PATIENT INFORMATION

DATE:________________SOC SEC#:______________________DOB:________________

NAME:____
LAST NAME FIRST NAME INITIAL

ADDRESS:____

CITY:_______________________________ STATE:____________ ZIP:__________

HOME PHONE:______________________

CELL PHONE:______________________

SEX:________MALE ________FEMALE MARITAL STATUS:__________________

EMPLOYER:_______________________________ BUSINESS PHONE:__________

WHOM MAY WE THANK FOR REFERING YOU?_______________________________

IN CASE OF EMERGENY, WHO SHOULD WE CONTACT

1.____________________________________ PHONE:______________________

2.____________________________________ PHONE:______________________

ADDRESS TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

1. I authorize the release of any medical information necessary to process this claim.
2. I herby authorize Primary Health and Wellness Centers/ Irwin Family Care to apply benefits on my behalf for covered services rendered by him/her or by his/her order. I request the payment from my insurance company be made directly to Primary Health and Wellness Centers/ Irwin Family Care (or to the party who accepts assignments) I understand that I am ultimately responsible for payment of services rendered.
3. I certify that the information I have reported with regard to my insurance coverage is correct.
4. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

5. DATE:____________SIGNITURE____
Patient, Parent, or Guardian

Original Date:
☐ Entered EMR ____________
☐ Reviewed by Provider ____________

PRIMARY HEALTH AND WELLNESS CENTERS
HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.)*: ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and dates:		
	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting?			☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?			☐ Yes	☐ No
	# of meals you eat in an average day?				
	Rank salt intake	☐ Hi	☐ Med	☐ Low	
	Rank fat intake	☐ Hi	☐ Med	☐ Low	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?			☐ Yes	☐ No
	Have you considered stopping?			☐ Yes	☐ No
	Have you ever experienced blackouts?			☐ Yes	☐ No
	Are you prone to "binge" drinking?			☐ Yes	☐ No
	Do you drive after drinking?			☐ Yes	☐ No
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No

Sex			
	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

Primary Health & Wellness Centers
Irwin Family Care
AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

H I P A A

I ______________________________ authorize Primary Health & Wellness Centers/Irwin Family Care to use or disclose health information as described below regarding my treatment, hospitalization, and/or care for my condition, which may include psychiatric impairment, drug abuse, and/or alcoholism, sickle cell anemia, sexually transited disease or AIDS or tests for or infection of HIV.

Patient Name: ______________________________
Address: ______________________________ Birth Date: ____________

____

____

Description of information to be used or disclosed, which could include all or part of the following:

- Face sheet
- Chart notes
- Discharge summaries
- Histories/ Physicals
- Consultations from other Physicians
- Operative Reports
- Pathology Reports
- Laboratory Reports
- Diagnostic Testing Reports
- X-Ray Films
- Entire Records
- Release of Information to Specialists/ Home Health
- Messages left on answering machine or voicemail
- Other (please specify): ______________________________
- Additional Authorized Recipients(list names of family members/friends who can have access to information):

____

____

____

I understand that the information described above could possibly be re-disclosed by the recipient and no longer protected by the federal privacy regulations. The recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing as described in the Primary Health and Wellness Centers Privacy Practices. I understand that the revocation will not apply to information that has already been used to disclose in response to insurance coverage, as the insurer has the right by law to contest a claim or insurance policy. **Unless otherwise revoked, this authorization will expire upon transfer to records.**

I authorize the information stated above concerning the federal HIPAA Privacy Rule and understand that all communication and information regarding HIPAA Privacy Rule will be in written form.

______________________________ ____________
Signature of Patient or Legal Representative Date

I have received a copy of the Notice of Privacy Practice as written by Primary Health and Wellness Centers.

______________________________ ____________
Signature of Patient or Legal Representative Date

______________________________ ____________
If signed by legal Representative, Relationship to Patient Date

______________________________ ____________
Signature Witness Date

LIVING WILL DECLARATION

I,________________________________, being of sound mind, willfully and voluntarily make this declaration to be followed if I become incompetent. This declaration reflects my firm and settled commitment to refuse life-sustaining treatment under the circumstance indicated below.

I direct my attending physician to withhold or withdraw life-sustaining treatment that serves only to prolong the process of my dying, if I should be in terminal condition or in a state of permanent unconsciousness.

I direct the treatment to be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing life-sustaining treatment.

In addition, if I am in the condition described above, I feel especially strong about the following forms of treatment: (please circle choice)

I	do	do not	want cardiac resuscitation.
I	do	do not	want mechanical respiration.
I	do	do not	want tube feeding or any artificial or invasive form of nutrition (food) or hydration (water).
I	do	do not	want blood or blood products
I	do	do not	want any form of surgery or invasive diagnostic tests.
I	do	do not	want kidney dialysis
I	do	do not	want antibiotics.

I realize that if I do not specifically indicate by preference regarding any of the forms of treatment listed above, I will receive that form of treatment. Other instructions:

I	do	do not	want to designate another person as my surrogate to make medical treatment decisions for me if I should be in terminal condition or in a state of permanent unconsciousness.

Name and address of surrogate (if applicable):______________________________
____
____
____

I	do	do not	want to make any anatomical gift of all or part of my body, subject to limitations, if any:

I make this declaration on the ____________ day of ________________, 20______.

Declarant's Signature:____Address:______________________
____
____

The declaring or the person on behalf of and the direction of the declaring knowingly and voluntarily sign this writing signature or mark in my presence.

Witness's Signature:____________________________ Address:__________________________ Date:________

I have **refused** filling out this living will: Signature:____ Date:________

Primary Health and Wellness Centers
Irwin Family Care
Agreement to Participate in Surescripts

I, ______________________________ agree to participate with Surescripts pharmacy services in providing and coordinating electronic prescription transmittal services between Primary Health and Wellness/Irwin Family Care and the pharmacy I select.

I understand the purpose of this agreement is to allow my physician to access information through Surescripts to be used in the coordination of my medical care and to allow the electronic transmission of prescriptions to and request from my pharmacy.

I understand this agreement will remain in effect for as long as I seek medical care with this practice and will terminate should I transfer my care, request termination of this agreement or after a period of three years without activity with this practice.

In order to receive prescriptions from any providers at Primary Health and Wellness/ Irwin Family Care this form must be signed.

______________________________ Date:______________
Patient Signature

______________________________ Date:______________
Witness Signature

Primary Health and Wellness Centers
& Irwin Family Care

905 Spruce St. Irwin PA, 15642
410 Pellis Rd. Ste 1A Greensburg PA, 15601

Consent and Treatment Agreement for the Treatment of Non-Cancer pain with controlled substances
(Please read fully and carefully before signing)

(Print Name) ______________________________, agrees to the following:

1. I agree to obtain all prescriptions for controlled substances and pain medications from my Irwin Family Care/Primary Health and Wellness Centers Provider. I agree to properly store and safeguard these medications.
2. I agree to use only one pharmacy for the filling of prescription pain medications or controlled substances and to supply the name, address, and telephone number of this pharmacy.

(Pharmacy Info) ______________________________

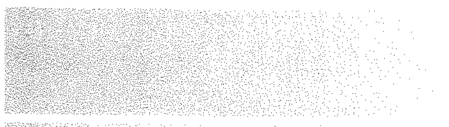
3. I agree to let my Provider and Irwin Family Care/PHWC to communicate with any physicians, insurance co., or pharmacist involved in my care regarding the use of controlled substances and/or pain medications.
4. I agree to take the medications only as prescribed.
5. I agree to follow the advice in regards to stopping pain medications should it be advisable.
6. I certify that I am not pregnant. I certify that I will use appropriate measures to prevent pregnancy during the course of my treatment with controlled substances/pain medications.
7. I understand that no allowances will be made for lost prescriptions.
8. I agree to undergo random drug screening and/or pill counting.
9. I will not share illicit drugs.
10. I understand there is the potential for addiction, dependency, tolerance, and possible withdrawal symptoms to occur with the use of some controlled substances.
11. I understand controlled substances and/or some pain medications can interfere with my ability to drive and operate equipment. I agree to refrain from driving when taking these substances. I also understand that I can be charged with "Driving Under the Influence (DUI)" when taking these substances.
    A. I understand that Irwin Family Care/PHWC has an obligation to notify the Pennsylvania Department of Transportation at our discretion if this agreement is ever violated.
12. I understand that this mode of treatment will be stopped if any of the following occurs:
    A. I give, sell, or abuse medications.
    B. I am found non-compliant with any conditions of the agreement.
    C. I develop rapid tolerance or loss of effectiveness of the agreement.
    D. I obtain a controlled substance from sources other than Irwin Family Care/PHWC.
13. I agree to be referred to a pain management clinic and will do so at the discretion of my Provider.

I HAVE READ THIS AGREEMENT, UNDERSTAND IT, AND HAVE ALL MY QUESTIONS ANSWERED SATISFACTORILY. I CONSENT TO THE USE OF CONTROLLED SUBSTANCES AND/OR PAIN MEDICATION UNDER THE TERMS OF THIS AGREEMENT. I UNDERSTAND VIOLATIONS OF THIS AGREEMENT MAY RESULT IN DISCHARGE FROM THIS PRACTICE. THIS AGREEMENT REMAINS IN EFFECT AS LONG AS I AM A PATIENT OF THIS PRACTICE.

(Signature) ______________________________ (Date) ______________

(Print Name) ______________________________ (DOB) ______________

(Witness) ______________________________



Primary Health & Wellness Centers

Family Practice · Osteopathic Medicine · Geriatric Medicine · Occupational Medicine · Women's Care

Irwin Family Care
905 Spruce Street
Irwin, PA 15642
724-864-9595

Family Practice
410 Pellis Road Ste. 1A
Greensburg, PA 15601
724-832-7877

Primary Health and Wellness Centers will be implementing use of a ***Patient Portal*** through our EMR system. In order to gain access through this portal, we will need to collect an email address to attach to your chart.

The patient Portal will allow patients to:

Request RX refill

Request appointments

View results

And so much more!

Patients Name: ______________________________ DOB: ____________________

I am authorizing Primary Health and Wellness Centers (Irwin Family Care and/or Family Practice) to add the following email address to my chart:

Email Address: ______________________________

Patients Signature: ______________________________