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

CHI St. Vincent Arkansas Neuroscience Institute
6020 Warden Road, Suite 110 Sherwood, AR 72120
Phone (501) 552-6412 Fax (501) 552-6413

Briefly describe the reason for your visit today:

_____

_____

_____

Symptoms:

_____

_____

_____

Social History

Employer: _____

Occupation: _____

( ) full-time ( ) part-time ( ) not employed ( ) retired ( ) disabled

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

Living with: ( ) alone ( ) with spouse ( ) with parents ( ) with children other: _____

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

Do you use other tobacco products (dip, vape)? ( ) no ( ) yes If yes, how much? _____ can(s) per day
For how long? _____

Have you smoked/used tobacco products in the past? ( ) no ( ) yes If yes, how much and for how long?

_____ pks per day or _____ can(s) per day How long? _____When did you stop? _____

What kind? ( ) Cigarettes ( ) Cigars ( ) Chew ( ) Dip

Do you drink alcohol? ( ) no ( ) yes If yes, how often? daily weekly monthly rarely

What kind (circle) beer wine whisky other _____

Did you drink alcohol in the past? ( ) no ( ) yes If yes, how often? daily weekly monthly rarely

Do you consume any street drugs? ( ) no ( ) yes If yes, what kind? _____

How often? _____

Have you consumed any street drugs in the past? ( ) no ( ) yes If yes, what kind? _____

How often? _____

This is very important for the physician to know to avoid anesthesia-related complications during surgery

Family History (briefly describe your family's medical problems and if they are currently living)

Mother: Living ( ) Deceased ( ) Medical Problems: _____

_____

Father: Living ( ) Deceased ( ) Medical Problems: _____

_____

Siblings: Brothers: _____ Medical Problems: _____

Sisters: _____ Medical Problems: _____

Children: Boys: _____ Medical Problems: _____

Girls: _____ Medical Problems: _____

Past Surgical History (list any surgical procedures you have had and when)

Date (MM/DD/YYYY)	**Procedure**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Past Medical History:

Neurological

Present	Past	No	Speech problems:
Present	Past	No	a) expressing something
Present	Past	No	b) understanding something
Present	Past	No	Fainting spells
Present	Past	No	Paralysis:
Present	Past	No	Stroke:
Present	Past	No	Seizures
Present	Past	No	Vertigo (spinning/dizziness):
Present	Past	No	Unsteady:
Present	Past	No	Weakness:
Present	Past	No	Numbness:

Skin

Present	Past	No	Psoriasis:
Present	Past	No	Skin cancer:

Psychological

Present	Past	No	Depression:
Present	Past	No	Crying often:
Present	Past	No	Excessive worrying:
Present	Past	No	Anxiety/Nervousness:
Present	Past	No	Other

Blood/Lymph Glands

Present	Past	No	Anemia:
Present	Past	No	Bleeding tendency:
Present	Past	No	Previous blood transfusion:
Present	Past	No	Reaction to transfusion:

Peripheral Vascular

Present	Past	No	Varicose veins:
Present	Past	No	Blood clots in legs/phlebitis:
Present	Past	No	Leg or hip cramps:
Present	Past	No	Blockage of arteries:

Metabolic /Glandular

Present	Past	No	Sugar diabetes:
Present	Past	No	Thyroid disease:
Present	Past	No	Hormone dysfunction:
Present	Past	No	Gout:

Heart

Present	Past	No	Chest pain:
Present	Past	No	Palpitations:
Present	Past	No	Swelling in legs:
Present	Past	No	Heart attack:
Present	Past	No	Angina:
Present	Past	No	Heart failure:
Present	Past	No	Valve disease:
Present	Past	No	Any other heart disease:

Head and Neck

Present	Past	No	Severe headaches (frequent):
Present	Past	No	Eyes: Glaucoma:
			Glasses:
			Field loss:
Present	Past	No	Reduced/loss of vision:
Present	Past	No	Serious hearing problems:
Present	Past	No	Dentures:
Present	Past	No	Neck lumps/swelling:

Musculoskeletal

Present	Past	No	Arthritis:

GI (Stomach/Intestines)

Present	Past	No	Heartburn:
Present	Past	No	Stomach ulcer:
Present	Past	No	Vomiting blood:
Present	Past	No	Black/tarry stools:
Present	Past	No	Persistent diarrhea:
Present	Past	No	Severe constipation:
Present	Past	No	Recent vomiting:
Present	Past	No	Gallstones:
Present	Past	No	Hepatitis:

Respiratory

Present	Past	No	Asthma (wheezing):
Present	Past	No	Daily cough:
Present	Past	No	Coughing up blood:
Present	Past	No	Severe shortness of breath:
Present	Past	No	Tuberculosis or positive test:

GU (Kidneys & Reproductive Systems)

Present	Past	No	Kidney failure:
Present	Past	No	Kidney infection:
Present	Past	No	Bladder infection:
Present	Past	No	Burning during urination:
Present	Past	No	Frequent urination:
Present	Past	No	Venereal disease:

Men Only

Present	Past	No	Prostate trouble:
Present	Past	No	Trouble starting urination:
Present	Past	No	Discharge:
Present	Past	No	Other:

Women Only

Present	Past	No	Abnormal menstruation:
Present	Past	No	Vaginal discharge:
Present	Past	No	Breast lumps:
Present	Past	No	Birth control pills:
Pregnancies: _____			**Deliveries:** _____

General

Have you ever had trouble with any of the following?		
Yes	No	Unexpected weight loss:
Yes	No	Recurrent fever:
Yes	No	Night sweats:

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.

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

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

ent / Responsible Party Signature: _____ Date: _____

gned by other than patient, indicate relationship: _____

ess: _____ Date: _____

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