

William Luster MD
Health Questionnaire for the First Visit

Please answer all questions as well as you can on the front and back. The nurse may help you, if needed. Dr. Luster will need this information to help you.

Name of the Patient: _____ Date of Birth: _____

Why are you seeing Dr. Luster today?

This is a new illness old illness.
Has it been treated before? Yes No
If treated before, what was done?

When? _____ Where? _____

Please list all medicine and herbals you take:

Please list any medicines you are allergic to or cannot take, and why:

Social History

I am married single divorced widowed

I have _____ children

My occupation is _____

Do you drink alcohol? Yes No

Do you smoke tobacco? Yes No
 In the Past

Packs per day: _____ Years: _____

Have you ever used illicit drugs? Yes No
(this is confidential)

Medical History

What illnesses, injuries, or surgeries have you had that required hospitalization and when?

Have you had problems with any of these in the past two weeks?

	Yes	No	Yes	No
fever	<input type="checkbox"/>	<input type="checkbox"/>	excess thirst	<input type="checkbox"/> <input type="checkbox"/>
wt. loss	<input type="checkbox"/>	<input type="checkbox"/>	joint pain	<input type="checkbox"/> <input type="checkbox"/>
balance	<input type="checkbox"/>	<input type="checkbox"/>	stiffness	<input type="checkbox"/> <input type="checkbox"/>
ears	<input type="checkbox"/>	<input type="checkbox"/>	skin	<input type="checkbox"/> <input type="checkbox"/>
eyes / vision	<input type="checkbox"/>	<input type="checkbox"/>	lumps	<input type="checkbox"/> <input type="checkbox"/>
chest pain	<input type="checkbox"/>	<input type="checkbox"/>	headache	<input type="checkbox"/> <input type="checkbox"/>
breathing	<input type="checkbox"/>	<input type="checkbox"/>	bleeding	<input type="checkbox"/> <input type="checkbox"/>
cough	<input type="checkbox"/>	<input type="checkbox"/>	bruising	<input type="checkbox"/> <input type="checkbox"/>
sex	<input type="checkbox"/>	<input type="checkbox"/>	sadness	<input type="checkbox"/> <input type="checkbox"/>
abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	worry	<input type="checkbox"/> <input type="checkbox"/>
urine	<input type="checkbox"/>	<input type="checkbox"/>	menstruation	<input type="checkbox"/> <input type="checkbox"/>

Have you or a blood relative ever had:

	You	Family	No
cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
liver trouble or hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV or AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
an STD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
asthma or lung trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
kidney trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
mental health trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
genetic problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Immunizations

Did you receive all of your childhood shots?

Yes No

Would you like us to look up your vaccinations in the Louisiana state database (LINKS)?

Yes No

Everyone over age 6 months should get a flu vaccine every year.

Would you like yours today?

Yes No

All adults should get a tetanus booster every 10 years.

Would you like one from us today?

Yes No

All adults who have not had the pertussis (whooping cough) vaccine should get a booster with a tetanus shot once.

Would you like one from us today?

Yes No

The pneumonia and shingles vaccines are recommended for men and women over 60 and others with chronic disease.

Would you like to discuss them?

Yes No

HIV

The CDC and American College of Physicians now recommend that every American aged 15 to 65 take a periodic HIV test, whether you are at risk or not. It is completely confidential.

Would you like yours today?

Yes No

Would you like any other STD tests done? They are also completely confidential.

Yes No

Cancer Screening for Adults

People over 50 and those at higher risk should get regular colon cancer screening. Have you?

Yes No Not applicable

How and when last?

Do you have any worrisome moles or marks on your skin you would like Dr. Luster to check?

Yes No

For Women only:

Most women over 40 should have an annual mammogram, earlier if you are more at risk.

Would you like one ordered today?

Yes No

Have you had a normal pap smear in the last 3 years (from ages 21 to 65)?

Yes No Never ask a woman her age

For Men only:

Men over 50 should have their prostate checked with a digital exam and/or PSA yearly.

Would you like yours checked today?

Yes No



Today's date:

Physician:

PATIENT INFORMATION

Patient's last name: _____ First: _____ Middle: _____ Mr. Miss Mrs. Ms. Marital status (circle one)
Single / Mar / Div / Sep / Wid

Is this your legal name? Yes No If not, what is your legal name? _____ (Former name): _____ Birth date: ____/____/____ Age: ____ Sex: M F

Street address: _____ Social Security no.: _____ Home phone no.: _____

P.O. Box: _____ City: _____ State: _____ ZIP Code: _____

Occupation: _____ Employer: _____ Employer phone no.: _____

Race: African American Caucasian American Indian Asian Other (Please Specify) _____

Chose clinic because/Referred to clinic by (please check one box): Dr. _____ Insurance Plan Hospital
 Family Friend Close to home/work Yellow Pages Other

Pharmacy: _____ E-mail: _____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person responsible for bill: _____ Birth date: ____/____/____ Address (if different): _____ Home phone no.: _____

Is this person a patient here? Yes No

Occupation: _____ Employer: _____ Employer address: _____ Employer phone no.: _____

Is this patient covered by insurance? Yes No

Please indicate primary insurance Humana Aetna Cigna Tricare Medicare
 United Healthcare Office of Group Benefits Sterling BCBS Other

Policy Holder's name: _____ Policy Holder's S.S. no.: _____ Birth date: ____/____/____ Group no.: _____ Policy no.: _____ Co-payment: \$ _____

Patient's relationship to policy holder: Self Spouse Child Other

Name of secondary insurance (if applicable): _____ Subscriber's name: _____ Group no.: _____ Policy no.: _____

Patient's relationship to policy holder: Self Spouse Child Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): _____ Relationship to patient: _____ Home phone no.: _____ Work phone no.: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Natchitoches Medical Specialists or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

Patient Release of Information

Please list the family members or other persons, if any, whom we may inform about your general medical condition and diagnosis (including treatment, payment, and health care operations).

Name: _____ Relationship: _____

Last four digits of their social security #: _____

Date of Birth: _____

Name: _____ Relationship: _____

Last four digits of their social security #: _____

Date of Birth: _____

Name: _____ Relationship: _____

Last four digits of their social security #: _____

Date of Birth: _____

Cane River Family Medicine

Message to Our Patients

We appreciate the opportunity to serve your medical needs. We hope you appreciate the value of the services you have received. Accordingly, we ask all our patients/guarantors to pay for their services at the time the services are rendered or upon receipt of a statement from our office.

We attempt to make this payment as easy as possible by accepting cash, check, and credit cards. For those of you desiring payment programs, a series of payments can be arranged after a payment plan agreement has been executed.

By offering these payment services, we are able to save time, hassle, and money. Thank you.

Payments

- Payment for services rendered is due at the time of service.
- All first visits must be paid at the time of service. We accept Visa, Discover, MasterCard, Cash, and Checks.
- All co-pays must be paid at the time of service.
- There is a \$30 service charge for each returned checks.

Insurance

If Cane River Family Medicine is a provider for your insurance, we will file it providing your co-pay and/or deductible is paid at the time of your visit. If your insurance does not pay within 60 days, you will be billed, and be responsible for any balance due. You are also responsible for providing us with any updated information.

Patient Signature: _____ Date: _____

Cane River Family Medicine

Notice of Privacy Practice Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 (“HIPPA”), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of this Notice of Privacy Practices.

Patient Name or Legal Guardian: _____

Signature: _____

Date: _____

Practice Use Only

I attempted to obtain the patient’s signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____