# *Lifespan Family Healthcare*

***80 River Road***
***Newcastle, ME 04553***
***(207) 563-3366 Fax (207) 563-3393***


**Patient Information** **WEB**

| | | | |
|---|---|---|---|
| Patient Name (Last, First, Middle) | | | Social Security # _____-_____-_____<br>Date of Birth ____/____/____ |
| Male__ Female__ | Marital Status:<br>S____M____W____D____O____ | | Name of Spouse: |
| Street Address | City & State | | Zip Code |
| Preferred method of contact<br>Phone WebView Mail | Email | | |
| Preferred Pharmacy | Home Phone | Work Phone | Cell Phone |
| | Race | Ethnicity | Language |
| Occupation | Employer Name | Employer Address | |

**Insurance Information**: Please provide a copy of your insurance card(s)

| | | | |
|---|---|---|---|
| Name of Company: | | | |
| Plan | Group Number | Policy Number | |
| Subscriber's Name (who holds the insurance?) | | Relation to Patient (circle one)<br>Self Spouse Parent Employer Other | |
| Subscriber's Social Security # | Subscriber's Street address | City & State | Zip Code |
| Subscriber's Home Phone<br>( ) | Subscriber's Work Phone<br>( ) | Date of Birth | M ___ F___ |
| Subscriber's Employer | Employer's Street address | City & State | Zip Code |
| Effective Date | Expiration Date | Is Patient covered by additional Insurance<br>Yes___ No____ | |
| Medicaid Number | Medicare Number | Co-Pay Amount | |

**Emergency Contact Information**

| | | |
|---|---|---|
| In case of Emergency contact | Relationship to Patient | Emergency Phone Number<br>( ) |

If this patient is a minor or student: Please indicate how you would like statements addressed if you do not want them addressed directly to the patient.

## Health History Questionnaire

### Have *You* ever had:

- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart attack
- ☐ Hardening of the arteries or coronary heart disease
- ☐ Heart valve disease
- ☐ Rheumatic fever
- ☐ Heart murmur
- ☐ Diabetes (circle): Type I (juvenile-onset) Type II (adult-onset)
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Asthma
- ☐ Hay fever or allergic rhinitis
- ☐ Emphysema
- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Stomach ulcers
- ☐ Anxiety or panic attacks
- ☐ Depression
- ☐ Bipolar disorder
- ☐ Other psychiatric disease:_____
- ☐ Alcoholism
- ☐ Stroke
- ☐ Migraine headaches
- ☐ Kidney stones
- ☐ Gout
- ☐ HIV/AIDS
- ☐ Other sexually transmitted infections:_____
- ☐ Hepatitis B or C (circle)
- ☐ Anemia
- ☐ Hemophilia/bleeding disorder
- ☐ Glaucoma
- ☐ Epilepsy/seizures
- ☐ Cancer: Where or What Type(s):_____
- ☐ (Men) Prostate Enlargement

Women:

- ☐ Abnormal pap smear
- ☐ Tubal Pregnancy
- ☐ Diabetes in pregnancy
- ☐ Toxemia/preeclampsia
- ☐ Total # of Pregnancies:_____

# of Births: Term:___Preterm:___
Miscarriages:___Abortions:___

- ☐ Other disease:_____

### Surgeries *You* Have Had:

(Please include approx. date/year)

- ☐ Tonsillectomy_____
- ☐ Sinus surgery_____
- ☐ Appendectomy_____
- ☐ Gall bladder removal_____
- ☐ Exploratory surgery_____
- ☐ Cataract removal_____
- ☐ Hysterectomy_____
  Were ovaries removed?
  (circle) No / Left / Right / Both
- ☐ Mastectomy:_____
  (circle) Right / Left
  Lumpectomy / Simple / Radical
- ☐ Hernia repair_____
  (circle) Right / Left
- ☐ Coronary artery bypass_____
- ☐ Balloon angioplasty_____
- ☐ Pacemaker placement_____
- ☐ Hip Replacement: R L _____
- ☐ Knee Replaced: R L_____
- ☐ Back Surgery_____
- ☐ Tubal Ligation_____
- ☐ Prostate Surgery_____
- ☐ Vasectomy _____
- ☐ Other_____

## Family Health History **Adopted:_____**

| Family Member | If Living or dead (age of death) | Current Illness / Cause of Death |
|---|---|---|
| Mother | | |
| Father | | |
| Brother / Sister (circle) | | |
| Brother / Sister (circle) | | |
| Brother / Sister (circle) | | |
| Brother / Sister (circle) | | |
| Brother / Sister (circle) | | |

### Does a family member HAVE OR HAD:
### (Please circle to indicate Mother Father Sister Brother Grandmother or Grandfather)

- ☐ High blood pressure: *M F S B GM GF*
- ☐ High cholesterol: *M F S B GM GF*
- ☐ Heart attack: *M F S B GM GF*
- ☐ Osteoporosis: *M F S B GM GF*
- ☐ Diabetes (circle): *M F S B GM GF*
  Type I (juvenile) or Type II (adult)
- ☐ Cancer: (who, where and what type):
  *M* _____
  *F* _____
  *S* _____
  *B* _____
  *GM* _____
  *GF* _____
- ☐ Thyroid Problems: *M F S B GM GF*
- ☐ Asthma: *M F S B GM GF*
- ☐ Genetic Disease or "birth defect"
  What type:_____ *M F S B GM GF*
- ☐ Rheumatoid Arthritis: *M F S B GM GF*
- ☐ Anxiety panic attacks: *M F S B GM GF*
- ☐ Psychiatric Illness: *M F S B GM GF*
- ☐ Depression: *M F S B GM GF*
- ☐ Alcoholism: *M F S B GM GF*
- ☐ Stroke: *M F S B GM GF*
- ☐ Migraine headaches: *M F S B GM GF*
- ☐ Gout: *M F S B GM GF*
- ☐ Bleeding Disorders: *M F S B GM GF*
- ☐ Epilepsy: *M F S B GM GF*
- ☐ Other : _____

**Please list all *Prescription Medications* that you are currently taking: (Print clearly)**

Medication Name Strength/Dose Quantity taken Times per day

**Please list all *Supplements, Herbals or Over the Counter Remedies* that you currently take:**

Name Strength(if known) How often

**Please list any *Allergies* to *medications*:**

Name of Medication: Type of reaction (e.g. rash, itching, swelling, difficulty breathing, etc)

**Please list *Other Sensitivities* and *Allergies* you have experienced:**

Name of Allergen Type of reaction Comments

**Health/Diet/Lifestyle:**

Describe your diet: _____

How often do you exercise: _____

Do you currently use tobacco? _____ Are you a former tobacco user? _____ Year Quit _____
Never used tobacco _____

What is your daily alcohol intake: _____

**Please describe your current living situation:**
☐ House or apartment ☐ Staying with friends ☐ Group home ☐ Senior housing
☐ Assisted living ☐ Nursing home ☐ Homeless/ in shelter ☐ Other _____
**Who lives with you:**
☐ Alone ☐ Spouse ☐ Partner or significant other ☐ Children ☐ Parents or other family members
☐ Roommate(s) ☐ Other _____

**Please check any that apply:**
☐ Exclusive sexual relationship with spouse or partner ☐ Not currently having sex ☐ Have sex but not always with same person ☐ Heterosexual ☐ Homosexual ☐ Other _____

**Do you have a living will?** ☐ Yes ☐ No (We encourage patients to provide a copy for our records)

**Vaccination status:** (Please provide any copies of vaccination records that you have)
If you were born after 1957, have you had a **2nd** measles, mumps and rubella vaccine? ☐Yes ☐No ☐Unsure
If you are at least 65 years old or have a chronic health problem or breathing problems, have you received the **pneumococcal vaccine**? ☐ Yes (date): ____ /____ /____ ☐ No ☐ Unsure
Date of last tetanus booster: ____ /____ /____

## Self Care and Prevention

Is your time well balanced between your job, family, self-care and hobbies? ☐ Yes ☐ No
If you are a ***female***, do you do a monthly self-breast exam? ☐ Yes ☐ No
When was your last breast exam by your physician? Date: ____ / ____ / ____
Date of last mammogram: ____ / ____ / ____ ☐ Never had a mammogram
*Note: One out of every 10 women will get breast cancer. The best approach is early detection by doing a monthly self-breast exam, an annual breast exam by your physician and periodic mammograms.*
Date of last pap smear: ____ / ____ / ____ ☐ Never had a pap smear
Date of last bone mineral density test (DEXA scan): ____ / ____ / ____ ☐ Never had this test

If you are a ***male***, do you do a monthly self-testicular exam? ☐ Yes ☐ No
*Note: Testicular cancer is a leading cause of cancer for men under the age of 50.*

## Spirituality and Faith

Do you consider yourself a spiritual or religious person? ☐ Yes ☐ No
Are you part of a spiritual or religious community or church? ☐ Yes ☐ No
Which faith tradition or denomination do you identify with? _____☐ or None
Do you feel good about or supported by your current spiritual beliefs, practices or level of participation with your church/faith community? ☐ Yes ☐ No

## FINANCIAL POLICY

As a courtesy to our patients we file most insurance. Please be aware that some or perhaps all of the services rendered may or may not be covered. If your insurance company denies payment, you will be billed and payment in full is due upon receipt.

We cannot file your insurance unless you have your card with you. Your insurance must be current and verifiable at the time of treatment. Payment assignment must be made to this office. If you wish to have the check sent to you, payment in full is due at the time of service. Co-pays and payment for non-covered items are due at the time of treatment. We charge $35 for "No Show" appointments, to be paid prior to or on your next appointment. We accept cash, checks and major credit cards. Should it be necessary to utilize outside collection means for past due account, you are responsible for all cost, including attorney, court, and collection fees. A minimum $35.00 fee will be assessed on all returned checks.

I have read and understand the Financial Policies of Lifespan Family Healthcare, LLC and have completed this form to the best of my ability and will not hold Lifespan Family Healthcare, LLC responsible for my errors or omissions.

Signature_____Date_____

**IF YOU HAVE MEDICARE OR MAINECARE PLEASE READ:**

## MEDICARE/MEDICAID AUTHORIZATION

I requested that payment of Authorized Medicare Benefits be made to Lifespan Family Healthcare, LLC for any services furnished to me by Michael H. Clark, MD. I authorize any holder of information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents information needed to determine benefits. If I have other insurance, my signature authorizes releases of information to that insurer or agency. In Medicare/Medicaid assigned cases, the physician agrees to accept the determination of the carrier as payment in full and the patient is responsible for deductibles, coinsurance, and non-covered services.

Beneficiary
Signature_____Date_____

# Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Lifespan Family Healthcare, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Lifespan Family Healthcare, LLC describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Lifespan Family Healthcare, LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Office Manager, 80 River Road, Newcastle, ME 04553.

I have the right to request that Lifespan Family Healthcare, LLC restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

With this consent, Lifespan Family Healthcare, LLC **may call my home** or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others. □ **yes** □ **no**

With this consent, Lifespan Family Healthcare, LLC **may mail to my home** or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential." □ **yes** □ **no**

With this consent, Lifespan Family Healthcare, LLC **may e-mail to my home** or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. □ **yes** □ **no**

The following person(s) may contact LifeSpan Family Healthcare, LLC inquiring in regards to my health information. You have my permission to release information to them.

Name _____ Relationship _____

Name _____ Relationship _____

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Lifespan Family Healthcare, LLC may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable

# Lifespan Family Healthcare, LLC

## AUTHORIZATION TO RELEASE MEDICAL RECORDS

**PATIENT INFORMATION (Please Print):**

Name: _____ Date of Birth: _____

Social Security Number: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

**RELEASE MY MEDICAL RECORDS FROM:**

DR. Name: _____ Business Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

**SEND MY MEDICAL RECORDS TO:**

Michael H. Clark, MD/Shane B Lovley, PA-C
Lifespan Family Healthcare, LLC
80 River Road
Newcastle, ME 04553

Phone: 207-563-3366
Fax: 207-563-3393

**REASON**: □ Selected new physician in the area □ Second opinion/Consult □ Other
□ Change of insurance □ Moving out of town _____

**PORTION OF RECORDS TO BE RELEASED:**

□ Entire Medical Record □ Other _____
_____

**Restrictions:** I understand that the recipient of this information may not use this information except for the express purpose identified above, unless another authorization is obtained from me or unless such or disclosure is specifically required or permitted by law.

**Notice:** Unless specified below this authorization is for full disclosure of all records, including clinical findings, diagnoses, treatments, assessments, recommendations for further care, names of all health care personnel, dates of hospitalizations and ambulatory visits, charges and any information that may be related to drug, alcohol, psychiatric conditions, and/or sexually transmitted disease, including AIDS/HIV information.

Exclusions (please initial): _____ Drug/Alcohol _____ Sexually Transmitted Disease
_____ HIV/AIDS _____ Mental Health/Psychiatric

Patient signature: _____ Date: _____

**A photocopy of this release is as valid as the original**

I understand that this consent is only for the specific purpose stated and may be revoked at any time. This consent expires automatically when its purpose has been accomplished.