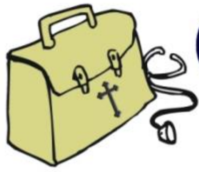

GracePointe Healthcare PLLC

Modern medicine the old fashioned way

PLEASE PRINT AND COMPLETE IN FULL

Date___________________

Name:____ Nickname____________________
Last First M

Sex: Male____Female____ Birthdate:_____________Age:_____ Social Security#:_______________________

If Patient is a minor, Parent / Guardian's Name____

Patient's Street Address____

City/State____________________________________ Zip Code_________________

Home Phone:___________________ Work Phone:__________________ Cell Phone:___________________

Email Address____

Emergency Contact Name and Phone Number: ____

Patient's Marital Status: Married___ Single____ Spouse Name______________________________________

How did you Hear about us? Dave Ramsey_____ Supertalk 99.7_____ Friend/Family_____ Internet______

Coupon____ Television____ Networking Event____ Newspaper: ____ Other___________________________

Reasons for visit (please be specific)____

____

____

How will you pay today? Cash______Check______Credit Card______ HSA/FSA Card _______

I understand payment in full is due at time of service.

I understand that a 24 hour notice is required for appointment cancelations and I will be charged a $49 fee if I fail to make my appointment without canceling at least 24 hours in advance.

Patient (or legal guardian) Signature____

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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: ___________

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Dr. Edward C. Leichner, D.O.
Robert M. Tomsett Jr., PA
Jennifer Heinrich, PA-C
Retha Thomas, FNP

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: ________________________

………

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: ____

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: ________________

……….

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: _________________