JAMES J. VOPAL, M.D.

PATIENT INFORMATION SHEET

NAME: ____
(First) (Middle) (Last)

Address: ____

City: ______________________________ State: ______________ Zip: ________

Address #2 (if applicable) : ____

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Home Phone: ______________________ Birthdate: ______________ Age: ______

Cell Phone: ____

E-mail: ____

Patient Employer: ______________________ Occupation: ______________ Phone: ______________

Social Security Number: ______________________ Marital Status: S M W D

Person Responsible for Account: ____

Relationship to Patient: ____

I will be paying (fees or co-pay) today by Cash__________ Check__________ Credit Card__________

EMERGENCY CONTACT: ______________________________ PHONE: ______________

REFERRING M.D. ______________________________ FAMILY M.D. ______________

INSURANCE INFORMATION:
(PLEASE HAVE YOUR INSURANCE CARD OUT TO COPY)

PRIMARY: ______________________________ SECONDARY: ______________________________

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO DR. JAMES VOPAL. I REALIZE THAT I AM RESPONSIBLE TO PAY NON-COVERED SERVICES (INCLUDING COLLECTION COSTS IN THE EVENT OF DEFAULT). A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AS ORIGINAL. I FURTHER AUTHORIZE RELEASE OF MEDICAL INFORMATION TO SECURE PAYMENT.

PATIENT SIGNATURE: ______________________________ DATE:

SOCIAL HISTORY

Single____________ Married____________ Divorced____________ Widowed__________ # of Children ____________

Occupation ____

If Retired, Before Retirement: ____

TOBACCO yes no How long? How much? Quit when? ______________________________

ALCOHOL yes no How much? Quit when? ______________________________

CAFFEINE yes no How much? ______________________________

STREET DRUGS Marijuana ______________ Cocaine __________ Heroin __________ Others ____________

WEIGHT Present ___________ Usual _____________ Any weight change in past year? yes ___ no ___ How Much?______

FAMILY HISTORY

(Please indicate whether living or deceased, age, medical illnesses and cause of death if deceased.)

Mother ____

Father ____

Brother ____

Sister ____

MEDICAL HISTORY

Medications (list each with dosage and frequency):

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Drug Allergies and Reaction:

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Surgical History (list all past operations and the year):

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PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING AND INDICATE WHEN LAST DONE.

_______ Complete medical exam

_______ Electrocardiogram (EKG)

_______ Stress test (cardiac)

_______ Pulmonary function test

________ Blood work

________ Ultrasound Breast/Thyroid/Carotid

________ Chest X-ray

________ Mammogram

Medical History (check all that apply)

______ High Blood Pressure
______ Heart Arrythmias
______ Hepatitis ________ When
______ Pneumonia ________ When
______ Cancer
Where
____
____
____

______ Heart Attack __________ When
______ High Cholesterol
______ Peptic Ulcer Disease _______ When
______ Emphysema
______ Asthma

______ Heart Failure
______ Diabetes
______ Liver Disease/Cirrhosis
______ Vascular Disease
______ Hiatal Hernia/Reflux
When
____
____
____

REVIEW OF SYSTEMS: Please check if you have a personal history of these in the past two years.

GENERAL
______ Weight Gain/Loss (which)
______ Fatigue/Lethargy
______ Loss of Appetite
______ Fever
______ Chills
______ General Weakness
______ Night Sweats

EARS
______ Radiating Pain
______ Hearing Impairment
______ Ringing

EYES
______ Double Vision
______ Blurred Vision
______ Glasses/Reading/Distance (which)

NOSE
______ Nose Bleeds
______ Stuffiness
______ Post Nasal Drip
______ Sinusitis

Neurologic
______ Memory Loss
______ Headache - Frequent/Severe (which)
______ Numbness: Where __________
______ Blacking Out Spells
______ Dizziness
______ Balance Problems

ORAL
______ Dentures
______ Periodonitis
______ Dental Pain
______ Ulceration or Sores

NECK
______ Enlarged Glands
______ Lumps or Swelling
______ Limitation of Movement
______ Pain

RESPIRATORY
______ Hoarseness
______ Shortness of Breath
______ Cough
______ Wheezing
______ Cough up Blood

CARDIAC
______ Chest pain/Angina
______ Palpitations
______ Murmur
______ Arrhythmia
______ Low Exercise Tolerance
______ Swollen Ankles
______ Inability to Sleep Flat
______ Nocturia (more than 2x night)

GI
______ Nausea/Vomiting
______ Difficulty Swallowing
______ Diarrhea
______ Constipation
______ Abdominal Pain
______ Vomit Blood
______ Blood in Stool
______ Change in Bowel Habits
______ Reflux/Heartburn (which)

GU
______ Blood in Urine
______ Frequent Urination
______ Frequent Urinary Tract Infection
______ Burning with Urination
______ Difficulty Starting & Stopping Stream

VASCULAR
______ Varicose Veins
______ Claudication/Pain in Leg/Buttock
______ Cold Feet/Toes

HEMATOPOETIC
______ Swollen Glands
______ Anemia
______ Easy Bruising/Bleeding
______ Transfusions

ENDOCRINE
______ Swollen or Enlarged Thyroid
______ Thyroiditis/Hyperthyroidism
______ Heat/Cold Intolerance (which)
______ Family History of Thyroid Cancer
______ Family History of Goiter
______ History of Radiation to Face/Neck (anytime during life)
______ Elevated Serum Calcium
______ Steroid Use

MUSCULOSKELETAL
______ Joint Pain ______ where?
______ Muscle Pain ______ where?
______ Pain in Legs with Walking
______ Sciatica
______ Lumps on Bones, Joints, Muscles

INTEGUMENTARY
______ New or Changing Moles
______ Rash
______ Pigmentation

GYNECOLOGIC
______ Breast Lump
______ Nipple Discharge
______ Hot Flashes
______ Breast Pain
______ Pain with Intercourse
______ Irregular Menses
______ Post Menopausal Bleeding

PSYCHOLOGICAL
______ Depression
______ Anxiety
______ Phobias-What? ____________
______ Considered Suicide

I hereby certify that the information given is to the best of my knowledge true and accurate.

Patient Signature ____ **Date** ____________

JAMES J. VOPAL, M.D.

CONSENT AGREEMENT

By signing this form, you are granting consent to Dr. James Vopal, M.D. to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

I understand and authorize, that at times it will be necessary for Dr. Vopal and /or Staff to call my home or place of business and leave messages on an answering machine, voice mail or e-mail.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your request.

I wish to have the following restrictions to the use or disclosure of my health information.

I fully understand and accept / decline the terms of this consent.

SIGNATURE________________________________

DATE________________________________

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information *(PHI)*. The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home Telephone ____________________
  - ☐ O.K. to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Work Telephone ____________________
  - ☐ O.K. to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Cell Telephone ____________________
  - ☐ O.K. to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Written Communication
  - ☐ O.K. to mail to my home address
  - ☐ O.K. to mail to my work/office address
  - ☐ O.K. to fax to this number ____________
- ☐ Other (Please Print Name & Relation to Patient)

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______________________________ Patient Signature

______________ Date

______________________________ Print Name

______________ Birthdate

PLEASE DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized

(2) Type key: T=Treatment Records: P=Payment Information; O=Healthcare Operations; A=Authorization on File; D=Discretionary

(3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other