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	☐	☐	excess thirst	☐	☐
wt. loss	☐	☐	joint pain	☐	☐
balance	☐	☐	stiffness	☐	☐
ears	☐	☐	skin	☐	☐
eyes / vision	☐	☐	lumps	☐	☐
chest pain	☐	☐	headache	☐	☐
breathing	☐	☐	bleeding	☐	☐
cough	☐	☐	bruising	☐	☐
sex	☐	☐	sadness	☐	☐
abdominal pain	☐	☐	worry	☐	☐
urine	☐	☐	menstruation	☐	☐

Have you or a blood relative ever had:

	You	Family	No
cancer	☐	☐	☐
liver trouble or hepatitis	☐	☐	☐
HIV or AIDS	☐	☐	☐
an STD	☐	☐	☐
heart trouble	☐	☐	☐
high blood pressure	☐	☐	☐
asthma or lung trouble	☐	☐	☐
diabetes	☐	☐	☐
kidney trouble	☐	☐	☐
mental health trouble	☐	☐	☐
genetic problems	☐	☐	☐

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: O Mr. O Miss o Mrs. oMs. Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? If not, what is your legal name? (Former name): Birth date: Age: Sex:

OYes O No / / OM OF

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): O Dr. _____________ O Insurance Plan O Hospital

O Family O Friend O Close to home/work O Yellow Pages O 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? OYes O No

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

Is this patient covered by insurance? OYes O No

Please indicate primary insurance O Humana o Aetna OCigna O Tricare O Medicare

O United Healthcare O Office of Group Benefits O Sterling O BCBS O 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: O Self O Spouse O Child O Other

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

Patient's relationship to policy holder: O Self O Spouse O Child O 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: _________________________

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY CONSENT FORM

Accurate prescription history reduces medication errors and enhances patient safety. Authorizing Cane River Family Medicine to view your external prescription history provides our staff with information about medications you are already taking to minimize the number of adverse drug events.

I understand that my prescription history from medical providers, insurance companies, and pharmacy benefit managers may be viewable by my provider and staff here, and it may include prescriptions back in time for several years.

By signing this consent form you agree that Cane River Family Medicine can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

My signature certifies that I have read and understand the scope of my consent and that I authorize Cane River Family Medicine access.

____

Signature of Patient or Legal Guardian

____

Print Patient's Name

____

Print Name of Legal Guardian, if applicable

____

Date