Patient Registration

☐ Initial ☐ Update

Name________________________________ Date of birth______________

Address____

City: ____________________ State: __________ Zip Code: ______________

Primary phone number: ____________________ Alternative phone number: ____________________

SSN: ______-_______-_______ Gender: ☐Female ☐ Male Race: ____________ Ethnicity: ☐Hispanic ☐Non-Hispanic

Identified as: ☐ Female ☐ Male ☐ Non-conforming gender ☐ Male-to-female transgender ☐ Female-to-male transgender ☐ Other ____________________

Preferred Language: ____________________ Marital Status: ☐ Single ☐Married ☐Widowed ☐Divorced

Ok to release information via email: ☐ No ☐ Yes Email address: ____________________

Job Title: ____________________ Employer: ____________________

Insurance Information

Primary Insurance Carrier: ____________________ Policy Holder's Name: ____________________

Relationship to Policy Holder: ____________________ Policy Holder's DOB: ____________________

Secondary Insurance Carrier: ____________________ Policy Holder's Name: ____________________

Relationship to Policy Holder: ____________________ Policy Holder's DOB: ____________________

HIPAA REQUIREMENT

THIS SECTION IS REQUIRED FOR THE TREATMENT OF ALL PATIENTS. PLEASE LIST THE NAME OF ANY PERSON WHO MAY HAVE ACCESS TO THE PATIENT'S HEALTH INFORMATION

Name: ____________________ Date of Birth: ____________________

Relationship to Patient: ____________________ Phone Number: ____________________

Name: ____________________ Date of Birth: ____________________

Relationship to Patient: ____________________ Phone Number: ____________________

Name: ____________________ Date of Birth: ____________________

Relationship to Patient: ____________________ Phone Number: ____________________

Patient Signature: ________________________________ Date: ______________

PAST DUE ACCOUNTS

If your account is past due, please contact the billing office at 866-557-2612, so that we can assist you with a payment plan. If your account has been referred to a collection agency or attorney, you must pay the balance in full, including any collection fees. If you require further treatment and your account is in collections, the full balance will be due, and you will be required to pay the cost of the next visit in full, prior to being seen.

RETURNED CHECKS

A fee may be required for returned checks. This amount will be applied to your account, in addition to the insufficient funds amount. Your account may be assigned "self-pay" status, requiring upfront payments following a returned check.

REFERRALS & PRE-AUTHORIZATIONS/NOTIFICATIONS/CERTIFICATES

Your insurance company may require a referral from another physician and/or a pre-authorization, notification, or certification. While it is your responsibility to obtain these, someone in the office will help you if necessary. Please make sure that all referrals are in our office prior to your visit. Failure to obtain these may result in a lower payment or no payment from your insurance company, and the balance will be your responsibility.

MINORS

The parent(s) or guardian(s) presenting the child for treatment is responsible for full payment and will receive the billing statements. In addition, we may pursue payment from a non-custodial parent of guardian.

PATIENT AUTHORIZATION, ACKNOWLEDGEMENT, AND AGREEMENT

I hereby authorize payment of health insurance benefits and, if applicable, government benefits directly to Heritage Urgent & Primary Care for services provided to me. I authorize the release of my healthcare information necessary to process my claims. I further authorize the release of my healthcare information to other healthcare providers, hospitals, and facilities involved in my treatment.

I understand, acknowledge, and agree that I am financially responsible for my deductible, co-pay, coinsurance, and any amount exceeding what my insurance company pays, except where exempt by contractual agreement. I understand that I am financially responsible for any balance remaining after my claim has been processed. I further upstand that I am responsible for complying with any requirements that my insurance carrier may have regarding referrals, prior approvals, and pre-authorizations.

I HAVE READ THE PATIENT FINANCIAL POLICY AND/OR IT HAS BEEN FULLY EXPLAINED TO ME. I CERTIFY THAT I UNDERSTAND ITS CONTENTS, AND THATI AM COMPETENT TO EXECUTE IT OR THAT I AM AUTHORIZED TO EXECUTE IT ON THE PATIENT'S BEHALF.

Print Patient's Name: ______________________________

Signature: ______________________________ Date: ______________

Parent/Guardian Name (if applicable): ______________________________

Parent/Guardian Signature: ______________________________

Wake Forest
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F: 919.761.5680

Leesville
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P: 919.741.4677
F: 919.741.6349

CANCELLATION AND NO SHOW POLICY

We understand that a situation may arise which might require the cancellation of your appointment. It is therefore requested that a 24-hour notice be provided to our office. This will give patients who are waiting for appointments an opportunity to fill this appointment slot.

- **Appointments that are cancelled with less than a 24-hour notification will be subject to a $75 cancellation fee.**
- **Patients who do not show up for their scheduled appointment without a 24-hour notification will be subject to a $75 no show fee.**
- **These fees are the sole responsibility of the patient and must be paid in full prior to being seen again or scheduled for another appointment.**
- **Patients who cancel or no show to 3 or more consecutive appointments may be subject to discharge from the practice.**

Heritage Urgent & Primary Care believes that a good provider-patient relationship is based upon understanding and communication.

By signing below, I acknowledge that I have read, understand, and agree to Heritage Urgent & Primary Care's Cancellation and no show policies.

Patient/Guardian Signature: ______________________________ Date:__________

Heritage Urgent and Primary Care

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name:____ **DOB:**________________

I have received a copy of the Notice of Privacy Practices for the above-named practice.

____ ______________________

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:

  ____

- ❑ Other:

  ____

Prepared By ____________________________________

Signature ____________________________________

Date ____________________________________

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Heritage Urgent & Primary Care FAQ's and Policies

Thank you for choosing HUPC as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient policies is important to our professional relationship.

PLEASE INITIAL

______**Insurance Policies:**

All copays and past due balances are expected at the time of service. We will, as a courtesy, file insurance claims that we participate with on your behalf. If you fail to provide us with the correct insurance policy, and we are unable to file your claim within the timely filing limits put in place by your insurance carrier, these charges will become your responsibility.

All registration forms require the insurance field to be filled out, even if you present your card. This protects our practice from errors occurring. Thank you for understanding.

______ **General Insurance & Billing Information**

Your insurance company is responsible for explaining benefits to you, and each patient is responsible for understanding their insurance plan. ***All benefit and claims processing related questions should be directed to your insurance carrier.*** Our office should not be contacted for an explanation of benefits or with questions as to how a claim was processed. We do not have the information necessary to assist you with these concerns. It is the patient's responsibility to check with your insurance company to determine covered benefits. The patient/guarantor is responsible for 100% of charges the insurance company does not cover.

ALL visits will be billed as Primary Care. It is patient responsibility to understand if this affects coverage.

______ **Self-Pay:**

You will be considered a "Self-Pay" patient if you do not have insurance or carry an insurance plan we are not in network with. Payment is expected at time of service. We do not retroactively file claims after date of service.

______ **LABS & Pathology:**

All labs and specimens will be sent out to our participating lab, Quest Diagnostics. The bills are all handled by Quest Diagnostics and need to be addressed with Quest Diagnostics. Labs will be billed under the diagnosis codes that are addressed on the date of service labs are drawn.

Quest Billing Department can be reached at 1-866-697-8378.

______ **LABS & Pathology Results:**

A Medical Assistant will contact you 5-7 days after labs are drawn to review results interpreted by your provider. Please refrain from reaching out to our office before this window is reached. This allows for appropriate provider interpretation. Hormone labs will take 10 days minimum to be resulted so please allow extra time for your results. Any emergent labs/pathology results will be relayed as soon as possible.

(OVER)

_____ **Nurse Calls:**

Messages on our nurse line will be returned within 48-72 hours, including calls about medication refills. It is the patient's responsibility to call in a timely manner regarding medication refills. Please make sure you have contacted your pharmacy before reaching out to our office about refills.

_____ **Portal Messages:**

Any messages sent to the providers via the portal will be returned within 48-72 hours. In most cases, the portal is used for clarification on something already discussed and not a new issue or concern, our providers also do not offer medical advice over the portal message system.

_____ **Missed Appointments/No-Show/Same-Day Cancellation:**

Understand that not showing up to appointments prevents other patients from being seen. If you do not present for you appointment without prior notification of at least 24 hrs you will be charged a **$75.00 no-show/late cancelation fee.** This fee will need to be paid before being seen for any future appointments. After three missed appointments, we reserve the right to dismiss you from the practice.

We do send appointment reminders, as a courtesy, but, ultimately it is the patient's responsibility to know their appointment date and time.

_____ **Follow Up Appointment Policy**

Standard of care for chronic conditions is an appointment every 6 months (annual exam and 6 month follow up). When starting new medications or handling medication dosage changes the standard follow up protocol is 1 month, then 3 months, until cleared by your provider to move to 6 months maintenance follow ups.

We hope this information is helpful, please let us know if there are any questions.

Heritage Urgent & Primary Care Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED BY HERITAGE URGENT AND PRIMARY CARE AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

YOUR RIGHTS: When it comes to your health information you have certain rights. This section explains your rights.

Upon written request:

- Ask to see or get an electronic or a paper copy of your health record or other information we have about you. We will also provide a summary of your health information if requested. We will charge a reasonable, cost based fee. We will provide this information as soon as possible but no later than 30 working days of the request.
- Ask us to correct your health information you think is incorrect or incomplete. We may say "no" but will tell you why in writing within 60 days.
- You can ask us to communicate with you in a certain way (for example, home or office phone) or to send mail to a different address. We will accommodate all reasonable requests.
- Ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree with your request and may say "no" if it would affect your care.
- If you pay for a service or health care item out of pocket in full and you ask us not to share that information for payment or our operations with your health insurer we will agree unless we are required by law to share that information.
- Ask us for a list or an accounting of the times we have shared your health information for reasons other than treatment, payment, healthcare operations, and when you have asked us to share information. We will provide a list for the past six years for the request. One request per year will be provided free of charge. For additional requests we will charge a reasonable, cost based fee.
- Revoke an authorization to use or disclose PHI at any time except where action has already been taken.

You may also:

- Choose someone to act on your behalf. If you have given someone medical power of attorney or they are your legal guardian, that person can exercise your rights and make choices about your health information. We will ask for proof of this relationship before we take any action.
- Ask for a paper copy of this document even if you have agreed to receive the notice electronically. We will provide that copy promptly.
- File a complaint. If you feel your rights have been violated you may contact the designated Privacy Officer, [Practice officer, address, phone number and email address]
- File a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, D.C. 20201, calling 1.877.696.6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.
- We will not retaliate for filing a complaint.

OUR RESPONSIBILITIES: The law requires us to:

- Maintain the privacy and security of your protected health information.
- Notify you promptly if a breach occurs that may compromise the privacy or security of your information.
- Follow the duties and privacy practices described in this notice and give you a copy of it.
- Not to use or share you information other what is described in this notice unless you tell us we can in writing. If you tell us we can and then change your mind, just let us know in writing you have changed your mind.

(OVER)

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 situations described below, talk to us.

- In these cases you have both the right and the choice to tell us to: share information with your family, close friends, or others involved in your care and share information in a disaster relief situation.

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 DISCLOSURE – We typically use or share your health information in the following ways:

Treatment: We can use your health information and share it with other professionals who are treating you. Example: we may share your health information to an outside doctor for referral. We will also provide your health care providers with copies of various reports to assist them in your treatment.

Payment: We can use or 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 healthcare.

Health Care Operations: 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.

Other ways we can 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.

- **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 medication, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health and safety.
- **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 if we are complying with federal privacy law.
- **Respond to organ and tissue donation requests:** We will 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 you die.
- **Address workers' compensation, law enforcement, and other government requests:**
  - 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 your health information to respond to a court or administrative order, or in response to a subpoena.
- **Research:** We can use or share your information for health research.

CHANGES TO 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 website.

Effective date: 01/01/2016

Revision Date: 01/01/2022

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PATIENT FINANCIAL POLICY

Thank you for choosing Heritage Urgent & Primary Care. While your health and well-being are our primary concerns, we realize that the cost of healthcare is an issue for many patients. We offer the following information to help you understand our financial policies and aid you in planning for payment. Carefully review the information and please ask our staff if you have any questions.

INSURANCE

It is your responsibility to provide Heritage Urgent & Primary Care with current insurance information. We will ask you for your insurance card at your first visit and keep a copy for your records. We may request a copy at a later date in order to update your records, so please bring your insurance card to each visit. We will help you receive the maximum benefits your insurance allows, however, please remember that your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claims for you as primary care and provide necessary information, including primary and secondary insurance information changes, to your insurance company. Failure to provide complete insurance information may result in reduced insurance benefits for you.

Not all services are covered through all insurance plans. Some health plans select certain services that they will cover. Your insurance company will make the final determination of your eligibility and benefits. In the even that your health plan determines a service to be "not covered", you will be responsible for the entire charge. Also, please be aware that if we are out-of-network for benefits, you will receive a bill and be responsible for the remaining balance. This balance is due upon receipt of your statement. In the event that you are unable to pay the balance in full, we encourage you to promptly contact our billing office at 866-557-2612 for assistance in creating a payment plan. Be aware that if your treatment requires biopsy or culture, you may receive a bill from a third party.

CO-PAYS

Co-payments may be required by your insurance plan. All co-payments must be paid prior to your appointment at check in. If you do not have your co-payment, your appointment may be rescheduled.

DEDUCTIBLES AND COINSURANCE

For patients who have insurance plans that have applicable deductibles and coinsurance, be aware that you will be responsible for payment of the deductible or coinsurance applicable to procedures. It is also the patient's responsibility to check with insurance carrier concerning deductibles and coinsurance.

SELF-PAY ACCOUNTS

Self-pay accounts are for patients without insurance coverage. It may also include patients covered by insurance plans that Heritage Urgent & Primary Care is not in network with or patients without an insurance card on file. It is your responsibility to know if care at Heritage Urgent & Primary Care is covered by your plan. If there is a discrepancy of your information, you will be considered a self-pay patient until you provide information proving otherwise.

Health History Questionnaire:

☐ Initial ☐ Annual

Name______________________________ Date of birth______________________

Address____

Local phone number____________________ Alternative phone number____________________

Special Communication Needs: Requires Updating Annually

Language preference:			
If 'yes' to any of the questions below, how can we assist?			
Visual impairment	☐ Yes ☐ No		
Hearing impairment	☐ Yes ☐ No	Cognitive impairment	☐ Yes ☐ No
Speech impairment	☐ Yes ☐ No	Sensory impairment	☐ Yes ☐ No
		Other:	

Family History

Relationship	Living Y/N	Age	Major Medical Problems and/or Cause of Death
Father			
Mother			
Siblings			
Children			

Specifically have any of your relatives had the following conditions

Condition	Relative	Condition	Relative
☐ Mental illness		☐ Chemical dependency	
		☐ Opioid dependency	

Personal Health History

No Change Since Previous Year ☐

Please check past or current problems or conditions

Condition	Condition
☐ Hypertension	☐ Seizures
☐ High cholesterol	☐ Headaches
☐ Diabetes	☐ Stroke
☐ Heart attack or angina	☐ Prostate problem
☐ Irregular heart rhythm	☐ Breast problem
☐ Congestive heart failure	☐ Urinary tract infections
☐ Asthma	☐ Osteoarthritis
☐ Emphysema or chronic bronchitis	☐ Cancer (Please list type)
☐ Pneumonia	☐ Thyroid problem
☐ Gastroesophageal reflux disease	☐ Bleeding disorder
☐ Stomach ulcer	☐ Addiction Issues
☐ Kidney problems	☐ Depression or anxiety
☐ Liver disease/hepatitis	☐ Mental Illness
☐ Colon cancer	☐ Other (please describe)

Previous Surgical Procedures

No Change Since Previous Year ☐

Please check if you have had any of the following

Procedure	Year
☐ Heart surgery	
☐ Carotid artery surgery	
☐ Vascular surgery / stent	
☐ Abdominal aneurysm repair	
☐ Hysterectomy	
☐ Gallbladder removed	
☐ Appendix removed	
☐ Tonsillectomy	
☐ Joint replacement	
☐ Breast cancer surgery	
☐ Prostate cancer surgery	
☐ Hernia	
☐ Pacemaker	
☐ Other (please describe)	

Specialty Providers: Requires Updating Annually	
In order that we can best coordinate your care, please list any medical providers you see outside of this practice and list the year that you last saw them	
☐ Eye doctor	☐ Nephrologist
☐ Cardiologist	☐ Psychiatrist
☐ Oncologist	☐ Allergist
☐ Urologist / Gynecologist	☐ Vascular
☐ Gastroenterologist	☐ Pulmonologist
☐ Endocrinologist	☐ Other
☐ No new specialist visits since previous year	

Please list any new medications prescribed by Specialists or Providers other than your PCP. Please include name, dose and frequency	

It is very important that you take the medication(s) your health care professional has given you. Please check any of the below

Are you unable to fill your prescription(s) because of the cost	☐ Yes	☐ No
Are you unable to fill your prescriptions because of lack of transportation	☐ Yes	☐ No
Have you ever applied for any pharmacy assistance	☐ Yes	☐ No

Opioid History and Current Usage:

It is very important that you take the medication(s) your health care professional has given you. Please check any of the below

Have you ever taken drugs called Opioids (ex: morphine, oxycontin, dilaudid, fentanyl)?	Yes	No
Are you currently taking an Opioid for chronic pain?	Yes	No
Did you utilize non-medication treatments for your pain before taking medication? (Heat/Cold/Physical Therapy/)	Yes	No

Allergies:	
Please list any allergies to medications or foods	

Social History: Initial

Please circle appropriate answers below and provide explanations where appropriate

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner

Education level: ☐ Did not Graduate ☐ High School ☐ Some College ☐ Bachelor's Degree ☐ Master's Degree or Higher

Job concerns: ☐ Stress ☐ Hazardous substances ☐ Heavy lifting ☐ Transportation

How stressful would you rate your current living situation: (Circle number)

Not Very Stressful 0 1 2 3 4 5 6 7 8 9 10 Very Stressful

Do you fear for your safety in your current living situation? ☐ No ☐ Yes If yes, describe below:

Are there financial concerns that affect your ability:

1) to go to the doctor ☐ No ☐ Yes If yes, describe:

2) to obtain food and shelter ☐ No ☐ Yes If yes, describe:

Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?

☐ No ☐ Yes If yes, describe:

Current Health Concerns

Please check problems or conditions that you are CURRENTLY experiencing

☐ Chest pain	☐ Rectal bleeding	☐ Eye pain	☐ Nervousness
☐ Shortness of breath	☐ Black/tarry stools	☐ Loss of vision	☐ Pain in testicles
☐ Wheezing	☐ Weight loss	☐ Double vision	☐ Loss of libido
☐ Cough	☐ Weight gain	☐ Memory loss	☐ Impotence
☐ Coughing up blood	☐ Loss of appetite	☐ Ringing in ears	☐ Breast pain
☐ Sore throat	☐ Difficulty swallowing	☐ Pain in ears	☐ Breast discharge
☐ Nasal congestion	☐ Diarrhea	☐ Nose bleeds	☐ Other (please describe below)
☐ Irregular heartbeat	☐ Constipation	☐ Hoarseness	
☐ Fast heartbeat	☐ Painful urination	☐ Easy bleeding	
☐ High blood pressure	☐ Blood in urine	☐ Easy bruising	
☐ Low blood pressure	☐ Urine frequency	☐ Rash	
☐ Lightheadedness	☐ Decrease in urine flow	☐ Changes in mole	**Females - Please complete**
☐ Dizziness/fainting	☐ Urine leakage	☐ Sore that won't heal	Menstrual flow:
☐ Abdominal pain	☐ Headache	☐ Fatigue/lethargy	☐ Reg. ☐ Irreg. ☐ Pain/cramps
☐ Heartburn	☐ Weakness	☐ Insomnia	Days of flow __ Length of cycle__
☐ Indigestion	☐ Loss of strength	☐ Forgetfulness	1st day of last period
☐ Ankle swelling	☐ Balance problems	☐ Depression	☐ Pain or bleeding after sex
☐ Nausea	**Pain, weakness, or numbness in**		Number of pregnancies
☐ Vomiting	☐ Arms ☐ Hips	☐ Back	Miscarriages
☐ Vomiting blood	☐ Legs ☐ Neck	☐☐ Shoulders	Birth control method
☐ Change in bowel habits	☐ Hands ☐ Feet		

Patient Signature:______________________ Date:______________

Provider Reviewed:______________________ Date:______________

Preventive Health Screening

☐ Initial ☐ Annual

Health Literacy Questionnaire:	
It is really important to your provider that you understand the information related to your health. Please rate the following questions on a scale of 1 to 10; 1 being strongly disagree and 10 being strongly agree	
I feel that I have a thorough understanding of the instructions that my doctors and nurses give me about my health	1 2 3 4 5 6 7 8 9 10
I feel that I remember the instructions given to me at my doctor's office when I get home	1 2 3 4 5 6 7 8 9 10
I feel that I have a strong understanding of medical language	1 2 3 4 5 6 7 8 9 10

Health Maintenance:

Please check whether you have had the following preventive services and enter the year of the service

Immunizations			Year	Tests			Year
Tetanus vaccine / Tdap	☐ Yes	☐ No		Pap smear/pelvic	☐ Yes	☐ No	
Pneumonia vaccine	☐ Yes	☐ No		Mammogram	☐ Yes	☐ No	
Influenza vaccine	☐ Yes	☐ No		Bone dexascan	☐ Yes	☐ No	
Shingles vaccine	☐ Yes	☐ No		Colonoscopy	☐ Yes	☐ No	
				Prostate test	☐ Yes	☐ No	

Additional Vaccines taken since previous year ☐ Yes ☐ No If yes, list vaccine name and date:

Health Behaviors: Requires Updating Annually for 11 years and older

Tobacco use: ☐ Never ☐ Quit (when)_____________ ☐ Current smoker

If current smoker how many packs per day for how many years___________

Alcohol intake: ☐ No ☐ Yes If yes how many drinks/how often_______________

Have you or are you currently taking an Opioid medication? (ex: morphine, oxycontin, dilaudid, fentanyl)? ☐ Yes ☐ No

If yes, Did you utilize non-medication treatments for your pain before taking medication? (Heat/Cold/Physical Therapy/) ☐ Yes ☐ No

Illicit drug use (including marijuana, cocaine, steroids): ☐ Never ☐ Past ☐ Current

If Past or Current drug use describe:

Exposure to secondhand smoke	☐ Yes	☐ No	Wear a seatbelt	☐ Yes	☐ No
Eat a diet high in fruits and vegetables	☐ Yes	☐ No	See a dentist at least once a year	☐ Yes	☐ No
Get 30 minutes of exercise 5 times a week	☐ Yes	☐ No	Wear sunscreen	☐ Yes	☐ No

Urinary Incontinence Assessment: Requires Updating Annually for 65 years and older

Do you experience leaking in the following situations:	Not at all	A little	Sometimes	A lot
During daily activities (work, household task)	☐	☐	☐	☐
During physical activities (walking, swimming, or other exercise)	☐	☐	☐	☐
During recreational activities (movies, hobbies)	☐	☐	☐	☐
During social activities (going out with friends, family visits)	☐	☐	☐	☐

Fall Risk Screening: Requires Updating Annually for 65 years and older

In the last 12 months have you fallen?	☐ Yes ☐ No ☐ Unsure
If yes, how many times?	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+

Functional Assessment: Requires Updating Annually for 65 years and older				
Do you need assistance in the following areas?	Not at all	A little	Sometimes	A lot
Bathing, dressing and grooming	☐	☐	☐	☐
Daily activities (cooking, cleaning other household tasks)	☐	☐	☐	☐
Walking or driving	☐	☐	☐	☐
Communicating needs and feelings	☐	☐	☐	☐
Understanding directions	☐	☐	☐	☐
Keeping appointments, taking medications and performing other medical treatments	☐	☐	☐	☐
If yes to any of these questions, who helps with these activities?				

Mood Screening: Requires Updating Annually for age 11 and up	
A person's mood can have a strong influence on their health status and overall wellbeing. Over the past 2 weeks, how often have you been bothered by any of the following problems?	
Little interest or pleasure in doing things	Feeling down, depressed, or hopeless
☐ Not at all	☐ Not at all
☐ Several days	☐ Several days
☐ More than half the days	☐ More than half the days
☐ Nearly every day	☐ Nearly every day

Social History: Requires Updating Annually

Please circle appropriate answers below and provide explanations where appropriate

Job concerns: ☐ Stress ☐ Hazardous substances ☐ Heavy lifting ☐ Transportation

How stressful would you rate your job situation: (Circle number)

Not Very Stressful 0 1 2 3 4 5 6 7 8 9 10 Very Stressful

Have you had CHANGE in Marital Status: ☐ No ☐ Yes If yes, describe below:

How stressful would you rate your current living situation?

Not Very Stressful 0 1 2 3 4 5 6 7 8 9 10 Very Stressful

Do you fear for your safety in your current living situation? ☐ No ☐ Yes If yes, describe below:

Are there financial concerns that affect your ability:

1) to go to the doctor ☐ No ☐ Yes If yes, describe:

2) to obtain food and shelter ☐ No ☐ Yes If yes, describe:

Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?

☐ No ☐ Yes If yes, describe:

Patient Signature:______________________________ Date:______________________

Provider reviewed:______________________________ Date:______________________