CULLMAN INTERNAL MEDICINE

CIM Dr:_____

Appt date:_____

PATIENT'S PERSONAL HISTORY

BLACK INK ONLY

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Gender: MALE / FEMALE

LastName:_____Phone#:_____

First Name:_____Work orCell#:_____

Middle Name:_____Social Security #_____

Address:_____Birthday:_____

City:_____ State:_____Zip _____

Marital Status:_____Spouse Name:_____

Employer:_____Spouse Social #_____

Spouse Employer:_____Spouse work #:_____

E-Mail:_____Language:_____

Contact Preference: Phone / E-Mail / Mail Race:_____

Primary Insurance:_____ Ins #_____

Secondary Insurance:_____ Ins #_____

Previous Physician or Referring Physician_____

(Bring Ins. Cards, Medications, Medical Records, and New Patient Forms with you to your appointment)

Signature of Responsible Party _____ Date: _____

Person to notify in an Emergency(Not living in your household:

_____

Relationship_____ Phone# _____

Late Cancellation Policy: Patients are responsible for canceling all scheduled appointments within 24 hours. **Failure to keep an appointment without giving at least 24 hours notice will generate a charge of $25.00 to the patients account.** The patient is responsible for this charge, which is non-billable to the insurance company.

Responsible Party:_____ Relationship to Patient:_____

I hereby authorize Cullman Internal Medicine P.C. to furnish to the above insurance company'(s) all information, which said insurance company, may request. I hereby assign to Cullman Internal Medicine P.C., all money to which I am entitled for medical/surgical expense relative to the service rendered but not to exceed my indebtedness to the professional corporation. I understand that I am financially responsible to the said corporation for charges not covered by this assignment, I further agree, in the event of nonpayment, to bear the cost of collection and /or court cost and responsible legal fees, should this be required. I herby consent to any and all medical treatment which may be deemed advisable by his or her physician practicing at Cullman Internal Medicine.

Patient Signature:_____

Parent/Guardian Signature:_____

Patient History and Symptom Form

Name:_____ DOB ___/___/____ Today's Date ___/___/____

What brings you in to our office?

_____

_____

Medical History: Please check any of the following conditions that apply to you or your family .

	Yourself	Father	Mother	Children	Sibling	Grandma	Grandpa	
Acid Reflux……	____	____	____	____	____	____	____	_____
Alcoholism……	___	____	____	____	____	____	____	_____
Anemia……	___	____	____	____	____	____	____	_____
Arthritis……	___	____	____	____	____	____	____	_____
Asthma……	___	____	____	____	____	____	____	_____
Bleeding disorder……	___	____	____	____	____	____	____	_____
Cancer……..	___	____	____	____	____	____	____	_____
Chronic Back Pain……	___	____	____	____	____	____	____	_____
Congestive Heart Failure.	___	____	____	____	____	____	____	_____
Depression……	___	____	____	____	____	____	____	_____
Diabetes……	___	____	____	____	____	____	____	_____
Diverticulosis……	___	____	____	____	____	____	____	_____
Emphysema/COPD…….	___	____	____	____	____	____	____	_____
Fibromyalgia……	___	____	____	____	____	____	____	_____
Glaucoma……..	___	____	____	____	____	____	____	_____
Heart Attack/ Heart disease……	____	____	____	____	____	____	____	_____
Hepatitis/liver disease….	____	____	____	____	____	____	____	_____
High Blood Pressure……	____	____	____	____	____	____	____	_____
High Cholesterol……	____	____	____	____	____	____	____	_____
Irregular heart rhythm.	____	____	____	____	____	____	____	_____
Kidney disease……	____	____	____	____	____	____	____	_____
Kidney Stones……	____	____	____	____	____	____	_____	_____
Migraine Headaches…	____	____	____	____	____	____	____	_____
Prostate Enlargement..	____	____	____	_____	____	____	____	_____
Seizures/ Epilepsy…….	____	____	____	_____	____	_____	_____	_____
Sickle Cell Disease…….	____	____	____	_____	____	_____	_____	_____
Stomach Ulcers…….	____	____	____	_____	____	_____	_____	_____
Stroke…….	____	____	_____	_____	____	_____	_____	_____
Tuberculosis……..	____	____	____	____	_____	_____	_____	_____
Thyroid Disease…….	____	____	____	____	_____	____	_____	_____
Other…….	____	____	____	_____	_____	_____	_____	_____

Past Surgeries: What surgeries have you had in the past?

Abdominal surgery……_____ ___/___/___ Hysterectomy…_____ ___/___/____

Appendectomy……_____ ___/___/___ Heart Surgery …_____ ___/___/___

Hernia……_____ ___/___/___ Gallbladder……..._____ ___/___/___

Cardiac Cath……_____ ___/___/____ Tonsillectomy..._____ ___/___/____

Other……_____

_____

Current Medications: Please indicate any prescription medication, vitamins, herbs, and over the counter medications.

1._____ 4,_____ 7._____

2._____ 5._____ 8._____

3._____ 6._____ 9._____

Allergies:_____

Social History: Please check all that apply to you.

Alcohol use……. ___Current ___Past _____ History of sexually transmitted disease….___ _____
Smoke tobacco… ___Current ___Past _____ Sexually Active…….. ___ _____
Chew tobacco …… ___Current ___Past _____ Marital Status: __Single __Engaged __Married
Drug Use ……..___ Current ___Past_____ __Separated __Divorced __Widowed
Caffeine …….. ___ Current ___ Past _____ Children…….___Yes…….. ___No……how many?_____
Regular Exercise..___Current ____Past_____ Occupation _____ Religion_____
Hobbies _____
_____
_____

Gynecological History: (for women only)
Number of pregnancies……_____ Are you currently Pregnant…….. ___Yes ___ NO
Number of deliveries……_____ Are your periods regular every month?..... ___Yes ____NO
Number of miscarriages……_____Are your periods heavy for painful? …….. ___Yes ____ NO
Number of abortions ……_____ Date of your last Menstrual period …… ___/___/____
Complications during pregnancies (High blood pressure, Diabetes, etc._____
_____
_____

Immunizations and Preventions: check the following and list the last date performed to the best of your recollection

Pneumonia shot ___ ___/___/___ Sigmoidoscopy …. ____ ___/___/___ PSA test……____ ___/___/___
Flu shot…… ___ ___/___/___ Colonoscopy…. …..____ ___/___/___ Cholesterol test …… ____ ___/___/___
Tetanus shot…. ___ ___/___/___ Mammogram …… ____ ___/___/___ Diabetes test…….. ____ ___/___/___
Hepatitis B Shot ___ ___/___/___ Pap Smear…… ___ ___/___/___ Stool test for blood…. ___ ___/___/___
TB Skin test…….___ ___/___/___ Rectal exam …… ___ ___/___/___ DEXA…….. ___ ___/___/___

Review of Symptoms: check any symptoms that applies to you at this time.

General
__Fever/chills
__Weight gain/loss
__Fatique
__Poor appetite
__Hot flashes

Gastrointestinal
__Nausea/vomiting
__Stomach pains
__Difficulty swallowing
__Heart Burn
__Constipation
__Diarrhea
__Black or bloody stools

Psychological
__Depression
__Anxiety
__Hallucinations

Eyes/ENT
__Headaches
__Difficulty hearing
__Difficulty seeing
__Sinus trouble
__Sneezing/watery eyes
__Nose bleeds
__Cold symptoms

Skin
__New or changing moles
__Rash
__Lesions
__Itching
__Easy bruising
__Hair loss

Breast
__Breast discharge
__Breast lump

Cardiovascular
__Chest pains
__Shortness of breath
__Rapid/skipped heartbeats
__Ankle swelling
__Leg pain with walking

Neurological
__Numbness/tingling
__One sided weakness
__Tremors
__Difficulty talking
__Difficulty walking
__Dizziness

Genital
__Genital discharge
__Pain with intercourse
__Testicular pain or lump
__Difficulty getting pregnant

Urinary
__Blood in urine
__Painful urination
__Frequent urination
__Night time urination
__Urinary incontinence
__Difficulty starting stream

Pulmonary
__Chronic cough
__Coughing blood
__Wheezing
__Shortness of breath
__Sputum production

Musculoskeletal
__Muscle pain
__Joint pain
__Back pain
__Swelling

Do you have someone to make health decisions for you in case you were incapacitated? ___YES ___NO
_____
Do you wish to add anything else?_____
_____
_____

I certify that the above information is accurate to best of my knowledge. I understand withholding information be it intentional or by negligence to fill out this form, could result in improper medical care and could be a detriment to my health or even life threatening.

Signature

CULLMAN INTERNAL MEDICINE, P.C.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____ SSN: _____

_____

By signing below, you hereby authorize us to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose and time period described below. You may refuse to sign this authorization. Subject to certain exceptions, you have the right to inspect and copy the protected health information. Information to be used or disclosed (must be identified in a specific and meaningful fashion); and purpose to the use and disclosure:

Please list the family members or others persons, if any, we may inform about your general medical condition and your diagnosis, which might include medical history, treatment, laboratory reports, x-rays, and treatment and /or reference to any mental or nervous disorders, drug, an/or alcohol abuse, or sexually transmitted disease.

_____ *Relationship:* _____

_____ *Relationship:* _____

_____ *Relationship:* _____

Please list the family members or other persons, if any, we may inform about your general medical condition and your diagnosis ONLY in an emergency situation:

_____ *Relationship:* _____

_____*Relationship:* _____

This information about you is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised, however that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuel to sign the authorization.

_____ _____

Patient Signature or Personal Representative Date

As a personal representative, I have authority to act for the individual because I am:_____

Cullman Internal Medicine
1890 Al Hwy 157 Suite 300
Cullman, Al 35058
256-737-8030 Fax: 256-737-8058

Authorization for Medical Records Release

Patient Name:_____(Please Print)

Date of Birth :_____

Date Request Received: _____Date of Expiration:_____

Persons/Place providing the information: _____

Phone # _____ Fax# :_____

Persons/Place receiving the information:_____

Specific description of information (including date(s)): _____

_____

Purpose of use or disclosure:_____

The patient or the patient's representative must read and initial the following statements: I understand that I may revoke this authorization at any time by notifying the Cullman Internal Medicine Privacy Officer in writing, but if I do, it will not have any effect on any actions Cullman Internal Medicine took before they received the revocation.

Initials:_____

I hereby authorize the use of disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
I understand that Cullman Internal Medicine may not condition the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on signing this authorization, except under the following circumstances:

- Participating in research projects can be conditioned on my signing an authorization to use and disclose PHI in the research.
- Initial enrollment in health plans can be conditioned on signing an authorization for the health plan in review PHI to make eligibility determinations.
- Furnish healthcare services to me at the request of a third party can be conditioned on me signing an authorization for disclosure of the PHI to the third party requesting the treatment.

Initials:_____

Signature of patient or patient's representative:_____

Printed name of patient or patient's representative:_____

Relationship to Patient:_____ Date signed:_____

Doctor:_____

Cullman Internal Medicine
1890 Alabama Highway 157, Suite 300
Cullman, Alabama 35058

William F Peinhardt, M.D.
Phillip W. Freeman, M.D.
L. James Hoover, M.D.
W. Michael Hall, M. D.
NayKala Ruse, M.D.
Lisa Ellard, CRNP
Kelley Johnson, CRNP
Rebecca Harris, CRNP

C. Anthony Rutledge, M.D.
Lane Friedman, M.D.
Melinda Hart, M.D.
Jeremy Stidham, M.D..
Bethany Lamar, CRNP
Anne Armstrong, CRNP
Marcia Tillman, CRNP
Allison Newman, M.D.

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO RURAL HEALTH CLINIC EXTENDED PATIENT SIGNATURE AUTHORIZATION

_____ _____

Name of Beneficiary HI Claim Number

I request payment of authorized Medicare benefits on my behalf for any services furnished me by Cullman Internal Medicine, P.C. I authorize any holder of medical and other information about me to release to Medicare and its agents, any information needed to determine these benefits for related services.

_____ _____

Date Patient Signature