Bristol Health Medical Group

Today's Date_____ **PATIENT HISTORY INFORMATION**

NAME:_____ Date of Birth _____

EMAIL: _____ ☐ I certify this is my own personal email address.

DRUG ALLERGIES _____

_____

Occupation_____Marital Status_____Living Will/Healthcare Directive? Y / N

Birth Sex: _____ Gender Identity: _____ Sexual Orientation: _____

PERSONAL HEALTH - Circle all that apply

AIDS	Cancer _____	Gout	Lyme Disease	Rheumatic Fever
Alcoholism	Cataracts	Heart Disease	Murmur, Heart	Scarlet Fever
Anemia	Chicken Pox	Hepatitis	Measles	Stroke
Anorexia	Drug Dependency	Hernia	Migraines	Suicide Attempt
Anxiety	Depression	Herpes	Mononucleosis	Thyroid problem
Arthritis	Diabetes	High Cholesterol	Multiple Sclerosis	Tuberculosis
Asthma	Diverticulitis	High Blood Pressure	Osteoporosis	Ulcers, stomach
Bleeding Disorders	Emphysema	HIV Positive	Pacemaker	Vaginal Infection
Blood Clots in legs	Glaucoma	Kidney Disease	Pneumonia	Venereal Disease
Bronchitis	Goiter	Kidney Stones	Prostate Problems	Other _____
Bulimia	Gonorrhea	Liver Disease	Psychiatric Care	Other _____

MEDICAL HISTORY - List illness/surgery and dates

OTHER CHRONIC ILLNESSES, HOSPITALIZATIONS OR MAJOR SURGERIES & Dates	

FAMILY HISTORY	AGE IF LIVING	AGE AT DEATH	PRESENT CONDITION(s) OR CAUSE OF DEATH
FATHER			
MOTHER			
BROTHERS			
SISTERS			
CHILDREN			

HAS ANY PARENT/SIBLING HAD THE FOLLOWING:

- ❑ Alcoholism _____
- ❑ Alzheimer's _____
- ❑ Anemia/Low Blood Count _____
- ❑ Lung Problems _____
- ❑ Cancer, Breast _____
- ❑ Cancer, Colon _____
- ❑ Cancer, Prostate _____
- ❑ Cancer, Other _____
- ❑ Heart Disease _____
- ❑ Depression _____
- ❑ Bipolar Disorder _____
- ❑ Diabetes _____
- ❑ Blood Clots _____
- ❑ Hearing Loss _____
- ❑ High Blood Pressure _____
- ❑ High Cholesterol _____
- ❑ Osteoporosis _____
- ❑ Stroke _____
- ❑ Other _____

IMMUNIZATIONS/VACCINATIONS (dates)

Flu_____Tetanus_____Pneumonia_____COVID_____
Other _____

SOCIAL HISTORY

Exercise: Type/frequency_____
_____

Smoking: Packs/day _____
_____ # of years _____
_____ Year stopped _____

Alcohol: Drinks/day _____
Drinks/week _____

Recreational Drugs: Type/frequency _____
_____

NAME:_____ Date of Birth _____

PLEASE LIST CURRENT PRESCRIPTION MEDICATIONS, OVER THE COUNTER & HERBAL SUPPLEMENTS:

Medication Name	Medication Dose	# Times per Day	Who Prescribed Med

Please provide any other information regarding your medical history that you think would be important for us to know:

_____

_____

_____

_____

_____

Thank you for trusting your care to Bristol Health!

PATIENT FINANCIAL RESPONSIBILITY & ACKNOWLEDGEMENT FORM

I acknowledge that (as an adult patient or as the parent/guardian of a pediatric patient):

- I will provide a copy of my photo ID and insurance card today and at all BHMG visits
- Some/all portions of the bill are my responsibility & collected at the time of service, including but not limited to:
    - Co-pays, annual deductibles and cost sharing coinsurance
    - Amounts applied to my high deductible health plan (minimum $100 payment to be applied toward deductible amount, including health savings account (HSA) compatible plans)
    - Amounts not covered by my benefits plan and/or any outstanding prior BHMG balances

I request that payment of authorized benefits be made to me or on my behalf to Bristol Health Medical Group, Inc. for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents, or any other supplier of medical benefits, any information needed to determine those benefits, or the benefits for the related services. If for some reason my insurance company denies my claim, BHMG has the right to appeal on my behalf. I understand it is my responsibility to pay my bill regardless of my insurance coverage. I understand not all services are covered by Medicare or other insurance and acknowledge I am responsible to pay for those services. I agree to pay all costs of collection, including reasonable attorney's fee incurred in the collection of any amounts not paid, as required above.

PRIVACY POLICY: The Bristol Health Notice of Privacy Practices (subject to change) was made available to me. I may obtain a copy at any BHMG office or online via the Bristol Health website.

MULTIDISCIPLINARY APPROACH: Bristol Health provides a range of services all utilizing the same electronic medical record. Medical information is shared among these practices.

NOTIFICATIONS: I agree to receive voice and text notifications from BHMG practices, including appointment reminders, billing alerts/updates and other health reminders or information. I agree to receive text notifications regarding BHMG balances that may be owed. Should you choose to opt out and NOT receive any text messages, please initial here_____.

HEALTH INFORMATION EXCHANGE: I consent to BHMG sharing my protected health information (PHI) with providers involved in my care via a health information exchange (HIE). Should you choose to opt out and NOT participate in a HIE, you may do so by calling 1.866.987.5514 or completing and submitting an opt-out form to Connie by mail, fax or through their website at www.conniect.org.

APPOINTMENT/CANCELLATION: I agree to confirm appointments promptly, arrive on time and notify the office a minimum of one day prior should I need to reschedule. A combination of three (3) or more no shows and/or same day cancellations in a calendar year may result in discharge from a practice. A $30 fee may be charged for missed appointments or late cancellations.

PRESCRIPTION REFILLS: I will call my pharmacy to request routine prescription refills and understand the pharmacy will contact BHMG directly to obtain continuation authorization, unless a visit to your provider is warranted. Providers may consult your prescription history prior to issuing scripts.

REFERRALS: It is my responsibility to contact my insurance company to see if a referral from my Primary Care Provider (PCP) is required to see a specialist.

Printed Name:_____Patient Signature:_____Date:_____

Bristol Health
Medical Group

Protected Health Information (PHI)
Restrictions

The purpose of this form is to document specific patient requests in regards to restricting access to their health information. Bristol Health will put forth best efforts to comply with these requests, however such requests do not supersede disclosures that are required by law.

I request Bristol Health Medical Group staff to **NOT** share and discuss my health information with:

NAME

Name:_____Phone:_____Relationship: _____

Name:_____Phone:_____Relationship: _____

Name:_____Phone:_____Relationship: _____

Name:_____Phone:_____Relationship: _____

Please note any specific reason(s) for authorization of sharing or restricting information:

_____

_____

_____ _____ _____

Patient Name (print) Patient Signature Date

This authorization is valid for one year from the date of signature and is applicable to only the identified specialty practice above. Patients may, at any time, modify the above in writing. That modification shall be documented and honored by the practice.

Patient Name: _____
DOB: _____
Today's Date: _____

PRAPARE
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

Paper Version of PRAPARE® for Implementation as of September 2, 2016

Personal Characteristics

1. Are you Hispanic or Latino?

☐	Yes	☐	No	☐	I choose not to answer this question

2. Which race(s) are you? Check all that apply

☐	Asian	☐	Native Hawaiian
☐	Pacific Islander	☐	Black/African American
☐	White	☐	American Indian/Alaskan Native
☐	Other (please write):		
☐	I choose not to answer this question		

3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?

☐	Yes	☐	No	☐	I choose not to answer this question

4. Have you been discharged from the armed forces of the United States?

☐	Yes	☐	No	☐	I choose not to answer this question

5. What language are you most comfortable speaking?

Family & Home

6. How many family members, including yourself, do you currently live with? _____

☐	I choose not to answer this question

7. What is your housing situation today?

☐	I have housing
☐	I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
☐	I choose not to answer this question

8. Are you worried about losing your housing?

☐	Yes	☐	No	☐	I choose not to answer this question

9. What address do you live at?
Street:_____
City, State, Zip code: _____

Money & Resources

10. What is the highest level of school that you have finished?

☐	Less than high school degree	☐	High school diploma or GED
☐	More than high school	☐	I choose not to answer this question

11. What is your current work situation?

☐	Unemployed	☐	Part-time or temporary work	☐	Full-time work
☐	Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) Please write:				
☐	I choose not to answer this question				

12. What is your main insurance?

☐	None/uninsured	☐	Medicaid
☐	CHIP Medicaid	☐	Medicare
☐	Other public insurance (not CHIP)	☐	Other Public Insurance (CHIP)
☐	Private Insurance		

13. During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits.

_____

☐	I choose not to answer this question

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14. In the past year, have you or any family members you live with been **unable** to get any of the following when it was **really needed**? Check all that apply.

Yes	No	Food	Yes	No	Clothing
Yes	No	Utilities	Yes	No	Child Care
Yes	No	Medicine or Any Health Care (Medical, Dental, Mental Health, Vision)			
Yes	No	Phone	Yes	No	Other (please write):
	I choose not to answer this question				

15. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.

	Yes, it has kept me from medical appointments or
	Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
	No
	I choose not to answer this question

Social and Emotional Health

16. How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

	Less than once a week		1 or 2 times a week
	3 to 5 times a week		6 or more times a week
	I choose not to answer this question		

17. Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?

	Not at all		A little bit
	Somewhat		Quite a bit
	Very much		I choose not to answer this question

Optional Additional Questions

18. In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

	Yes		No		I choose not to answer this

19. Are you a refugee?

	Yes		No		I choose not to answer this

20. Do you feel physically and emotionally safe where you currently live?

	Yes		No		Unsure
	I choose not to answer this question				

21. In the past year, have you been afraid of your partner or ex-partner?

	Yes		No		Unsure
	I have not had a partner in the past year				
	I choose not to answer this question				

Would you like someone to contact you for assistance with any concerns you may have identified in the above survey? ___ Yes ___ No

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