BENEFITS • FINACIAL AGREEMENT

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Saline Clinics, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In an event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature:____

Date:__________

Saline Health System
Saline Clinics

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At Saline Clinics, LLC, we are committed to ensuring your privacy. We are a covered entity pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"). As a covered entity, the Clinic creates protected health information ("PHI") and receives your PHI from other health care providers. You have the right to adequate notice of the uses and disclosures of your PHI that may be created by the Clinic. Clinic must also inform you of your rights with regard to PHI and of the Clinic's legal duties with regard to PHI.

We are required by law to maintain the privacy of your PHI. PHI is information that individually identifies you and concerns:

- your past, present, or future physical or mental health condition;
- the provision of health care to you; or,
- the past, present, or future payment for your health care.

We will only share your PHI in manners described within this Notice. We do not sell your PHI for marketing purposes unless you expressly provide permission to do so.

USES AND DISCLOSURES

We may use and disclose your PHI for each of the following purposes without your written authorization:

1. TREATMENT. We may use or disclose your PHI to provide you treatment. For example, we may provide your PHI to another healthcare provider so he will have the necessary information to treat or diagnose you.
2. PAYMENT. We may use or disclose your PHI to secure payment from you, your insurance company, or any other third party. For example, a bill may be sent to your insurance company that identifies you, your diagnosis, procedures and supplies used.
3. HEALTH CARE OPERATIONS. We may use or disclose your PHI for the operation of the Clinic. For example, your PHI may be utilized by the quality improvement team to continually improve the quality and effectiveness of the services provided by Clinic.
4. APPOINTMENT REMINDERS. We may use or disclose your PHI to contact you to remind you of a medical appointment or to contact you regarding alternative treatment options.
5. BUSINESS ASSOCIATES. We may disclose your PHI to our business associates who perform functions on our behalf or provide us with services. All of our business associates are obligated to protect the privacy and ensure the security of your PHI.
6. DATA BREACH NOTIFICATION PURPOSES. We may disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your PHI.
7. HEALTH OVERSIGHT ACTIVITIES. We may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor government programs and compliance with federal and state laws.
8. TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY. We may use or disclose your PHI when necessary to prevent a serious threat to your health or safety or to the health or safety of others. Disclosure will be limited to someone who would be able to help prevent the threat.
9. ABUSE, NEGLECT, OR DOMESTIC VIOLENCE. We may disclose your PHI to the appropriate law enforcement or government authority if we believe you are the victim of abuse, neglect, or domestic violence.
10. WORKERS' COMPENSATION. We may disclose your PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.
11. SPECIALIZED GOVERNMENT FUNCTIONS. We may disclose your PHI: (1) if you are a member of the armed forces, as required by military command authorities; (2) if you are an inmate or in custody, to a correctional institution or law enforcement official; (3) in response to a request from law enforcement, under certain conditions; (4) for national security reasons authorized by law; or (5) to authorized federal officials to protect the President, other authorized persons or foreign heads of state.
12. LAWSUITS AND DISPUTES. We may disclose your PHI in response to a court or administrative order, a subpoena, a discovery request, or other legal process, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may use or disclose your PHI to defend ourselves in the event of a lawsuit.
13. ORGAN AND TISSUE DONATION. We may disclose your PHI to organ or tissue procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant if you are an organ or tissue donor.
14. CORONER. We may disclose your PHI to coroners to carry out their duties consistent with applicable law.
15. AS REQUIRED BY LAW. We will disclose your PHI as required by federal, state or local law.
16. PERSONAL REPRESENTATIVE. We may disclose your PHI to a person legally authorized to act on your behalf under applicable law or persons you designate to receive PHI.

USES AND DISCLOSURES THAT REQUIRE YOUR WRITTEN AUTHORIZATION

Except as described in this Notice, we will not use or disclose your PHI without your written authorization. Specifically, we may not use or disclose your PHI for each of the following purposes without your written authorization:

1. MARKETING. We must obtain your authorization for any use or disclosure of PHI for marketing except for face-to-face communications made by us to you or situations where we provide you a promotional gift of nominal value. If we receive payment in exchange for marketing, we are required to inform you when we obtain your authorization.
2. SALE OF PHI. We must obtain your authorization for any disclosure of PHI which is a sale of your PHI.

Any authorization by you to disclose PHI must include: a description of the PHI to be used or disclosed; your name; the names of the entities to which we can disclose PHI; a description of the purpose of the PHI; an expiration date, and your signature.

If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose your PHI under that authorization, except to the extent we have already taken action in reliance of your written authorization.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights, subject to certain limitations, regarding your PHI:

1. RIGHT TO INSPECT AND COPY. You have the right to inspect and copy your PHI in our possession. Usually, this will include medical and billing records. We may have up to thirty (30) days to make your PHI available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. We will inform you of any copying costs at the time of your request and you may choose to withdraw or modify your request before the costs are incurred.
2. RIGHT TO A SUMMARY OR EXPLANATION. We can provide you with a summary of your PHI instead of your entire medical record. We can also provide you an explanation of the PHI which has been provided to you, so long as you agree to this alternative form and pay the associated fees.
3. RIGHT TO AN ELECTRONIC COPY OF ELECTRONIC MEDICAL RECORDS. If your PHI is maintained in an electronic format, you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. Your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.
4. RIGHT TO GET NOTICE OF A BREACH. You have the right to be notified in the event there is a breach of your unsecured PHI that poses a significant risk of financial, reputational, or other harm to you.
5. RIGHT TO REQUEST AMENDMENTS. You may request your PHI be amended if you believe the PHI is incorrect or incomplete. You have the right to request an amendment for as long as the information is kept by us. A request for amendment must be in writing to the Privacy Officer at the address provided at the end of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
6. RIGHT TO AN ACCOUNTING OF DISCLOSURES. You have the right to request a list of the disclosures we made of your PHI. The right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, for a resident directory, to your personal representatives or family involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Your request must specify a time period, which may not be longer than six (6) years from the date of your request for an accounting. Additionally, limitations are different for electronic health records. The first accounting of disclosures you request within any twelve (12) month period will be free. For additional requests within the same period, we may charge you the reasonable costs of provide the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.
7. RIGHT TO REQUEST RESTRICTIONS ON USES AND DISCLOSURES. You have the right to request a restriction or limitation of disclosure of your PHI. In general, we are not required to agree to any restrictions you request. To request a restriction on who may have access to your PHI, you must submit a written request to the Privacy Officer. Your request must state the specific restriction requested and to whom you want the restriction to apply. If we do agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. If you pay for the full amount of your treatment or product out-of-pocket, we will honor requests to restrict disclosures to health plans or insurers for payment or health care operation purposes unless required by law or used for treatment purposes.
8. RIGHT TO ALTERNATIVE COMMUNICATIONS. You may request we contact you about your PHI only in writing or at a different address than your residence. We will accommodate reasonable requests. To make a request, you must submit your request in writing to the Privacy Officer.
9. RIGHT TO A PAPER COPY OF THIS NOTICE. You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

For more information or to report a problem with regard to your PHI, you may contact our Privacy Officer at 501-776-6093. If you believe your privacy or security rights have been violated, you may file a complaint with the Privacy Officer or the Secretary of the Department of Health and Human Services, Office of Civil Rights. To file a complaint with the Secretary, mail it to:

Secretary of the U.S. Department of Health and Human Services
200 Independence Ave. S.W.
Washington, D.C. 20201
202-619-0257

We will not retaliate against you for reporting a problem or filing a complaint.

REVISIONS TO NOTICE

We reserve the right to revise or change the terms of this Notice. The revisions or changes will apply to your PHI we already possess and any PHI we receive in the future. We will post a copy of the current Notice in the lobby. If we change our Notice, you may obtain a copy of the revised notice by visiting our website at**www.salinememorial.org**, or upon request may receive a hard copy.

SALINE CLINICS, LLC.

PATIENT BILL OF RIGHTS and RESPONSIBILITIES

2019

We encourage you, as a patient at Saline Clinics, to speak openly with your health care team, take part in your treatment choices, and promote your own safety by being well informed and involved in your care. Because we want you to think of yourself as a partner in your care, we want you to know your rights as well as your responsibilities during your clinic visit. We invite you and your family to join us as active members of your care team.

Your Rights

1. You have the right to receive considerate, respectful and compassionate care in a safe setting regardless of your age, gender, race, national origin, religion, sexual orientation, gender identity, or disabilities.
2. You have the right to receive care in a safe environment free from all forms of abuse, neglect, or mistreatment.
3. You have the right to be told the names of your doctors, nurses, and all health care team members directing and/or providing your care.
4. You, and family, and friends with your permission, have the right to participate in decisions about your care, treatment and services provided, including the right to refuse treatment to the extent permitted by law. If you leave the hospital against the advice of your doctor, the hospital and doctors will not be responsible for any medical consequences that may occur.
5. You have the right to agree or refuse to take part in medical research studies. You may withdraw from a study at any time without impacting your access to standard care.
6. You have a right to make decisions about your care and to refuse treatment to the extent permitted by law and be informed of the medical actions.
7. You have the right to make an advance directive, appointing someone to make health care decisions for you if you are unable. If you do not have an advance directive, we can provide you with information and help to complete one.
8. Effective management of pain as appropriate to the medical diagnosis or surgical procedure.
9. Consideration of privacy in case discussion, consultation, examination and treatment. You may request transfer to another room if another patient or visitor in your room is unreasonably disturbing to you.
10. You have the right to be told by your doctor about your diagnosis and possible prognosis, the benefits, and risks of treatment, and the expected outcome of treatment, including unexpected outcomes.
11. You have the right to receive detailed information about your hospital and physician charges.
12. You have the right to have your pain assessed and to be involved in decisions about treating your pain.
13. You can expect full consideration of your privacy and confidentiality in care discussions, exams, and treatments. You may ask for an escort during any type of exam.
14. You have the right to communication that you can understand. The hospital will provide sign language and foreign language interpreters as needed at no cost. Information given will be appropriate to your age, understanding, and language. If you have vision, speech, hearing, and /or other impairments, you will receive additional aids to ensure your care needs are met.
15. You can expect that all communication and records about your care are confidential, unless disclosure is permitted by law. You have the right to see or get a copy of your medical records. You may add information to your medical record by contacting the Health Information Management Department. You have the right request a list of people to whom your personal health information was disclosed.
16. You have a right to give or refuse consent for recordings, photographs, films or other images to be produced or used for internal or external purposes other than identification, diagnosis, or treatment. You have the right to withdraw consent up until a reasonable time before the item is used.
17. You have a right to information about hospital policies that relates to your care. You have the right to express a concern or make a complaint.
18. If you or a family member needs to discuss an ethical issue related to your care, the hospital committee can be notified by contacting the nursing department.
19. You have the right to voice your concerns about the care you receive. Concerns expressed will not affect your care delivery. If you have a problem or complaint, you may talk with your doctor, nurse director, or administrator. If not resolved, the Saline Memorial Hospital contact number is 501-776-6012. To file complaints with the Arkansas Department of Health 5800 West Tenth, Suite 400, Little Rock, Arkansas 72204 or call 1-501-661-2201 or Fax 501-661-2165; e-mail: adh.hfs@arkansas.gov.
20. You or your support person (when appropriate) have the right to be informed subject to his or her consent to receive the visitors whom he or she designates including, but not limited to, a spouse, a domestic partner (including same sex domestic partner) another family member, or friend, and his or her right to withdraw or deny such consent at any time.
21. You have the right to be informed of the patient's rights in advance of furnishing or discontinuing patient care whenever possible.

Patient Responsibilities:

1. You are expected to provide complete and accurate information, including your full name, address, home telephone number, date of birth, Social Security number, insurance carrier and employer, when it is required.
2. You are expected to pay your bills in a timely manner.
3. You should provide the hospital and/or your doctor with a copy of your advance directive if you have one.
4. You are expected to provide complete and accurate information about your health and medical history, including present condition, past illnesses, hospital stays, medicines, vitamins, herbal products, and any other matters that pertain to your health, including perceived safety risks.
5. You are expected to ask questions when you do not understand information or instructions. If you believe you can't follow through with your treatment plan, you are responsible for telling your doctor. You are responsible for outcomes if you do not follow the care, treatment and service plan.
6. You are responsible for reporting unexpected changes in your condition to the responsible practitioner.
7. You are expected to actively participate in your pain management plan and to keep your doctors and nurses informed of the effectiveness of your treatment.
8. You are expected to treat all hospital staff, other patients and visitors with courtesy and respect; abide by all hospital rules and safety regulations, and be mindful of noise levels, privacy and number of visitors.
9. You have the responsibility to keep appointments, be on time, and call your health care provider if you cannot keep your appointments.
10. You are responsible for reporting whether you clearly understand a contemplated course of action and what is expected of you.

Saline Clinics Nondiscriminatory Statement

Saline Clinics, LLC does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment. For further information about this policy, contact: Section 504 Coordinator, 501-776-6000.

Saline Health System
Saline Clinics

No-Show Policy

Description

"No Show" shall mean any patient who fails to arrive for a scheduled appointment. "Late Cancellation" shall mean any patient who cancels an appointment less than 4 hours before their scheduled appointment. "Late Arrival" shall mean any patient who arrives at the clinic 15 minutes after the expected arrival time for the scheduled appointment.

Policy

It is the policy of the practice to monitor and manage appointment no-shows and late cancellations. Saline Clinic's goal is to provide excellent care to each patient in a timely manner. If it is necessary to cancel an appointment, patients are required to call or leave a message at least 4 hours before their appointment time. Notification allows the practice to better utilize appointments for other patients in need of prompt medical care

Procedure

A. A patient is notified of the appointment "No-Show, Late, & Cancellation Policy" at the time of scheduling. This policy can and will be provided in writing to patients at their request.

B. Established patients:
   a. Appointment must be cancelled at least 4 hours prior to the scheduled appointment time.
   b. In the event a patient arrives late as defined by "late arrival" to their appointment, and cannot be seen by the provider on the same day, they will be rescheduled for a future clinic visit, if available.
   c. In the event a patient has incurred three (3) documented "no-shows" and/or "same-day cancellations," the patient may be subject to dismissal from the clinic. The patient's chart is reviewed and dismissals are determined by a physician only, no exceptions.

C. New patients:
   a. Appointment must be cancelled at least 4 hours prior to scheduled appointment time.
   b. In the event of a no-show, Saline Clinics may require a new referral sent from the referring physician.
   c. In the event a patient arrives late as defined by "late arrival" to their appointment, Saline Clinic reserves the right to request a new referral sent from the referring physician.
   d. In the event of three (3) documented "late cancellations," the patient may be subject to dismissal from the clinic. The patient's chart is reviewed and dismissals are determined by a physician only, no exceptions.

Saline Health System
Saline Clinics

ACKNOWLEDGEMENTS

I acknowledge that I have received (not necessarily read) the following documents:

_________ Notice of Privacy Practices
Initials

_________ Patient Rights and Responsibilities
Initials

_________ No Show/Late Cancellation Policy
Initials

____   ________________________
Signature of Patient or Representative   Date

____
Relation to the Patient

RELEASE OF INFORMATION

I, ______________________________, authorize Saline Clinics, LLC to share protected health information with the individuals listed below:

Please print the name clearly.

____________________________________ Relationship: __________________ Phone: __________________

____________________________________ Relationship: __________________ Phone: __________________

____________________________________ Relationship: __________________ Phone: __________________

I understand that I can withdraw the above at any time, with written request, I also understand that it is my responsibility to ensure that my family member or signification other do not divulge or use the information in any way without discussing with me first.

____   ______________________
Signature   Date

Saline Health System
Saline Clinics

For Official Use Only: MR#: _______________

AUTHORIZATION TO RELEASE HEALTH INFORMATION

ALL ELEMENTS ARE REQUIRED PRIOR TO INFORMATION BEING RELEASED

Patient Name: ____ Date of Birth: ____________________

1. Who is authorized to disclose the information? Saline Clinics, LLC
2. Who is authorized to receive the information? Name: ______________________________________

   Complete Address: ____

   City: ______________________________ State: _________ Zip Code: __________

3. I understand that I may be charged for the costs of copying the information to be released.
4. The specific information to be requested or released is:

   List the dates of service: ____

   ❑ Clinic Report ❑ Lab ❑ Operative Report ❑ Physical ❑ Shot Record ❑ X−Ray Report

   ❑ Other: ____

5. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.
6. I understand that Saline Clinics may be paid for the cost of copying the information released.
7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I may inspect or obtain a copy of any information used/disclosed under this authorization.
8. I understand that I may revoke this authorization in writing at any time by delivering a copy of my revocation to Saline Clinics except to the extent that action has been taken in reliance on this authorization. **This authorization expires: 1 year from date signed.**
9. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental services and/or treatment for alcohols and drug abuse.

PLEASE INCLUDE A COPY OF A PHOTO ID

____ ____________________________

Signature of Patient or Representative Date

____ ____________________________

Phone Number Relationship to Patient

This is a confidential record: Please answer the following questions as completely as you can. If you are uncertain about the question, leave it blank. Information contained here will not be released without your authorization.

Name:______________________________________ Date:_______________________

REASON/SYMPTOMS FOR TODAYS VISIT:

____

____

ALLERGIES

□ No known allergies □ Latex Allergy □ Iodine/Shell Fish

DRUG/OTHER: REACTION:

_________________________________ ____________________________________

_________________________________ ____________________________________

_________________________________ ____________________________________

_________________________________ ____________________________________

MEDICATION RECORD: *Please list your preferred pharmacy that you currently use to fill your prescriptions*

Name of Pharmacy _____________________________

City________________________ State______________

Pharmacy's Phone #______________________________

MEDICATIONS: *(prescription, over the counter, herbal supplements, etc.)*

□ No medications □ List copied and attached

Medication/Strength:	Dose/Frequency:	Reason for medication:

PAST MEDICAL HISTORY: PLEASE CHECK ALL THAT APPLY TO YOU

□ Arthritis
□ Arrhythmia
□ Bladder problems
□ Blood clots in □ Legs □Lungs? Require blood thinners? □YES or □NO
□ Blood transfusion
□ Bleeding disorder
□ Cancer? What type or where_________________________________ Did you receive □ Chemo □ Radiation?
□ High Cholesterol or Lipids
□ Diabetes □diet controlled □on oral medication □ on insulin
□ High Blood Pressure
□ Liver problems □ Cirrhosis □ Hepatitis, Type_________
□ Lung Problems □ COPD □ Tuberculosis □ Emphysema □ Asthma □ Sleep Apnea □ Shortness of Breath
□ Other □ Lung Cancer
□ Mental health problems □Depression □ Bipolar □Dementia □ Other
□ Nerve or neuro problems □ Seizures □ Migraines
□ Stroke/TIA Any residual deficits?____
□ Thyroid Problems □ on medication
□ Coronary Artery Disease □ Heart Attack □ Congestive Heart Failure □Arrhythmia
□ Peripheral Vascular Disease
□ Skin Disorders □psoriasis □ skin cancer- □basal □ squamous □melanoma

PREVENTATIVE HEALTH HISTORY:

Influenza Vaccine? □ Yes Date:__________ □ No Pneumonia Vaccine? □ Yes Date:__________ □ No
Colonoscopy? □ Yes Date:__________ □ No Result? □ Normal □ Abnormal

Females Only:

Have you had a Pap Smear? □ Yes Date:__________ □ No Result? □ Normal □ Abnormal
Have you had a Mammogram? □ Yes Date:__________ □ No Result? □ Normal □ Abnormal

PAST SURGICAL HISTORY: □ No Prior Surgeries

Procedure	**Date if known**	
□ Appendectomy	__________	
□ Back Surgery	__________	□ Lower □ Neck
□ Breast Biopsy	__________	□ Left □ Right
□ Colon Surgery	__________	
□ Colonoscopy/EGD	__________	□ Polyps
□ Gallbladder	__________	
□ Heart	__________	□ Pacemaker □ Bypass □Stents
□ Hernia	__________	□ Lt Groin □ Rt Groin □ Umbilical □Incisional □ Epigastric
□ Hemorrhoidectomy	__________	
□ Thyroid	__________	
□ Tonsillectomy	__________	

□ Other Surgery ____

PAST HOSPITALIZATIONS: □ No Prior Hospitalization

Where?	Date if known	Why?
__________	__________	______________________
__________	__________	______________________
__________	__________	______________________

FAMILY HISTORY:

Do any of your blood relatives (parents, brothers/sisters, grandparents, aunts/uncles/cousins) have or ever had any of the following diseases? Please specify if relation is maternal or paternal.

□ NONE □ Unknown Family History

	Relationship:	Age:	State of Health:	Age at Death:
□ Cancer and what type	____________________	_________	__________________	_____________
□ Diabetes	____________________	_________	__________________	_____________
□ Heart Disease/Problems	____________________	_________	__________________	____________
□ High Blood Pressure	____________________	__________	__________________	____________
□ Lung Disease/Problems	____________________	__________	__________________	____________
□ Stroke	____________________	__________	__________________	____________
□ Kidney Disease	____________________	__________	__________________	____________
□ Blood Disease	____________________	__________	__________________	____________
□ Other	____________________	__________	__________________	____________

OCCUPATIONAL/SOCIAL HISTORY:

□ Currently Employed □ Retired □ Disabled

Employers Name:_______________________________________Occupation____

Marital Status: □ Single □ Married □ Widowed □ Divorced

Are you willing to accept Blood or Blood products in an emergency? □ NO □YES

Do you Smoke? □ NO □ YES __________packs per day for __________ years
Previous Smoker? □ NO □ YES __________packs per day for __________ years Quit Date:_____________

Do you use smokeless tobacco products? □ NO □ YES What and how much? ____________________________

Do you currently use any form of illegal substances? □ NO □ YES

Do you currently consume any alcohol? □ NO □ YES
If yes, how often? □ Daily □ Weekly □Socially Type? □ Beer □ Wine □ Liquor

SPECIALIST PHYSICIANS: *Please list all other physicians you currently see, including your PCP.*

Physician	**Specialty**	**Location**	**Phone Number**
_____________________	___________________	__________________	______________________
_____________________	___________________	__________________	______________________
_____________________	___________________	__________________	______________________
_____________________	___________________	__________________	______________________

Saline Health System
Saline Clinics

PATIENT HEALTH QUESTIONNAIRE – 9
(PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answer.	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or helpless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead or hurting yourself in some way	0	1	2	3
For office coding:	0 +	_______ +	_______ +	_________
			=Total Score: _______	

If you checked off any problems, how difficulty have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat Difficult	Very Difficult	Extremely Difficult
☐	☐	☐	☐

______________________________ Patient Name & Date of Birth

______________ Todays Date