PATIENT PROFILE and CONSENTS

Name: Today’s Date:

Sex:

Date of Birth:

Cell phone:

Email Address:

Home phone:

Work/Other phone:

Home Address/City/State/ZIP:

Employer:

Employer Address/City/State/ZIP:

Occupation/Profession:

Name of Responsible Party if other than patient:

Patient relationship to responsible party:

Street Address/City/State/ZIP:

Date of Birth:

Sex:

Primary phone:

Secondary phone:

Work/Other phone:

Employer:

Address:

Preferred pharmacy name, street address, and zip:

**Do you want Dr. Overkamp for your PCP, primary care provider?** (Yes, no or maybe are all OK.)

Next of Kin or Emergency Contact Name:

Relation to patient:

Phone:

Street Address/City/State/ZIP:

Children’s Names and Ages:

**Main reason you are coming for this first visit:**

History and Current Concerns

**Health Information:** Please put an **X** after any of these that you’ve had.

Anxiety

Asthma

Arthritis

Blood Clots

Cancer

Depression

Emotional Abuse

Female diseases

Head Injury

Headaches

Heart Problems

High Blood Pressure

Male health problems

Physical Abuse/Sexual Abuse

Seizures

Stroke

Thyroid Disease

Please explain Xs above **(include dates)**:

What other medical problems do you have?

What surgeries have you had? **(include dates):**

What have you been hospitalized for besides surgery?

List Current Medications and Supplements **AND dosing** (How much, how often? Please include over-the-counter meds and supplements. **PLEASE include dosing.**)

List Allergies, t**he type (rash, etc.) and severity** (mild, moderate, severe) of the reaction.

Drug allergies:

Environmental allergies:

Food allergies:

\*\*\***Women:**

Date of last mentrual period: Problems with period:

Number of times pregnant:Childbirth dates, vaginal (V), Cesarean (C):

Any compllications of pregnancy or childbirth, miscarriage, abortions **with dates:**

Age at menarche: Age at menopause:

Using contraception? if so, what method?

\*\*\*

**Family History**

List **family members** who have had the following:

Cancer: (include type)

Diabetes:

Depression or suicide:

Heart problems:

Thyroid problems:

Stroke:

Other illnesses (list illnesses and family members):

**Health Risks**

**Currently** use Tobacco? **Y N** How many packs per day? For how many years?

**Ever** used tobacco? **Y N** How many **packs per day max. for how long**?

Most recent quit date:

**Currently** use Alcohol? **Y N** **What type(s)**? **How often**?

How much i**n ounces**? **Per day/week/month/year**?

**Ever** use alcohol? **Y N** How much **in ounces max**?  **Per day/week/month/year**?

Most recent quit date:

**Currently** use Street Drugs? **Y N** **What type(s)**? **How often**?

**How much**? **Per day/week/month/year**?

**Ever** use Street Drugs? **Y N** **How much max**? **Per day/week/month/year?**

Most recent quit date:

Do you always wear a seatbelt in the car? **Y N**

Do you always wear a helmet on a bicycle? **Y N NA**

Do you have firearms in your home? **Y N**

Are they kept locked up and unloaded? **Y N**

Do you think you have any risk of HIV or other sexually transmitted infections? **Y N**

Do you feel safe at home, school, work? **Y N**

**Health Enhancers** Please share something about your home life.

Do you engage in daily continuous exercise? **Y N** If so, in what form(s)?

What do you do to keep yourself healthy or improve your health?

What are your health goals?

What is your life purpose, and what do you love doing?

**What are the top 2 or 3 things you want to address today?**

**What would make this a successful visit for you today?**

HIPAA Disclosure Form

for Patients of Susan M. Overkamp, DO

***You are not required to fill out, sign, and date this page. If you do, we will release information to the person(s) listed here in case of emergency. A separate form is required for specific releases to other medical entities. Please request that form at our front desk if you need one. It is called a Release of Information form.***

I, the patient, hereby authorize the doctor listed above to release my medical information

(appointments, lab/x-ray results, diagnoses, treatments, medications, surgeries, etc.) in person and via postal mail, telephone, fax, or email to the following family members or other trusted persons:

Name:

DOB:

Relationship:

Primary phone:

Street/City/State/ZIP:

Email address:

Name:

DOB:

Relationship:

Primary phone:

Street/City/State/ZIP:

Email address:

[Add others as desired.]

**Patient Signature:**

**Patient Printed Name:**

**Date:**

CONSENT FOR MEDICAL TREATMENT

CONSENT TO OFFICE POLICIES

CONSENT TO ACCESS PHI

*(If you are not able to sign, scan, and send this page by email, we will take care of that at your visit.)*

Medical Treatment Consent

I voluntarily consent to medical treatment and diagnostic procedures provided by Susan M. Overkamp, DO, and associated physicians, clinicians and all other personnel. I consent to the testing for infectious and other diseases as deemed advisable by my physician. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees, express or implied, have been made regarding the results of treatments, tests, or examinations.

The undersigned, as patient or guardian of patient, authorizes Susan M. Overkamp, DO, to medically or surgically manage the treatment of the patient and provide treatment deemed necessary for the benefit of the patient.

Consent to Office Policies

I have reviewed and will comply with office policies.

Consent to Access PHI

The “Notice of Privacy Practices” provides information about how Susan M. Overkamp, DO, may use and disclose protected health information (PHI) about me. I understand that I have the right to review the notice before signing this consent. As provided in the notice, the terms of the notice may change. If the notice is changed, I may obtain a revised copy by request.

I have the right to request that Susan M. Overkamp, DO, restrict how protected health information about me is used or disclosed for treatment, payment, or health care operations. Susan M. Overkamp, DO, is not required to agree to any such restrictions, but if the practice does agree, it is bound by our agreement.

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment, or health care operations. I have the right to revoke this consent, in writing, except where Susan M. Overkamp, DO, has already made disclosures in reliance on my prior consent.

Patient Signature (parent or guardian if minor patient):

Date: Printed name: