ROBERT W. EDWARDS III, M.D.

218 Undercliff Terrace
Princeton, WV 24740

Date:____________________ Chart #: ___________________ Ref. Doc.: _______________

Patient's Name: ____
First Middle Last

Mailing Address:____

____

Phone #: (______)______________________ Social Security #:______________________

Birth Date: _____/_____/_____ Age:________ Marital Status:__________________

Employer's Name & Phone #:____

Emergency Contact Person & Phone # (other than OWN number)

Name:____

Phone #: (______)______________________ Relationship:__________________________

Name of Responsible Party for Patient:____

Address:____

Phone #: (______)______________________ Spouse's DOB:_________________________

Spouse's Name & Employer/Phone #:____

____

Spouse's/Parent Social Security #:____

Pharmacy: ____

You have my consent to access my profile from my pharmacy: ☐ YES ☐ NO

Please list any ***CURRENT MEDICATION / NAME & Mg.***__________________________

____

____

____

Please list any ***DRUG ALLERGIES:*** ____

____

Reason for seeing Dr. today: ____

____

____

Name of Referring Physician: ____

Address & Phone #: ____

Personal Physician's Name/Phone #:_______________________________________

Do you have Advance Directives (Living Will, Power of Attorney, etc.)? ❑ YES ❑ NO

Are you interested in discussing Advance Directives? ❑ YES ❑ NO

**** IF YOU HAVE INSURANCE, PLEASE GIVE CARDS TO THE RECEPTIONIST FOR PHOTOCOPY ****

AUTHORIZATION TO PAY AND RELEASE OF INFORMATION

I hereby certify that I am insured with ______________________ Insurance Company. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment directly to Robert Edwards III, M.D. and any benefits due under the terms of this policy for services rendered, including Major Medical if applicable.

I understand that I am financially responsible for charges not covered by this authorization.

Date:______________________ Signature:_____________________________________

Witness (Office use only): ____

PATIENT QUESTIONNAIRE

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

____

____

II. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name ____________________ Phone _______________

Name ____________________ Phone _______________

III. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home:

____

____

IV. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":

YES _______ NO _______

V. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number: ____________________

**** I am fully aware that a cell phone is not a secure and private line.***

VI. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail?

YES _______ NO _______

PATIENT NAME ________________________ (guardian if under 18 years)

____________________________ _______________

PATIENT/GUARDIAN SIGNATURE DATE

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME ______________________________

BIRTHDATE ______________________ SOCIAL SECURITY # ______________________

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

☐ **I request the following restrictions to the use or disclosure of my health information:**

____

____

____

PATIENT:

✕ ______________________ ______________ ______________________

Signature of Patient or Legal Representative | Date | Witness Signature

OFFICE USE ONLY:

☐ **Accepted** ______________________ ______________ ______________

☐ **Denied** Signature | Title | Date

ROBERT W. EDWARDS III, M.D., INC.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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* You May Refuse to Sign This Acknowledgement *

I, ____, have received a copy of this office's Notice of Privacy Practices.

____

Please print Name

____

Signature

____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

( ) Individual refused to sign

( ) Communication barriers prohibited obtaining the acknowledgement

( ) An emergency situation prevented us from obtaining acknowledgement

( ) Other (Please Specify)

____

____

____

HEALTH HISTORY FORM

DATE:______________ CHART:______________

NAME:________________________________ B-DAY:______________ AGE:_____

MENSTRUAL HISTORY

When was the first day of your last menstrual period? ____________________

At what year did you start menstruating? ____________________

Are your periods regular? ____________________

Number of days between your periods? ____________________

Number of days of your flow? ____________________

Do you have pain/cramping with menstruation? ____________________

Date of last pap smear ______________ Date of last mammogram ____________

PREGNANCY HISTORY

Total number of pregnancies _________ Total number of births _____________

Miscarriages _________ Abortions _______ Total tubal pregnancies _________

MEDICAL HISTORY

Have you been diagnosed with any medical problems? (Diabetes, Hypertension, etc.)

EXPLAIN ____

____

SURGERY	WHEN	PHYSICIAN	HOSPITAL

REASON FOR THIS VISIT: ____

When have you had your cholesterol/lipid level checked? ____________________

When have you had any colon or rectal screening tests? _____________________