Coastal Medical
Lifespan. Delivering health with care.®

Dear Patient:

The following questions are designed to collect important information about you and your health. Answering these questions before your office visit will allow more time for a detailed discussion with your provider. Please complete all questions.

PATIENT INFORMATION & PREFERENCES (*Please print or type*)

Last Name:_____First Name:_____M.I. _____

Preferred Name: _____ Date of Birth:_____/_____/_____

Primary Insurance: _____ Subscriber Number: _____

Secondary Insurance: _____ Subscriber Number: _____

YOUR MAJOR HEALTH CONCERNS OR QUESTIONS

What matters most to you about your health? _____

_____

_____

_____

_____

Describe briefly the major medical problem(s) or question(s) that you have: _____

_____

_____

_____

_____

List below all the medications that you take regularly or have taken regularly in the past month (including aspirin products, vitamins, birth control pills, etc.):

Drug	Drug Strength	How often you take the drug each day	Length of time you have taken the drug

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Patient Name (Print): _____ Patient DOB: ____/_____/_____

Do you need medication refills today? ☐ Yes ☐ No If yes, please list below:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Are you having problems affording your medications? ☐ Yes ☐ No

Allergies: List any drug allergies (if any, briefly describe the reaction): _____

Are you allergic to antibiotics (such as penicillin or sulfa)? ☐ Yes ☐ No

Please answer the following questions regarding your Sexual Orientation and Gender Identity:

Birth Sex: ___ Male ___ Female ___ Unknown

What is your Gender Identity:

___ Male ___ Female

___ Female-to-Male (FTM) /Transgender Male/Trans Man ___ Male-to-Female (MTF) / Transgender Female/Trans Woman

___ Genderqueer, neither exclusively male nor female ___ Other: _____

___ Choose not to disclose

What is your Sexual Orientation:

___ Lesbian, gay, or homosexual ___ Straight or heterosexual ___ Bisexual

___ Do not know ___ Choose not to disclose ___ Other: _____

What is your current relationship status?

___ Single ___ Partner ___ Married

Please place a check mark next to the highest level of education you obtained in school:

____ Elementary ____ High School ____ College ____ Other: _____

How do you prefer to learn new information? (circle one)

Doing / Demonstration Reading / Written Materials Watching / Video or Presentations

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Patient Name (Print): _____ Patient DOB: ____/_____/_____

PAST MEDICAL HISTORY

Place a check mark on the line next to the illness or illnesses that you currently have or have had in the past:

____ Anemia	____ Gallstones	____ Kidney stones
____ Arthritis	____ Glaucoma	____ Liver disease
____ Asthma	____ Gout	____ Nervous stomach
____ Cancer	____ Heart attack	____ Rheumatic fever
____ Cirrhosis	____ Heart trouble	____ Spastic colon
____ Depression or other mental illness	____ Hepatitis	____ Stomach ulcers
____ Diabetes	____ High blood pressure	____ Thyroid trouble
____ Emphysema	____ Kidney infections	____ Yellow jaundice

Serious past injuries (describe the type of injury and approximate dates of occurrences):

_____

_____

Previous surgery (Place a check mark on the short line next to the type of surgery you have had. On the long line, indicate the approximate date of surgery.):

____ Appendix_____	____Hemorrhoids _____
____ Breast surgery_____	____Hysterectomy _____
____ Eye surgery_____	____Open heart surgery _____
____ Gallbladder_____	____Stomach or colon surgery _____

____ Other surgery: _____

_____

Previous hospitalizations (other than surgery):

Hospital	Year	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Patient Name (Print): _____ Patient DOB: ____/_____/_____

HEALTH MAINTENANCE

Vaccines

When was your last tetanus booster? _____

Have you had a flu (influenza) vaccine in the last 12 months? ☐ Yes ☐ No
If yes, please tell us when and where, if known: _____

Have you had a pneumonia vaccine in the last 12 months? ☐ Yes ☐ No
If yes, please tell us when and where, if known: _____

Have you ever had a shingles vaccine? ☐ Yes ☐ No
If yes, please tell us when and where, if known: _____

Screenings

Do you have eye exams regularly? ☐ Yes ☐ No Where and when was your last eye exam? _____

Do you have dental exams regularly? ☐ Yes ☐ No Where and when was your last dental exam? _____

Have you ever had a colorectal cancer screening (colonoscopy)? ☐ Yes ☐ No
If yes, please tell us when and where, if known: _____

What is your usual weight? _____ What was your approximate weight one year ago? _____ What is your present weight? _____

WOMEN:

Name and address of your GYN Provider: _____

Have you had a "Pap" smear in the last two years? ☐ Yes ☐ No
Have you ever had a Mammogram? ☐ Yes ☐ No If yes, where and when was your last scan? _____
Have you ever used birth control pills? ☐ Yes ☐ No

Obstetrical History: Number of pregnancies: _____ Number of deliveries: _____

Please tell us about any other Specialists you see: List the name, location, and how often you see them:

_____

_____

_____

_____

_____

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Patient Name (Print): _____ Patient DOB: ____/_____/_____

FAMILY HISTORY

Is your mother living? ☐ Yes ☐ No (cause of death and age at death_____)
Is your father living? ☐ Yes ☐ No (cause of death and age at death_____)

Have any family members, either living or dead, ever had any of the following diseases? If yes, place a check mark on the short line next to the illness. On the long line next to the illness, put the name of the family member or the initial code letter of the family member that had the illness. The following code initials may be used:

Mother [M]	Brother [B]	Aunt [A]
Father [F]	Child [C]	Uncle [U]
Sister [S]	Grandparent [GP]	Cousin [CS]

(For example: If one of your grandparents and a cousin had tuberculosis: ✓ Tuberculosis GP, CS)

	Family Member		Family Member
____	Alcoholism _____	____	Heart Attack _____
____	Cancer _____		At what age(s)? _____
____	Breast cancer _____	____	High blood pressure _____
____	Colon cancer _____	____	Kidney disease _____
____	Ovarian cancer _____	____	Osteoporosis _____
____	Colitis _____	____	Tuberculosis _____
____	Diabetes _____	____	Other _____

SOCIAL HISTORY AND HABITS

Do you drink alcoholic beverages (wine, beer, liquor, etc.)? ☐ Yes ☐ No
If yes, how many alcoholic beverages do you have on average in a week? _____ per week

Do you smoke? ☐ Yes ☐ No

If no, have you ever smoked? ☐ Yes ☐ No

Please tell us how many years you have/had been a cigarette smoker: _____ year(s)

Have you ever tried to quit smoking? ☐ Yes ☐ No

How many days per week do you exercise for at least 20 minutes? _____ days per week

Are you sexually active? ☐ Yes ☐ No

What method of contraception do you use? ____Birth control pill ____Condom ____Diaphragm

____ Other:_____

Have you ever been diagnosed with a sexually transmitted disease? ☐ Yes ☐ No

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Patient Name (Print): _____ Patient DOB: ____/_____/_____

ASSIGNMENT OF INSURANCE BENEFITS

Except where my plan provides for automatic payment of benefits to the provider of services, I authorize payment of benefits, otherwise payable to me, for services rendered by Coastal Medical, I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE TO THE PROVIDER FOR CHARGES NOT COVERED BY MY BENEFIT PLAN.

_____ _____/_____/_____

Patient's Signature — Date

Have you designated anyone to function as your legal guardian or decision maker (by completing a "living will" or "power of attorney" form) in the event that you are unable to make decisions regarding your health care?

☐ Yes ☐ No

If "YES," please write the name, address, phone number, and relationship of that individual:

Name:_____

Address: _____

Relationship to you: _____ Phone: _____

If "NO," please ask your physician about this.

I have reviewed the information in this questionnaire and verified that the information is accurate.

_____

Patient's Signature

If questionnaire was completed by someone other than the patient:

Relationship to patient: _____ _____

Patient's signature

PHYSICIAN'S NOTES:

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10 Davol Square, Suite 300
Providence, RI 02903
401.421.4000
www.coastalmedical.com

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

September 23, 2013

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NOTICE OF PRIVACY PRACTICES

Protected Health Information (PHI)/
Electronic Health Record (EHR)

Acknowledgement

Coastal Medical has provided me with a copy of its Notice of Privacy Practices with respect to PHI and their EHR. I have reviewed this document and all questions I had have been answered.

Patient Name (Please Print)	Date of Birth
Signature	Date

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CONTACT INFORMATION FORM

Patient Name: _____ DOB: _____ /_____ /_____

Emergency Contact Information

Please complete all information below. In the event of an accident or other emergency, we will use this information to notify your preferred contacts:

Primary Contact Person:

Name: _____ DOB: _____ / _____ / _____

Relationship to patient: _____

Are they a Coastal Medical Patient: ☐ Yes ☐ No

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Secondary Contact Person**:**

Name: _____ DOB: _____ / _____ / _____

Relationship to patient: _____

Are they a Coastal Medical Patient: ☐ Yes ☐ No

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Permission to Discuss

I, the undersigned, hereby give Coastal Medical permission to discuss my medical information with:

Name #1: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Name #2: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Please list any exclusions to discuss such as AIDS, HIV, psychiatric disorders, history of treatment for drug or alcohol abuse:

_____

_____

Patient/Legal Guardian Signature: _____

Date: _____ / _____ / _____

You may update this information at any time.

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient: _____ Address: _____

Date of Birth: _____/_____/_____ _____

Telephone: _____ _____

Transfer the following information:

To:* _____ From: _____

_____ _____

_____ _____

☐ Abstract of last 2 years for continuation of care**
☐ Complete record
☐ Other _____
☐ Consultation notes
☐ Laboratory Studies
☐ X-ray reports

This authorization includes allowing the transfer of information regarding: AIDS (Acquired Immunodeficiency Syndrome), HIV (Human Immunodeficiency Virus), psychiatric disorders, and history of treatment for drug or alcohol abuse.

Have you seen a behavioral health specialist in our office? ☐Yes ☐No

If yes, what is the provider's name? _____

Do you authorize the release of these records as well? ☐Yes ☐No

I understand that behavioral health diagnoses and medication are included in my medical record and will be included in releases of medical record information.

I understand that this authorization may be revoked at any time prior to an actual release of records made in good faith that occurred in reliance on this authorization. This authorization will automatically expire 90 days from the date below.

The purpose of this request is: _____

Signed: _____ Date: _____
Patient/Legal Guardian

Witness: _____

THIS AUTHORIZATION DOES NOT ALLOW AN AGENCY RECEIVING RECORDS FROM FURTHER DISTRIBUTING THEM WITHOUT ADDITIONAL WRITTEN CONSENT OF THE PATIENT.

* Requests for the patient's records will be billed to the patient according to state regulations. You may have a personal copy delivered to you electronically upon request.

**Abstract includes progress notes, laboratory and other testing results, telephone encounters, and consultation documents from the last two years; additional preventive immunizations and most recent mammogram, colonoscopy and cardiac testing results will be forwarded if present.