CHRISTINE MEYER, MD and associates

Welcome to our Practice!

Today's Date: ____/____/_____

Patient Information:

Name: _____ Date of Birth: ____/____/_____
First Middle Last

Address: _____
Street

_____ _____ _____
City State Zip

SS#: _____ - _____ - _____ Preferred Language: _____ Gender: _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Work Phone: (_____) _____ - _____ Email: _____

Race: (select one or more)

☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Asian
☐ Caucasian ☐ Black or African American ☐ Undisclosed

Ethnicity:

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Undisclosed

How did you learn of our office? _____

Preferred Local Pharmacy: _____ Pharmacy Phone: (____) _____- _____

Pharmacy Address/Location: _____

Mail-Away Pharmacy (if applicable): _____

Emergency Contact:

Name: _____ Relationship: _____

Address: _____
Street City State Zip

Phone: _____ Alternate Phone: _____

Insurance Information: *(Please bring your insurance card with you to your appointment.)*

Assignment of Benefits: I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plan to the doctor above. This assignment will remain in effect until removed by me in writing. A photocopy of this assignment may be considered valid. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all medical information necessary to secure payment.

Patient Signature: _____ **Date:** _____/____/_____

750 West Lincoln Highway Exton, PA 19341 P: 610-363-0100 F: 610-363-3923

CHRISTINE MEYER, MD and associates

Patient Health History

Patient Name: _____ Today's Date: ___/___/_____

Age: _____ Birthdate: ____/___/_____ Date of last physical exam: ___/___/_____

What is your reason for today's visit? _____

Please arrive a few minutes ahead of your appointment time. Late arrivals, regardless of reason, may need to be rescheduled.

Which of our Providers would you like to designate as your preferred Provider? _____

{If you need to schedule an appointment for a sick visit, you are still able to see any available provider but we prefer you designate a provider for your regular visits and physical exams.}

Preferred Email address for contact: _____

{We do not have a NO NEWS IS GOOD NEWS POLICY. Please provide your email address for quickest email notification. If you don't hear from us in 7 days, please call or email us. Do not assume that all results were fine.}

List any *current* medical problems and/or conditions:

_____

_____

_____

List any *chronic* medical problems and/or conditions:

_____

_____

_____

List any physicians/specialists that you currently see:

Name	Specialty	Most Recent Visit

Date of Last Physical Exam: ___/__/_____ Date of Last Colonoscopy: ___/__/_____

Date of Last Flu Shot: ___/__/_____ Date of Last Blood Work: ___/__/_____

For Females: Date of Last Menstrual Period: ___/__/_____ Date of Last Pap Smear: ___/__/_____

Date of Last Mammogram: ___/__/_____ Are you currently pregnant? _____

Number of Pregnancies: _____ Miscarriages: _____ Living Children: _____

SURGERIES: (Please list any surgeries that you have had.)

Year	Type of Surgery	Hospital/Physician

HOSPITALIZATIONS: (Please list any hospitalization/emergency room visits that you have had.)

Year	Reason for Hospitalization	Hospital/Physician

MEDICATIONS: (Please list <u>all</u> prescription and non-prescription medications that you are currently taking.)
Please bring all medications to your appointment.

Name of Medicine	Dosage (mg, units, puffs)	Frequency (How often do you take it?)	Purpose (Why do you take it?)	Physician who prescribed this medication

ALLERGIES: (Are you allergic to medications, iodine, food, latex, etc.?)

Allergy	Reaction	Allergy	Reaction

FAMILY HISTORY: (Please list any family health problems and cause of death if applicable.)

Relative	Living/Deceased	Age	Medical Issues
Father			
Mother			
Children			
Siblings			
Grandparents			
Other			

(Please use additional paper if you need more space.)

TOBACCO HISTORY:

☐ Never ☐ Previous (Quit: _____) ☐ Current Smoker [___packs/day for ___ years]

Are you interested in quitting? ☐ Yes ☐ No

ALCOHOL HISTORY:

Do you drink alcohol? ☐ No ☐ Yes If Yes, how often? _____

SOCIAL HISTORY:

{Our practice does not discriminate on the basis of sexual orientation, gender identity, or expression. In order to effectivity treat our patients, please consider answering the following questions:}

Birth Sex: ☐ Female ☐ Male

Gender You Identify As: ☐ Female ☐ Male ☐ Transgender ☐ Prefer not to answer

What do you think of yourself as? ☐ Lesbian, Gay, or Homosexual ☐ Straight or Heterosexual ☐ Bisexual ☐ Something Else ☐ Don't know

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Same-Sex Partnership/Marriage

Number of Children: _____ Children's Names/Ages _____

_____

Employment Status: ☐ Full time ☐ Part time ☐ Unemployed ☐ Retired ☐ Student ☐ Other: _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I ever have a change in health.

_____ ___/__/_____

Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

CHRISTINE MEYER, MD and associates

750 West Lincoln Highway, Exton, PA 19341
P: (610) 363-0100 F: (610) 363-9323

AUTHORIZATION FOR VERBAL COMMUNICATION & RELEASE OF HEALTH INFORMATION

PATIENT NAME: _____ Date of Birth: __/__/____

I authorize the physicians and staff at Christine Meyer MD. & Associates to leave detailed messages and/or speak with persons other than myself regarding information specific to my medical care, including test results, on the phone number(s) listed below. We will not leave messages on an answering machine that does not have the name or telephone number on the recorded message. I understand that once a voicemail message exists it is no longer covered under HIPAA and therefore is not protected from unauthorized access. I understand that this authorization can be revoked at any time by submitting a written request to the practice. Information will not be left with an unauthorized person who may answer the telephone.

Home Telephone ☐ Yes ☐ No Number: (_____) _____ - _____
Can we leave a voicemail message at this number? ☐ Yes ☐ No

Cell Telephone ☐ Yes ☐ No Number: (_____) _____ - _____
Can we leave a voicemail message at this number? ☐ Yes ☐ No

Work Telephone ☐ Yes ☐ No Number: (_____) _____ - _____
Can we leave a voicemail message at this number? ☐ Yes ☐ No

Email Address ☐ Yes ☐ No Address: _____

Speak with Spouse/Partner ☐ Yes ☐ No Number: (_____) _____ - _____
Can we leave a voicemail message at this number? ☐ Yes ☐ No

Speak with other person(s) ☐ Yes ☐ No Number: (_____) _____ - _____
Can we leave a voicemail message at this number? ☐ Yes ☐ No

Name _____ Relationship: _____

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE:

X_____ Date: ___/___/____

If you are not the patient, please specify your relationship to the patient _____.

If signed by a person other than the patient, complete the following:

1) Individual is: ☐ a minor ☐ legally incompetent or incapacitated ☐ deceased

2) Legal Authority: ☐ parent* ☐ legal guardian ☐ next of kin/executor of deceased

☐ POA of Healthcare

**By signing above, I hereby declare that I have not been denied physical placement of this child.*

CHRISTINE
MEYER, MD
and associates

Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices Form

I, _____, hereby give my consent to the practice to use or
(Name of Patient or Authorized Legal Representative)

disclose, for the purpose of carrying out treatment, payment, or health care operations, all information

contained in the patient record of _____ Date of Birth ___/___/_____ .
(Patient's Name)

I acknowledge receipt of the practice's Notice of Privacy Practices. 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 a 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 and/or available to me on the christinemeyermd.com website.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the practice. I also understand that I will not be able to revoke this consent in cases where the practice has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the practice's office.

Signed: _____ **Date**: ___/___/_____

If you are not the patient, please specify your relationship to the patient _____

Receipt of Notice of Privacy Practices Form

I, _____, hereby acknowledge receipt of the Notice of Privacy Practices.
(Patient's Name)

☐ Received Paper Copy ☐ Prefer web site access - 'christinemeyermd.com'

☐ Individual refused to sign

Signed: _____ **Date**: ___/___/_____

If you are not the patient, please specify your relationship to the patient _____.