PATIENT INFORMATION

Last name: **First:** **Middle:** **Marital:**

Is this your legal name? **Former name:** **Birth date:** **Sex:**

Address:

Social Security: **Home phone:** **Cell phone:**

E-Mail Address:

Primary Language:

Race: **Black or African American** **Asian** **Other** **White** **Hispanic** **American Indian**

Local Pharmacy: **City:**

Medical Insurance name: **Policy #:** **Co-payment:** **$**

IN CASE OF EMERGENCY

Name of local friend or relative: **Relationship to patient:** **Cell phone:**

I hereby give Yarmouth Medical Center my consent for any necessary medical evaluation and treatment. I hereby assign all medical/surgical benefits to include major medical benefits to which I am entitled including Medicare, private insurance and other health plans to Yarmouth Medical Center. A photo copy of this assignment is to be considered as valid as original. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize said assign to release all information necessary to secure payment.

Patient/Guardian signature **Today's Date**

Assignment of Insurance Benefits

I, the undersigned, certify I have health insurance coverage with:

Insurance Company Name (above line)

And assign directly to Yarmouth Medical Center, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by my insurance company. I hereby authorize Yarmouth Medical Center to release all information necessary to secure payment of benefit. I authorize the use of my signature on all insurance submissions.

Patient Signature Today's Date

Personal Health History

CURRENT MEDICATIONS

Please list all medications you are currently taking and include the dosage:

.   .   .   .

List all known allergies / drug allergies:

Name of previous primary care provider:_____

Do you use tobacco? YES NO If yes, type of tobacco and frequency:_____

Do you or have you used illegal drugs? YES NO Marijuana? YES NO

Do you drink alcoholic beverages? YES NO If yes, how many a week:_____

Do you have a health care proxy? YES NO If yes, please provide us with a copy.

Do you have an advanced directive? YES NO If yes, please provide us with a copy.

HEALTH ISSUES (**check mark** all that apply)

AIDS/HIV	Fainting	Rheumatic Fever	Sinus Problems
Anxiety	Growths (skin)	Radiation Treatments	Stroke/TIA
Osteoarthritis	Hay Fever	Liver Disease	Thyroid Disease
Asthma/Emphysema	Heart Attack	Pacemaker	Tuberculosis
Artificial Joints	Heart Disease/Murmur	Ulcers	Tumors
Blood Disease	Hepatitis: Type:	Glaucoma	Vision Problems
Cancer:	High Blood Pressure	Rheumatoid Arthritis	Chronic Pain
Depression	Insomnia	Stomach Issues	Alcoholism
Diabetes; Type:	Jaundice	Head Injury	STDs
Dizziness	Kidney Disease	Mental Health Issues	Headaches/Migraines
Seizures	Respiratory Problems		

By signing below, you acknowledge that you understand the policy and attest to the truthfulness of the information provided above.

Patient Signature:_____ Today's Date:_____

Family Health History

Please **circle** appropriate responses:

Father: ALIVE DECEASED

Mother: ALIVE DECEASED

Number of Brothers:_____ Number of Sisters:_____ Are all alive? YES NO

FAMILY HEALTH ISSUES

Osteoarthritis	F	M	B	S	Heart Attack	F	M	B	S
Asthma/Emphysema	F	M	B	S	Heart Disease/Murmur	F	M	B	S
Blood Disease	F	M	B	S	Hepatitis; Type:	F	M	B	S
Cancer; Type:	F	M	B	S	High Blood Pressure	F	M	B	S
Cancer; Type:	F	M	B	S	Kidney Disease	F	M	B	S
Diabetes	F	M	B	S	Respiratory Problems	F	M	B	S
Seizures	F	M	B	S	Liver Disease	F	M	B	S
Fainting	F	M	B	S	Ulcers	F	M	B	S
Glaucoma	F	M	B	S	Rheumatoid Arthritis	F	M	B	S
Mental Health Issues	F	M	B	S	Stroke/TIA	F	M	B	S
Thyroid Disease	F	M	B	S	Tumors	F	M	B	S
Alcoholism	F	M	B	S	Headaches/Migraines	F	M	B	S

Patient Signature:_____ Today's Date:_____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

I hereby authorize the release of my medical record to Yarmouth Medical Center.

_____

(Previous Doctor's Name, City/State, Phone Number)

In accordance the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE**, **MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 2. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 2, I specifically authorize release of such information to the person indicated.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization
3. I have the right to revoke this authorization at any time by writing to Yarmouth Medical Center. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment at Yarmouth Medical Center, or eligibility benefits will not be conditioned upon my authorization of disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted in #2 above), and this redisclosure may no longer be protected by federal or state law.

☐ **Medical Record dating back 2 years, including patient histories, office & consult notes, test results, radiology studies, films, labs, mammograms, pap smear results, bone density, colonoscopy, hospitalizations, CT's, MRI, EKG's & immunization history providers.**

Include: (**Indicate by checking**)

__ Alcohol/Drug Treatment

__ Mental Health Information

__ HIV-Related / STD-Related Information

This authorization will be in effect for one year.

All items on this form have been completed and my questions about this form have been answered. In addition, I have kept a copy of this form for my records.

_____ _____

Signature of Patient or Representative Today's Date

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION TO CERTAIN INDIVIDUALS

I hereby authorize Yarmouth Medical Center to disclose information contained in my medical record to the individual(s) listed below, if they request it. I understand that when information is disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and no longer considered protected health information (PHI). I understand that I can revoke this authorization, in writing, at any time.

This authorization applies to the indicated PHI (check all that apply):

__ All Personal Health Information (PHI)

Our providers may discuss your PHI as authorized above. The individuals listed cannot receive copies of any information from your medical record without your written consent. If there is no one we can communicate with, please write 'no one' in each space provided.

AUTHORIZED INDIVIDUALS:

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

Patient Signature:_____ Today's Date:_____

Acknowledgement & Agreement

Yarmouth Medical Center Code of Conduct Policy

To maintain a safe, respectful, and professional environment for our patients, visitors, and staff, Yarmouth Medical Center strictly prohibits the following behaviors:

1. **Possession of Weapons:** Bringing firearms, knives, or any other weapons onto the premises is strictly prohibited.

2. **Harassment or Intimidation:** Engaging in any form of harassment, intimidation, yelling, or the use of profane or abusive language directed at staff, patients, or visitors.

3. **Unauthorized Entry:** Entering staff-only areas, including leaning into or reaching through the front desk window, without explicit permission.

4. **Threats of Violence:** Issuing threats—whether verbal, written, or electronic (including phone calls, emails, voicemails, texts, or letters)—to inflict harm upon any individual or entity.

5. **Physical Aggression:** Any physical assault, inappropriate physical contact, or threat of bodily harm to staff, patients, or visitors.

6. **Destruction of Property:** Damaging or attempting to damage property belonging to Yarmouth Medical Center or others on the premises.

7. **Menacing or Derogatory Conduct:** Engaging in threatening gestures, racial or cultural slurs, or other discriminatory, derogatory, or abusive behavior.

Any patient, visitor, or staff member who observes or is subjected to such conduct is encouraged to report the incident to Yarmouth Medical Center administration immediately.

Policy Enforcement:
Violations of this Code of Conduct may result in immediate removal from the premises, formal warning, discharge from the practice, and/or notification to local law enforcement, depending on the severity of the behavior.

Patient Signature: _____ Today's Date: _____