

Lake Erie Medical Group, PC

Erie Family Medical Group

Niagara Internal Medicine

2014

Physician _____ Account Number _____

Patient Information: This section refers to the PATIENT ONLY

Social Security Number _____
Last Name: _____ Jr., II, _____
First Name: _____ MI _____
Maiden Name: _____ Nickname: _____
Address: _____
City, State: _____ Zip Code: _____

If employed, Employer: _____
Address: _____
City, State: _____ Zip Code: _____

Home Phone: () _____
Work Phone: () _____ ext: _____
Cell Phone: () _____

Health Related Msgs Allowed: YES NO
Health Related Msgs Allowed: YES NO
Health Related Msgs Allowed: YES NO
Text Msgs Allowed: YES NO
Health Related Msgs Allowed: YES NO

EMAIL: _____ @ _____

Birth Date (mm/dd/yy): _____ Sex: Male Female
Marital Status: Married Single Separated Divorced Widowed
Race: African American American Indian Asian Caucasian Hispanic Pacific Islander
Preferred Language: English Other _____

EMERGENCY CONTACT: _____ Relationship: _____ Phone: () _____
If Student: Full Time Part Time Name of School: _____

>> Complete Subscriber Information and Responsible Party if different from Patient <<

Subscriber Information: Primary card holder

Relationship to patient:

Self Parent Spouse Other

If same as subscriber, skip this section.

Social Security Number: _____
Last Name: _____ Jr., II, _____
First Name: _____ MI _____
Address: _____
City, State: _____ Zip Code: _____
Home Phone: () _____
Birth Date: _____ Sex: Male Female
Employer: _____
Address: _____
Work Phone: () _____ Ext: _____

Responsible Party: (Who receives the bill)

Relationship to patient:

Self Parent Spouse Other

If same as subscriber, skip this section.

Last Name: _____ Jr., II, _____
First Name: _____ MI _____
Address: _____
City, State: _____ Zip Code: _____
Home Phone: () _____
Work Phone: () _____ Ext: _____

Release of Information/HIPAA

I understand this release will be in effect unless changed by myself either in writing or by filling out a new release. I also understand that extraordinary confidential information is not included in this release, this includes: HIV, mental health, drug/alcohol, and sexually transmitted disease information.

I have been made aware of Lake Erie Medical Groups HIPAA compliance policy however, I authorize Lake Erie Medical Group or one of their associates employed by their practice to release medical test results or other medical information relating to my treatment to:

Check all that apply:

May leave a message to call the LEMG office:
on home answering machine/voice mail at work
Leave results/appointments on home answering machine/voice mail
May only release test results to myself
May give results/appointment information to person(s) listed below

Name: _____
Relationship: _____
Phone #: _____
Signature: _____ Date: _____

FINANCIAL RESPONSIBILITY POLICY
Lake Erie Medical Group, PC

Consent to services:

Patient hereby requests registrations at Lake Erie Medical Group, PC office and voluntarily consents to any facility services deemed necessary or advisable as determined by, as appropriate, the attending physician or his or her assistants/designees, or employees or agents of Lake Erie Medical Group, PC with appropriate clinical privileges. Patient (responsible party) acknowledges that no guarantees have been made as to the results of treatment or examination at the Lake Erie Medical Group, PC office.

Payment Guarantee:

For and in consideration of services rendered by the Lake Erie Medical Group, PC office, patient (responsible party) hereby agrees to and guarantees payment of all charges incurred for the account of the patient. **Payment is due in full when services are rendered. We accept cash or credit card.**

If the patient is eligible with Lake Erie Medical Group, PC participating insurance company and identification is provided, the insurance company will be billed for the services rendered in lieu of cash payment by the patient (responsible party); **co-pays and deductible to be paid at the time of service.**

Consent to release information:

The undersigned hereby authorizes Lake Erie Medical Group, PC office to release to employer group, insurance companies, government agencies or other third party payers and their agents information that may be necessary for the purpose of determining eligibility and available benefits and obtaining payments on the patient's behalf for the health care services rendered to the patient. Patient (responsible person) acknowledges that he or she will be financially responsible for charges incurred for the patient's treatment if revocation or refusal to authorize the disclosure of the medical records results in a payment denial of the insurance claim.

Medicare:

Patient certifies that the information given in applying for payment under Title XVIII (18) of the Social Security Act is correct Patient (responsible party) authorizes any holder of medical or other information about patient to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medical claim. Patient (responsible party) requests that payment of authorized benefits be made on his or her behalf to the name of provider of service for any services furnished to the patient by that provider of service.

Medigap:

Patient (responsible party) requests that payment of authorized Medigap benefits be made on patients behalf to the provider of service furnished to the patient by that provider of service. Patient (responsible party) authorizes any holder of Medicare information about patient to release to

(Medigap Name) _____ any information needed to determine these benefits payable for related services.

Assignments of Insurance Benefits and Agreement to Pay at the time of services:

Patient (responsible party) irrevocably assigns and transfers to Lake Erie Medical Group, PC all right, title and interest to medical reimbursement benefits under any and all applicable medical insurance policies covering patient, for the payment of hospital and medical care being provided. Patient (responsible party) authorizes payment directly to Lake Erie Medical Group, PC of said medical reimbursement benefits. In the event that said medical insurance coverage is not sufficient to satisfy the charge in full, patient (responsible party) acknowledges that the resulting balance is not covered by this assignment and agrees to be fully responsible for the payment if any balance is due. If the insurance is a non-contracted payer, or the patient does not have medical insurance, the balance will be deemed to be "patient responsible" and paid at the time of service. Patient (responsible party) acknowledges responsibility for any expenses incurred by Lake Erie Medical Group, PC for collecting any of the charges incurred on the account of the patient. Such shall specifically include any attorney's fee or any collection fees, or litigation and/or audit costs incurred by Lake Erie Medical Group on collecting said bill.

These agreements and authorizations shall be valid for one (1) year from the date of patient/parent/guardian signature.

PLEASE NOTE: Checks may be converted to electronic debits to your account. If returned, NSF fee may be electronically charged to your account.

Patient Name (Last, First, Mi) (print) Health Insurance Claim Number

Patient Signature (Parent/Guardian) Medigap Policy Number Date

Please check the appropriate description of your relationship to the patient:

_____self, _____Parent/Legal Guardian of Minor, _____Other

Lake Erie Medical Group, PC

11/01/2014

Lake Erie Medical Group, PC Payment Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with quality and affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibility for the services rendered, we thought it would be in your best interest to develop a payment policy. Please read it, ask any questions you may have, and sign in the space provided. A copy will be provided to you upon your request.

Insurance- We participate with most major insurance companies, including Medicare, Highmark & Health America. If you are not insured by a company that we participate with, we will bill your insurance company for you, but the balance will remain your responsibility until payment is received. If you are insured by a company that we are participating with but do not have your current insurance card, the balance will remain yours until we receive the updated insurance card and can verify coverage.

Co-payments and deductibles- All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

Self-Pay - Cash Payment Only required- Payment is due at the time of service unless other arrangements are made in advance of the service.

Non-covered services- Please be aware that some (and perhaps all) of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You may be asked to sign an acknowledgement or Medicare Waiver (ABN) that this was explained to you & you understood this before services are rendered and you may be responsible for the unpaid balance.

Proof of Insurance- All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Claim submission- We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

Coverage changes- If your insurance changes, please notify us before your next visit so that we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

Nonpayment- If your account is over 60 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payment will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from the practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days (unless stated otherwise) to find alternative medical care. During that 30 day period, our Physicians will be able to treat you only on an emergency basis. Once discharged from Lake Erie Medical Group, PC or ancillary, you will not have access to any of the Lake Erie Medical Group, PC facilities or Physicians.

Missed appointments- Our policy is charge for missed appointments not cancelled at least 24 hours in advance. These charges will be your responsibility and billed directly to you. Once a patient has had 3 or more missed appointments, you may be discharged from the practice as well. Please help us to serve you better by keeping your regularly scheduled appointment or canceling at least 24 hours in advance.

Financial Responsibility Form- You will be asked to read and sign our Financial Responsibility Form. This provides you with more information and gives us permission to bill your insurance company for any services incurred during your visit. It also validates your knowledge of our financial policy and your responsibility for any balances on your account. This form is good for one year and you will be asked to sign it at your first visit of the new year.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy as stated above and agree to abide by its guidelines.

Signature of patient or responsible party

Date

Due to new banking laws, Lake Erie Medical Group, PC will be using a function that will allow us to convert your patient payment from checks to electronic payments. If you pay by check, please read and sign the following disclosure.

I authorize my check to be converted to an electronic payment, and authorize the merchant, or its collection agent, to electronically charge my account as NSF Fee, not to exceed maximum set by law, if my check is returned for non-sufficient funds (NSF), CANCELLED CHECK.

Signature of patient or responsible party

Date

ALLEGHENY HEALTH NETWORK
Lake Erie Medical Group

Receipt of Notice of Privacy Practices Form

I, _____, hereby acknowledge receipt of the Notice of Privacy Practices for Allegheny Health Network/Lake Erie Medical, PC (Erie Family Medical Group and Niagara Internal Medicine).

The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the practice has reserved the right to change its privacy practices that are described in the notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

Name: (please print) _____

Signature: _____

Date: _____

LAKE ERIE MEDICAL GROUP

Physical Examination Form

Name: _____ Date of Exam: _____

Age: _____ Marital Status: _____ Emergency Contact: _____

Telephone: (H) _____ (C) _____ Occupation: _____

Reason for Visit: _____

Past Medical History: Have you ever been diagnosed with any of the following conditions? Please Check.

	Yes	No		Yes	No		Yes	No
(Cardiac)			Hepatitis:	<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus:	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure:	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice:	<input type="checkbox"/>	<input type="checkbox"/>	Vision Problems:	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease:	<input type="checkbox"/>	<input type="checkbox"/>	Gall Stone:	<input type="checkbox"/>	<input type="checkbox"/>	Vision Loss:	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol:	<input type="checkbox"/>	<input type="checkbox"/>	Cirrhosis(liver disease):	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma:	<input type="checkbox"/>	<input type="checkbox"/>
Stroke:	<input type="checkbox"/>	<input type="checkbox"/>	Constipation:	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts:	<input type="checkbox"/>	<input type="checkbox"/>
Vascular Disease:	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel:	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss:	<input type="checkbox"/>	<input type="checkbox"/>
PAD:	<input type="checkbox"/>	<input type="checkbox"/>				Headaches:	<input type="checkbox"/>	<input type="checkbox"/>
CAD/MI:	<input type="checkbox"/>	<input type="checkbox"/>	(Rheumatology)			Parkinson's:	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat:	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis:	<input type="checkbox"/>	<input type="checkbox"/>			
CHF:	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis:	<input type="checkbox"/>	<input type="checkbox"/>	(Pulmonary)		
Valvular Heart Disease:	<input type="checkbox"/>	<input type="checkbox"/>	Neck/Back Pain:	<input type="checkbox"/>	<input type="checkbox"/>	COPD:	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Disease:	<input type="checkbox"/>	<input type="checkbox"/>	Osteopenia:	<input type="checkbox"/>	<input type="checkbox"/>	Asthma:	<input type="checkbox"/>	<input type="checkbox"/>
Carotid Disease:	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis:	<input type="checkbox"/>	<input type="checkbox"/>	Other Lung Disease:	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur:	<input type="checkbox"/>	<input type="checkbox"/>	Vit D Deficiency:	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots: DVT/PE:	<input type="checkbox"/>	<input type="checkbox"/>
Aneurysm:	<input type="checkbox"/>	<input type="checkbox"/>				Environmental Allergies:	<input type="checkbox"/>	<input type="checkbox"/>
Atrial FIB:	<input type="checkbox"/>	<input type="checkbox"/>	(Hematology)			Sinus Infection:	<input type="checkbox"/>	<input type="checkbox"/>
			Cancer:	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema:	<input type="checkbox"/>	<input type="checkbox"/>
(Endocrinology)			AIDS / HIV infection:	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea:	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes:	<input type="checkbox"/>	<input type="checkbox"/>	Anemia:	<input type="checkbox"/>	<input type="checkbox"/>			
Hypo/Hyper Thyroid:	<input type="checkbox"/>	<input type="checkbox"/>	Skin Cancer:	<input type="checkbox"/>	<input type="checkbox"/>	(Other)		
Goiter:	<input type="checkbox"/>	<input type="checkbox"/>	Vit B12 Deficiency:	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism:	<input type="checkbox"/>	<input type="checkbox"/>
						Anxiety:	<input type="checkbox"/>	<input type="checkbox"/>
(Gastric)			(Renal)			Depression:	<input type="checkbox"/>	<input type="checkbox"/>
Peptic Ulcers:	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease:	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue:	<input type="checkbox"/>	<input type="checkbox"/>
GERD (Reflux):	<input type="checkbox"/>	<input type="checkbox"/>	Renal Cyst:	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis:	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis:	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Kidney Dz:	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disorder:	<input type="checkbox"/>	<input type="checkbox"/>
Gall Bladder:	<input type="checkbox"/>	<input type="checkbox"/>				Tobacco Abuse:	<input type="checkbox"/>	<input type="checkbox"/>
Pancreatitis:	<input type="checkbox"/>	<input type="checkbox"/>	(Neurology)			Urinary Incontinence:	<input type="checkbox"/>	<input type="checkbox"/>
Colon Polyps:	<input type="checkbox"/>	<input type="checkbox"/>	Seizures:	<input type="checkbox"/>	<input type="checkbox"/>	BPH:	<input type="checkbox"/>	<input type="checkbox"/>
Diverticulitis:	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's:	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Cancer:	<input type="checkbox"/>	<input type="checkbox"/>
			Vertigo:	<input type="checkbox"/>	<input type="checkbox"/>			

Past Surgical History: Have you ever had any of the following operations? Please Circle.

Tonsillectomy/Appendectomy:	Yes	No	If so, when:
Gallbladder Surgery:	Yes	No	If so, when:
Hernia Repair:	Yes	No	If so, when:
Back Surgery:	Yes	No	If so, when:
Thyroid Surgery:	Yes	No	If so, when:
Hip/Knee/Joint Surgery:	Yes	No	If so, when:
Eye Surgery:	Yes	No	If so, when:
Cataract Surgery:	Yes	No	If so, when:
Sinus Surgery:	Yes	No	If so, when:
Heart/Bypass/Valve Surgery:	Yes	No	If so, when:
Hysterectomy/Ovarian Surgery/Tubes Tied:	Yes	No	If so, when:
Breast Surgery:	Yes	No	If so, when:
Vasectomy:	Yes	No	If so, when:
Prostate Surgery:	Yes	No	If so, when:

Any other surgeries, List: _____

Do you have any **Drug Allergies or Intolerances** or any allergies to foods, iodine, seafood, etc.? Please list: _____

Patient Name: _____

DOB: _____

Are you currently taking any **Medication?** Yes No If so, please list below:

(Include prescription drugs, OTC meds, vitamins, etc.)

<u>Name of medication:</u>	<u>Dose:</u>	<u>Directions:</u>
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____
6) _____	_____	_____

Family History: Is there any history of diabetes, hypertension, heart disease, cancer, TB, stroke, osteoporosis, or Alzheimer's in your family? If so, please list: _____

	<u>Age</u>	<u>Living</u>	<u>Health Status</u>	<u>Cause of Death</u>
<u>Father:</u>		Yes No		
<u>Mother:</u>		Yes No		
<u>Brother:</u>		Yes No		
<u>Brother:</u>		Yes No		
<u>Sister:</u>		Yes No		
<u>Sister:</u>		Yes No		

Any family history of Breast Cancer:	Yes	No	If so, who?
Any family history of Ovarian Cancer:	Yes	No	If so, who?
Any family history of Testicular Cancer:	Yes	No	If so, who?
Any family history of Prostate Cancer:	Yes	No	If so, who?
Any family history of Colon Cancer:	Yes	No	If so, who?

Personal History:

Do you have any Children?	Yes	No	If so, how many?
Do you have a living will?	Yes	No	
Are you an organ donor?	Yes	No	
Previous occupations:	_____		
Have you ever smoked?	Yes	No	
If so, do you still smoke?	Yes	No	If so, how many packs per day?
If you quit, when?	_____		
Do you smoke cigars/chew snuff?	Yes	No	
Are you exposed to second hand smoke?	Yes	No	
Do you drink any alcohol?	Yes	No	If so, what and how much?
Have you ever used any illegal drugs?	Yes	No	If so, when?
Have you ever received a blood transfusion?	Yes	No	If so, when?
Are you sexually active?	Yes	No	If so, do you practice 'safe sex'?

Review of Systems:

Weight change of more than 5 lbs. In last year?	Yes	No	If so, how much?
Is your appetite <u>abnormal</u> ?	Yes	No	If so, in what way?
Are you thirstier than normal?	Yes	No	
Ever have a bleeding disorder/anemia/bruising?	Yes	No	If so, describe:
Are you more tired than normal?	Yes	No	
Do you have trouble sleeping at night?	Yes	No	If so, is this new:
Do you have to get up every night to urinate?	Yes	No	If so, how often?

Skin:

Have you had a recent rash/itching?	Yes	No
Have you had a change in any skin lesion/mole?	Yes	No

Eyes:

Have you had a recent change in your vision?	Yes	No
When was your last eye exam?	_____	

Ears:

Do you have any hearing problems?	Yes	No
-----------------------------------	-----	----

Nose:

Have you had recent nosebleeds/sinus problems?	Yes	No
--	-----	----

Oral Cavity:

Do you have problems with your teeth?	Yes	No
Do you have dentures/gum disease/oral ulcers?	Yes	No

Patient Name: _____

DOB: _____

Respiratory:

Have you ever had any lung disease?	Yes	No
Do you get short of breath at rest or with exertion?	Yes	No
Do you have a cough or wheezing?	Yes	No

Cardiac:

Have you ever had a heart problem?	Yes	No
Have you had chest pains/burning/pressure?	Yes	No
Do you have palpitations (skipping/racing heart)?	Yes	No
Have you been dizzy or blacked out?	Yes	No
Have you had Mitral Valve Prolapse?	Yes	No
Do you get pains in your legs with walking?	Yes	No
Do your feet/ankles swell?	Yes	No

Gastrointestinal:

Do you experience heartburn?	Yes	No
Do you have any difficulty or pain swallowing?	Yes	No
Have you had excessive belching/bloating?	Yes	No
Do you have any food intolerances/abdominal pains?	Yes	No
Have you ever had gallbladder disease/stone?	Yes	No
Have you ever had liver disease/cirrhosis?	Yes	No
Any change in your bowel habits/abnormal stools?	Yes	No
Do you have diarrhea/constipation?	Yes	No
Have you noted any rectal bleeding/black stools?	Yes	No
Do you have hemorrhoids?	Yes	No
Have you ever had a Colonoscopy?	Yes	No

Genitourinary:

Have you had urinary tract infections?	Yes	No
Do you have any history of kidney disease/stones?	Yes	No
Have you ever had any type of venereal disease (VD)?	Yes	No
Do you have any burning when you urinate?	Yes	No
Do you have to urinate more than usual?	Yes	No
Do you have urinary incontinence (loss of control)?	Yes	No
Have you had any sexual difficulties?	Yes	No

Gynecologic: (Women only)

Date of last pelvic/PAP smear?	_____	Facility/Dr.:
Do you have any vaginal bleeding/discharge?	Yes	No
Do you have any pelvic pain/pain with intercourse?	Yes	No
Do you perform self-breast exams monthly?	Yes	No
Have you had any changes in your breasts?	Yes	No
Have you had any changes in your nipples?	Yes	No
Have you had any nipple discharge?	Yes	No
Do you have any lumps in your breast/underarms?	Yes	No
Have you ever had a mammogram?	Yes	No

Facility/Dr.:

Date:

Urologic: (Men only)

Do you perform self-testicular exams monthly?	Yes	No
Have you ever had a prostate problem?	Yes	No
When was your last prostate exam?	_____	
Do you have urinary hesitancy, urgency or incontinence?	Yes	No

Musculoskeletal:

Do you have frequent back aches?	Yes	No
Have you ever broken a bone/or have arthritis?	Yes	No
Do you have painful muscles/muscle weakness?	Yes	No
Do you have any joint pain/stiffness?	Yes	No
Do you have osteoporosis/are you losing height?	Yes	No

Neurological:

Do you have headaches?	Yes	No
Have you ever had a seizure?	Yes	No
Any problems with coordination and or tremors?	Yes	No
Any change in your memory?	Yes	No

If so, how often:

Preventive Medicine:

How often do you exercise weekly?	_____	
What percentage of the time do you wear your seatbelt?	_____	%
Have you ever had your cholesterol checked?	Yes	No
Do you have smoke detectors in your house?	Yes	No
Have you been a victim of physical abuse?	Yes	No

describe your exercise:

If so when?

Result:

Patient Name: _____

DOB: _____

Vaccinations:

Date of last tetanus shot _____

Have you ever had pneumovax (Pneumonia shot)?

Yes No If so, date of last shot: _____

Have you ever had the flu shot?

Yes No If so, date of last shot: _____

Have you ever had Hepatovac (Hepatitis shot)?

Yes No If so, date of last shot: _____

Have you ever had the Zostavax (Shingles)?

Yes No If so, date of shot: _____

Behavioral Health:

Have you ever had a psychiatric illness?

Yes No If so, when? _____

Have you ever thought about/attempted suicide?

Yes No If so, when? _____

Do you have problems with anxiety/depression?

Yes No If so, describe: _____

Physical Examination: Appearance: Doctor to fill out

Pulse: _____ BP: _____ RR: _____ Temp: _____ Wt: _____ Ht: _____

Repeat BP: _____ Tilt Test: _____ Change in Wt: _____

Skin:

Color: _____

Rash/Lesions: _____

Hair/Nails: _____

Head:

Trauma: _____

Tenderness: _____

Eyes:

Acuity: _____

Pupils: _____

EOM: _____

Fields: _____

Nystagmus: _____

Conjunctiva/sclera: _____

Fundi: _____

Ears:

Acuity: _____

Pinna/Canals: _____

TM's: _____

Nares:

Septum: _____

Turbinates/Polyps: _____

TM'S: _____

Oral Cavity:

Breath: _____

Lips/Gums: _____

Teeth: _____

Tongue: _____

Mucosa: _____

Floor/Roof: _____

Submandibular nodes: _____

Neck:

Supple: _____

ROM: _____

JVD/HJR: _____

Carotid bruits: _____

Carotid upstroke: _____

Cervical/Supraciav. _____

Nodes: _____

Thyroid: _____

Lungs:

Percussion: _____

Auscultation: _____

Heart:

Rhythm/Tones: _____

Murmurs: _____

Gallops/Rubs: _____

Peripheral pulses: _____

Peripheral edema: _____

Breast:

Skin: _____

Dimpling: _____

Nipples: _____

Lumps/Masses: _____

Supraclav/infraclav/axilli _____

ary nodes: _____

Abdomen:

Shape: _____

Bowel sounds: _____

Abdominal Bruits: _____

Tenderness: _____

Guarding/Rebound: _____

Organomegally: _____

Masses: _____

Aorta: _____

Inguinal nodes: _____

Femoral arteries: _____

CVA tenderness: _____

Spinal tenderness: _____

Rectal:

Sphincter: _____

Hemorrhoids: _____

Masses: _____

Hem occult card result: _____

Prostate Size: _____

Prostate Nodule: _____

Genitalia Male:

Penis: _____

Testes: _____

Hernias: _____

Genitalia Female:

External: _____

Vagina: _____

Cervix: _____

Bi-manual: _____

Neurologic: Affect: _____

Oriented/Compreh: _____

Tremors/involuntary: _____

Movements _____

Speech: _____

Memory: _____

Cranial nerves: _____

Reflexes: _____

Toes: _____

Sensory: _____

Motor: _____

Romberg: _____

Gait: _____

Cerebellum (F-N): _____

Assessment:

- | | |
|-----------|-----------|
| 1.) _____ | 5.) _____ |
| 2.) _____ | 6.) _____ |
| 3.) _____ | 7.) _____ |
| 4.) _____ | 8.) _____ |

Plan: _____

Return: _____ days weeks months Doctor: _____ Date: _____
BP Check: _____ days weeks months

**Lake Erie Medical Group, PC
Niagara Internal Medicine**

Brian Lang, DO
Shawn Zeto, MD
145 West 23rd Street
Suite 202
Erie PA, 16502
Phone: 814-580-5600
Fax: 814-455-2584

Authorization for Release of Medical Information

Patient: _____

Address: _____

Date of Birth: ____ / ____ / ____ Phone: (____) ____ - ____

I hereby authorize _____ to release all my prior medical records to Lake Erie Medical Group, PC.

Specific records to be release: (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Health Summary |
| <input type="checkbox"/> Laboratory Testing | <input type="checkbox"/> ER Records |
| <input type="checkbox"/> Radiology Testing | <input type="checkbox"/> Hospital Records |
| <input type="checkbox"/> Cardiology Testing | <input type="checkbox"/> Medication List |

Time Period: _____

- Psychiatric/Psychological Eval.
 Other: _____

The purpose of release is for:

_____ Continuing of Care _____ Billing or Insurance Processing _____ Other

I specifically authorize the disclosure of the following type(s) of information if it is not included within the information requested above: _____ (initial) Mental Health _____ (initial) Drug and/or Alcohol Abuse/Treatment _____ (initial) HIV Status

This authorization will expire upon the following date(s) or event(s): _____

I understand that I have the right to revoke this authorization at any time. I may revoke it to the extent the Lake Erie Medical group has already relied on it, or if this authorization was signed as a condition of obtaining insurance coverage. In order to revoke this authorization, I understand that I must revoke it in writing to Lake Erie Medical Group.

I understand that information used or disclosed by Lake Erie Medical Group to any other person(s) under this authorization could potentially be re-disclosed by the person(s) receiving the information, and may no longer be subject to the privacy protection provided to me by law.

I understand that Lake Erie Medical Group may not require that I sign this Authorization in order to obtain treatment.

Date: ____ / ____ / ____ Patient Signature: _____

If you are the legal representative of the person listed above, please circle the basis for your authority and attach proof of authority:

Power of Attorney Guardianship Order Parents of Minor Executor/Administrator Other

Signature: _____ Date Signed: _____