CHI St. Vincent Medical Group New Patient Information

Patient Information

Is this work or accident related?_____ Date of Injury _____

Patient Name First	Middle	Last		
Mailing Address	APT #	City	State	Zip Code
Home Phone / Cell Phone	E-Mail Address			Date of Birth
Sex M F / Marital Status M S D W	Social Security Number	Spouses Work #	Spouses Name	

Emergency Contact	Phone Number
Name of Closest Relative Not Living With You	Relationship to Patient
Home Phone Number	Work Phone Number/ Extension

Patient's Race (Please check one)

☐ 01- Black/ African American ☐ 02- Asian ☐ 03- White ☐ 98- Unknown
☐ 08- American Indian/ Alaska ☐ 09- Native Hawaiian/ Other Pacific Islander ☐ 99- Declined

Patients's Ethnicity (Please check one)

☐ Hispanic/ Latino ☐ Non-Hispanic/Non-Latino ☐ Declined ☐ Unknown

Language	Primary Care Physician	Referring Physician
Patient's Employer	Patient's Work Phone/ Ext	

If Patient is a Minor or Student

Father's Name First	Middle	Last		
Mailing Address	APT #	City	State	Zip Code
Date of Birth / Social Security Number	Home Phone	Father's Employer		Work Phone
Mother's Name First	Middle	Last		
Mailing Address	APT #	City	State	Zip Code
Date of Birth / Social Security Number	Home Phone	Mother's Employer		Work Phone

Insurance Information

Primary Insurance Company	Policy Holder's Name, Date of Birth and Social Security Number	
Patient's Relationship to Policy Holder	ID Number	Group Number
Secondary Insurance Company	Policy Holder's Name, Date of Birth and Social Security Number	
Patient's Relationship to Policy Holder	ID Number	Group Number

Authorization and Consent: I hereby authorize CHI St. Vincent Medical Group to furnish information to insurance carriers concerning treatment provided by CHI St. Vincent Medical Group, and I hereby irrevocably assign to CHI St. Vincent Medical Group all payments for medical services rendered. I consent to the use or disclosure of my protected health information by St. Vincent Medical Group for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of St. Vincent Medical Group. I have the right to revoke this consent in writing at any time, except to the extent that St. Vincent Medical Group has taken action in reliance on this consent. I understand that I am financially responsible for all charges whether or not covered by insurance.

_____ _____

Signature of Patient or Guardian Date

PATIENT MEDICATION LIST

Name:	
Birth date:	Pharmacy Name: Phone: Location:

Allergies (include description of reaction)	

Name of Medication	Dose	Frequency	Directions	Reason for Taking	Doctor Name

ARKANSAS NEUROSCIENCE INSTITUTE

Today's Date: _____

Patient's Name: _____ Age: _____

CHIEF COMPLAINT (Briefly describe the reason for your visit today): _____

_____

HISTORY OF PRESENT ILLNESS

Location of pain/problem? _____
How long have you had this problem? _____
How did this problem start? _____
How often do you have the problem? _____
What makes it worse? _____
What makes it better? _____
What associated problems have you been having? _____
What is the severity of your pain (on a scale of 0-10 if 0=no pain and 10=worst pain ever)? _____
How would you describe your pain? (throbbing, shooting, sharp, dull) _____

CURRENT MEDICATIONS - Please fill out the attached **Patient Medication List Form**

Pharmacy name and phone number: _____

PAST MEDICAL HISTORY (Check any problem you have ever had)

- ☐ Arthritis
- ☐ Lupus
- ☐ Rheumatoid arthritis
- ☐ Osteoporosis
- ☐ GI bleed
- ☐ Stomach ulcers
- ☐ Heartburn/reflux
- ☐ High blood pressure
- ☐ Heart attack
- ☐ Heart failure
- ☐ Heart murmur
- ☐ Atrial fibrillation
- ☐ High cholesterol
- ☐ Psoriasis
- ☐ Skin cancer
- ☐ Insomnia
- ☐ Depression
- ☐ Anxiety
- ☐ Anemia
- ☐ Blood transfusion
- ☐ Cancer _____
- ☐ Varicose veins
- ☐ Blood clots _____
- ☐ Peripheral vascular disease
- ☐ Diabetes
- ☐ Hypothyroid
- ☐ Gout
- ☐ Kidney disease ☐ dialysis
- ☐ Bladder infection
- ☐ Hepatitis
- ☐ Cirrhosis
- ☐ Gallstones
- ☐ Stroke
- ☐ HIV/AIDS
- ☐ Venereal disease
- ☐ Tuberculosis
- ☐ Asthma
- ☐ COPD/emphysema
- ☐ Sleep apnea ☐ use CPAP
- ☐ Pneumonia
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Prostate problem
- ☐ Hernia _____
- ☐ Other _____

PAST SURGICAL HISTORY

List any surgical procedures you have had and when

DATE	TYPE OF SURGERY
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

Briefly describe your family's medical problems and if they are currently living:

Mother: ☐ Alive ☐ Deceased List medical problems _____

Father: ☐ Alive ☐ Deceased List medical problems _____

Siblings: How many brothers? _____ List medical problems _____
How many sisters? _____ List medical problems _____

Children: How many sons? _____ List medical problems _____
How many daughters? _____ List medical problems _____

SOCIAL HISTORY

Occupation: _____ ( )full-time ( ) part-time ( ) not currently employed

I live in a: ( ) House ( ) Apartment ( ) Condominium ( ) Mobile home ( ) Boat

I live: ( ) Alone ( ) with Spouse ( ) with Parents ( ) with Children

Marital Status: ( ) single ( ) married ( ) divorced ( ) separated ( ) widowed

Do you smoke? ( ) no ( ) yes If yes, how much? _____ pks per day For how long? _____

Have you smoked in the past? ( ) no ( ) yes If yes, how much? _____ pks per day
How long? _____ When did you stop? _____
What kind? ( ) Cigarettes ( ) Cigars ( ) Chew ( ) Dip

Do you drink alcohol? ( ) no ( ) yes If yes, how often (circle)? Daily Weekly Monthly Rarely
What kind (circle)? Beer Wine Whisky Other _____

Do you consume any street drugs? ( ) no ( ) yes If yes, what kind? _____ How often _____
This is very important for the physician to know to avoid anesthesia-related complications during surgery

REVIEW OF SYMPTOMS/SYSTEMS

Please place a checkmark next to the problems you currently have:

Constitutional

- ☐ Unexpected weight loss
- ☐ Unexpected weight gain
- ☐ Fever
- ☐ Night sweats
- ☐ Fatigue
- ☐ Malaise (general discomfort)

Head and Neck

- ☐ Headache
- ☐ Neck lumps

ENT

- ☐ Hard of hearing
- ☐ Ringing in the ears
- ☐ Stuffy nose
- ☐ Wears dentures

Eyes

- ☐ Wears glasses or contacts
- ☐ Reduced vision
- ☐ Blurred vision
- ☐ Double vision

Cardiology

- ☐ Chest pain
- ☐ Palpitations
- ☐ Swelling in the legs

Respiratory

- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath

GI (Stomach/Intestines)

- ☐ Nausea
- ☐ Vomiting
- ☐ Bowel changes

GU (Kidneys & Reproductive Systems)

- ☐ Burning during urination
- ☐ Frequent urination
- ☐ Urinary incontinence (loss of bladder control)
- ☐ Trouble starting urination
- ☐ Bladder changes

Musculoskeletal

- ☐ Joint pains
- ☐ Neck pain
- ☐ Back pain

Neurological

- ☐ Speech difficulty
- ☐ Dizziness
- ☐ Unsteadiness of gait
- ☐ Weakness
- ☐ Numbness/tingling
- ☐ Tremor

Endocrine

- ☐ Heat or cold intolerance
- ☐ Sweating
- ☐ Frequent thirst
- ☐ Frequent urination

Dermatology (Skin)

- ☐ Itching
- ☐ Skin rash

Hematologic (Blood/Lymph Glands)

- ☐ Easily bruising
- ☐ Easily bleeding

Peripheral Vascular

- ☐ Leg cramps

Psychological

- ☐ Depression
- ☐ Stress
- ☐ Anxiety
- ☐ Memory loss

Other Comments

_____

_____

_____

_____

_____

Patient Signature: _____ **Date:** _____

CHI St. Vincent Medical Group
Authorization for Medical Information Access

I, _____ (Print patient's name), Hereby consent to allow the following person(s) access to information on my account / medical record that would otherwise be considered protected health information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship. _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

Signature (Patient or Responsible Guardian) Date

Date of Birth: _____

ARKANSAS
NEUROSCIENCE
INSTITUTE

1. I, _____, hereby give my consent to

Name: _____
Street Address: _____
City, State, and Zip: _____
to release to:

Arkansas Neuroscience Institute
#5 St. Vincent Circle, STE 210
Little Rock, AR 72205
501-552-6400

2. Information from the medical record of:

Patient Name_____
Birth date and/or Soc Sec No._____
Date(s) of Treatment_____
Phone_____
Medical Record Number (if known) _____

3. Information to be released:

____Abstract ___Operative Report ___ER Record
____History & Physical ___Discharge Summary ___Clinic Record
____Psychiatric ___Other_____ _____

4. Purpose of disclosure:

____Medical care ___Personal Information ___Insurance
____Other_____

5. This authorization shall be in affect for 90 days following the date of signature. However, I understand that this authorization may be revoked at any time by giving written notice to the facility. A photocopy of this authorization shall constitute a valid authorization.

6. The facility, its employees and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Patient or Representative_____Date_____

Relationship to Patient_____

Notice to Recipient

The recipient of the enclosed information is not authorized to use this patient's medical records for any purpose other than for that stated above or to disclose any information from the record to any other person or facility without specific written authorization from the patient to do so.

__St Vincent Infirmary Medical Center
2 St. Vincent Circle, LR, AR 72205

__St. Vincent Doctors Hospital
6101 St. Vincent Circle, LR, AR 72205

__St. Vincent Medical Center North
2215 Wildwood Ave., NLR, AR 72120

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I, _____, SS #_____ hereby authorize St. Vincent Health System to use, disclose, and/or allow access to my individually identifiable health information as described below for the purpose of: _____

_____

I authorize the following person(s) or organization to receive and/or disclose the information:
Name_____ Title/Relationship _____
Street Address: _____
City, State, and Zip Code: _____

The following individually identifiable health information may be used, accessed and/or disclosed:

Check (√) all that apply:

__Billing Information
__Consultation/Evaluation Reports
__Discharge Summary
__Emergency Room Records
__Face sheets
__History and Physical Records
__Immunization (shot) Record
__Inpatient Records
__Outpatient Clinic Notes
__Outpatient Records
__Physical Therapy Notes
__Psychiatric Diagnosis/Tx
__Reports of Procedures
__Reports of Tests & X-rays
__Other:_____

_____

Dates of treatment to be released: _____

Expiration: This authorization will expire: _____ (insert date, event or "once purpose stated above is served").

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or HIV-related conditions.

Re-disclosure: I understand that the information used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient of the information and may no longer be protected by federal law.
Revocation: I understand that I may revoke this authorization at any time by notifying St. Vincent Health System in writing by sending a letter to St. Vincent Health System, c/o Health Information Management, 2 St. Vincent Circle, Little Rock, AR 72205 or completing the Revocation of Authorization form. I understand that if I revoke this authorization, it will not affect any actions that SVHS took before it received my revocation letter.

I understand that St. Vincent may not grant access to my health record under certain conditions (see reverse). In any event, this request will be made a part of my permanent health record, and I will receive a signed copy of this authorization.

(X)_____ _____ _____
SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE **DATE** **PHONE**
Printed name of individual's personal representative, if applicable: _____
Rationale for serving as personal representative to the individual (e.g., parent, legal guardian): _____
Witness: _____

CHI St. Vincent

Imagine better health.℠

CHI St. Vincent Medical Group
Medical Consent Form

Patient Name (Print): _____ Date of Birth: _____

Annual Consent for Services: I consent to the services that may be performed by a CHI St. Vincent Medical Group (SVMG) physician or non-physician ("provider") or facility. I understand I can withdraw this consent at any time. This consent and agreement applies to any provider services I may obtain from SVMG providers at a clinic or physician's office and any hospital services I may obtain at a SVMG hospital or from a hospital-based clinic location.

Financial Agreement: I guarantee and agree to pay for all goods and services provided to me or the patient named below at the rates listed in CHI St. Vincent Medical Group Charge Description Master as of the date of treatment, unless I am entitled to pay a different amount under my (or the patient's) health insurance plan or my (or the patient's) status as a Medicare or Medicaid beneficiary. Should an account be referred to an attorney or collection agency for collection, I will pay attorney's fees and collection expenses.

Assignment of Insurance Benefits: I assign my (or the patient's) rights under all insurance and benefit plan documents and authorize direct payment to SVMG of all insurance and plan benefits payments for services provided by SVMG. By paying SVMG, my insurance company or employer is fulfilling its obligations to me (or the patient) under the health insurance policy, or the employer is fulfilling its obligations as required by law. I also agree that I (or the patient) am financially responsible for charges not paid according to this assignment.

Medicare Assignment: I certify that the information given by me in applying for payment from any third party payer, including payment under Title XVIII of the Social Security Act, is correct: I request that payment of authorized benefits be made in my (or the patient's) behalf, and I authorize the Social Security Administration Office of the Department of Health and Human Services to release information regarding my (or the patient's) eligibility for coverage under Medicare Part A and Part B including but not limited to the effective date of such coverage. I also authorize SVMG to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim.

Legal Relationship between Hospital and Provider: I understand, when I am hospitalized, I am under the care and supervision of my attending provider, and it is the responsibility of the hospital and nursing staff to carry out his/her instructions. It is the responsibility of my provider or surgeon to obtain my informed consent, when required, for specific medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under instruction of the provider.

Clinic and Hospital Rules: I understand that my visitors and I must obey all SVMG clinic and hospital rules. I understand that if I or my visitors do not follow the rules, SVMG may pursue corrective action.

Notice of Privacy Practices: I acknowledge that I have received a copy of the Notice of Privacy Practices (NOPP), which describes when SVMG may use or disclose information for treatment, payment and health care operations. The NOPP is considered part of this Consent and Agreement by this reference. I understand that the NOPP is only provided the first time I receive services from the hospital and is otherwise available upon request.

Personal Valuables: I understand that as a patient, I am encouraged to leave valuable personal items at home. If I choose not to, I understand that SVMG is not responsible for the loss or damage to these items.

Demographic Information: I have reviewed the demographic information listed for me and confirm that it is correct. I am aware that I need to inform SVMG of any changes as soon as possible.

Independent Contractor/Providers: I understand that separate bills may be sent for professional services from non-SVMG providers such as radiologists, pathologists, and anesthesiologists in addition to the SVMG bill.

Patient Name (Print): _____ Date of Birth: _____

RX Consent: I consent to CHI St. Vincent Medical Group to obtain my medication history information electronically through a pharmacy health information exchange (e.g., Surescripts, E-Prescribe). Physicians and providers access the information to know what medications I am taking so that they can treat me appropriately and avoid adverse drug reactions.

_____ (Initial here) Agree _____ (Initial here) Disagree

Telephone Calls: By providing my landline, cell number and/or email address, I expressly consent to receiving communications from CHI St. Vincent Medical Group, it's staff, or it's contractors, including collection agents, to any landline, cell number, email, or other electronic communication I provide or that you later acquire for me. SVMG may use this information to contact me live or leave voicemail, text, email or pre-recorded messages regarding my account(s) and/or healthcare services(s) provided to me. SVMG may use an auto dialer to deliver messages to me. Providing you with my contact information is not a condition of receiving healthcare services.

Appointment Reminders: Please let us know how you would like to receive your appointment reminder calls. We can notify you by voice call, by text message (standard rates may apply) or both. Please indicate your preferences below.

_____ (Initial Here) Voice Calls _____ (Initial Here) Text messages _____ Both Voice and Text

Contact Number for Reminders: _____ (Home) _____ (Cell)

Preferred Language (Please check one): _____ English _____ Spanish

Preferred Time to Call (Please check one):

_____ Morning	_____ Afternoon	_____ Evening
(Starting at 8am)	(Starting at 12pm)	(6:30 pm – 8:30 pm)

A copy of this form shall have the same force and effect as the original. The undersigned is the patient or is duly authorized to act on behalf of the patient to sign for the patient and accept the terms written above. A signed copy of this form is available upon request.

Patient / Responsible Party Signature: _____ Date: _____

If signed by other than patient, indicate relationship: _____

Witness: _____ Date: _____