



Date of Visit: \_\_\_\_\_

Name: \_\_\_\_\_ Sex: M / F Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_ Did you travel out of the United States in the last year? YES / NO  
Where To? \_\_\_\_\_

Medication or Other Allergies: \_\_\_\_\_

Current medications: \_\_\_\_\_

**Past Medical History:** Please check (and/or circle) any of the below that apply to you or your family members.

	Me	Family	Explanation		Me	Family	Explanation
Hearing /Vision problems				High Cholesterol			
Heart Disease				Seizures			
High blood pressure				Migraine headaches			
Stroke				Arthritis or Gout			
Asthma/Emphysema/Bronchitis				Depression/Psychiatric problems			
Ulcers or digestive problems				Diabetes			
Cancer (list type)				Thyroid disease			
Kidney disease/stones				Sleep Apnea			
Gallbladder disease				Anemia / Blood disease			
Osteoporosis				Tuberculosis			
HIV / AIDS / STD's				Genetic disorders			
Drug or Alcohol Abuse				Insomnia			

Please list surgeries you have had: \_\_\_\_\_

Date of last Physical Exam: \_\_\_\_\_ Last colonoscopy: \_\_\_\_\_ **Males:** Last prostate exam: \_\_\_\_\_

**Females:** First day of last menstrual period: \_\_\_\_\_ Number of pregnancies: \_\_\_\_\_ Number of live births: \_\_\_\_\_

Last PAP: \_\_\_\_\_ Last Mammogram: \_\_\_\_\_

Did or do you smoke tobacco: Yes / No # Packs per day: \_\_\_\_\_ How many years: \_\_\_\_\_ Quit date: \_\_\_\_\_

Did or do you chew tobacco: Yes / No # Cans per day: \_\_\_\_\_ How many years: \_\_\_\_\_ Quit Date: \_\_\_\_\_

Do you drink alcoholic beverages: Yes / No How much / How often: \_\_\_\_\_

Did you have a Flu shot this year? Yes / No Have you had a Tetanus shot in the last 10 years? Yes / No

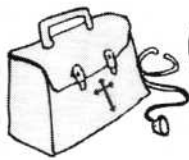
Are your other immunizations up to date? Yes / No / Unknown

**Provider Notes / Comments:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_



# GracePointe Healthcare PLLC

*Modern medicine the old fashioned way*

## ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Dr. Edward C. Leichner, D.O.  
Robert M. Tomsett Jr., PA-C  
Gigi McMurray, MSN, FNP-C

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

Conduct, plan and direct my treatment and follow up among the multiple healthcare provider's who may be involved in that treatment directly and indirectly.

Conduct normal healthcare operations such as quality assessments and physician certification's.

I have received, read and understand your Notice of Privacy Practices which contains a more complete description of the uses and disclosures of my health information. 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 at the above address to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my restrictions, but if you do agree then you are bound to abide by such restrictions.

Print Patient Name: \_\_\_\_\_

If Guardian; Relationship to Patient: \_\_\_\_\_

Patient / Guardian Signature: \_\_\_\_\_

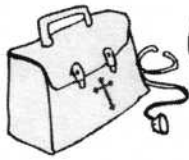
Today's Date: \_\_\_\_\_

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### OFFICE USE ONLY

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

Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Reason: \_\_\_\_\_



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## RELEASE AND ASSIGNMENT

I understand that in certain situations payment for services may not occur at the conclusion of my visit or in other cases, such as pathology services, GracePointe Healthcare may have to bill me for additional costs after my visit and that I am responsible for payment of all services rendered. I will pay all collection fees, court costs, attorney fees, and any other expenses required to reimburse GracePointe Healthcare, for services rendered.

Patient / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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I understand that the office staff of GracePointe Healthcare may need to reach me via telephone. In the event I am unavailable, I authorize the office staff of GracePointe Healthcare to leave a message on my voice mail requesting a return call.

Patient / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

.....

The office staff of GracePointe Healthcare may discuss my health care with the following individuals:

_____	_____
Name	Phone Number / Relationship
_____	_____
Name	Phone Number / Relationship
_____	_____
Name	Phone Number / Relationship

Patient / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_