HINTON HEALTHCARE GROUP

NEW PATIENT INFORMATION FORM

(The information provided is strictly confidential)

PATIENT INFORMATION

Name: _____ Date of Birth: _____
First MI Last

Address: _____ APT #: _____

City: _____ State: _____ Zip: _____

Social Security #: _____ Email: _____ Gender: _____

Ethnicity: _____ Pharmacy and Location: _____

CONTACT INFORMATION

Home Phone: _____ ☐ Okay to Leave a Detailed Message ☐ Call Back Number Only

Cell Phone: _____ ☐ Okay to Leave a Detailed Message ☐ Call back Number Only

Work Phone: _____ ☐ Okay to Leave a Detailed Message ☐ Call Back Number Only

INSURANCE INFORMATION

Primary Insurance: _____ Policy Holder: _____

Relationship to Patient: _____ D.O.B: _____ S.S: _____

Secondary Insurance: _____ Policy Holder: _____

Relationship to patient: _____ D.O.B: _____ S.S: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Number: _____ Relationship: _____

PARENT(S) INFORMATION IF MINOR

Name: _____ Number: _____

HIPPA rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Person(s) who we may discuss your health information with

(Please be aware that you are authorizing Hinton Healthcare Group to discuss any of your health information with the person(s) listed below, and that if at any time those person(s) listed should change it is your responsibility to inform Hinton Healthcare Group.)

Name: _____ Number: _____ Relationship: _____

Name: _____ Number: _____ Relationship: _____

X: _____ _____
Signature of Patient/Guardian Date

HINTON HEALTHCARE GROUP

HEALTH HISTORY FORM

To help us meet all of your healthcare needs, please complete both pages of this form.
(The information provided is strictly confidential)

Patient Name: _____ **Date of Birth:** _____

Social History

Tobacco Use: _____ Per Week: _____ Years: _____ Former: _____

Alcohol Use: ○Never ○ Occasionally ○ Daily Other Substance Use: _____

Occupation: _____ Hobbies: _____

Exercise: _____ Last Physical Exam: _____

Allergies (Medication, Food and/or Environment and Reaction): _____

_____

Please list all serious illnesses, operations and other hospitalizations

_____

Please List All Current Medications, Dose and Directions

_____

_____

_____

Please Circle All Of Your Past Medical History and Chronic Illnesses

Arthritis	Epilepsy	Migraine Headaches
Allergies	Gout	Pneumonia
Asthma	Glaucoma	Polio
AIDS/HIV	High Cholesterol	Scarlet Fever
Anemia	Heart Disease	Small pox
Bladder Infections	High Blood Pressure	Stroke
Back Trouble	Hemorrhoids	Tuberculosis
Bleeding Tendency	Hives/Eczema	Thyroid Disease
Bronchitis	Hepatitis	Ulcers
Chicken pox	Kidney Disease	Venereal Disease
COPD	Lung Disease	Whooping Cough
Cancer	Low Blood Pressure	Diphtheria
Diabetes	Measles	Mental Illness
DVT	Mumps	Meningitis

PLEASE CONTINUE TO THE NEXT PAGE ➧

Family History

If any blood relative has had any of the following, please circle and list who

Allergies: _____ High Blood Pressure: _____

Anemia: _____ High Cholesterol: _____

Asthma: _____ Kidney Disease: _____

Cancer: _____ Bleeding Tendency: _____

Stroke: _____ Chronic Lung Disease: _____

Diabetes: _____ Drug/Alcohol Problem: _____

Depression: _____ Mental Illness: _____

Epilepsy: _____ Migraine Headaches: _____

Leukemia: _____ Obesity: _____

Glaucoma: _____ Tuberculosis: _____

Gout: _____ Thyroid Disease: _____

Ulcers: _____ Heart Disease: _____

Please list other family history if not listed above: _____

Women Only

Last Pelvic Exam: _____

Last Mammogram: _____

Menopausal: Yes or No

Last Colonoscopy: _____

Of Pregnancies: _____

Men Only

Last Prostate Exam: _____

Last PSA Test: _____

Last Colonoscopy: _____

Preventive Care

Please Write the Date/Year

Flu Vaccine: _____ Shingles Vaccine: _____

Pneumonia Vaccine: _____ Tetanus Vaccine: _____

Bone Density Test: _____ Diabetic Eye Exam: _____

Lab work for Hep C: _____ Last A1C Test: _____

Implantable Devices

_____

By my signature, I verify that the information I provided is correct to the best of my knowledge.

X: _____ _____

Signature of Patient/Guardian Date

HINTON HEALTHCARE GROUP

Provider Policies and Expectations

Regular Office Hours: Hinton Healthcare Group hours vary from each location. All locations are closed from 12:00 p.m. to 1:00 p.m. for lunch. All physician visits are by appointment only.

Insurance Billing: Hinton Healthcare Group accepts most major insurance policies. It is the patient's responsibility to check if our doctors are covered by your specific insurance plan. If one of our providers is not listed or covered, we do accept self-pay.

Medical Records and Confidentiality: Your medical records are confidential and require your written authorization before they can be released to other health care providers or other approved recipients. Medical records will be completed within 30 days from the date they are requested.

Appointment Cancellations and Late Policy: Hinton Healthcare Group has a "No Call, No Show and Cancellation Policy". We require a 24 hour cancellation notice for all appointments, failing to do so may result in a fee of $25.00. Please be aware that if you are more than 15 minutes late you may be asked to reschedule.

Protected Health Information: "Protected Health Information" (PHI) is information that identifies you and relates to your identify and your past, present or future medical history. It includes your medical records and personal information such as your name, social security number, address, and phone number.

Family and Medical Leave Act: The family and medical leave act (FMLA) paperwork will be an additional charge of $25.00 and will take up to 7 business days to complete. All FMLA paperwork will require a visit with a provider prior to completing the form.

Patient Fusion: All patients are automatically enrolled into our patient fusion program if an email is provided.

Assignment of Medical Benefits and Authorization to Release Information

*I authorize Hinton Healthcare Group to release any medical information necessary to process insurance claims relating to the medical care provided
*I authorize payment of medical benefits to Hinton Healthcare Group for any medical care provided to me and/or my dependent(s),
*I understand that I will be responsible for any charges not covered by my insurance
*I understand that it is my responsibility to contact Hinton Healthcare Group with any changes to my insurance, address or phone number

By my signature, I verify that the information I provided is correct and I acknowledge that I understand my rights as a patient concerning my protective health information. I authorize Hinton Healthcare Group to perform the necessary health care services I/My child may need.

X: _____ _____

Signature of Patient/Guardian Date