Heritage Valley Health System

✓ Tri State Medical Group ____ Tri State Pediatric Group ____ Tri State OB/GYN ____ Sewickley Valley Medical Group

PATIENT INFORMATION

NAME: LAST FIRST MIDDLE INITIAL SEX BIRTHDATE

M F

ADDRESS: STREET CITY STATE ZIP TELEPHONE # MARITAL STATUS

( )

S M W Sep Div

SOCIAL SECURITY # E-MAIL ADDRESS RACE (CIRCLE ONE) ETHNICITY (CIRCLE ONE) OCCUPATION (CIRCLE ONE)

American/AK Indian; Black/African American Not of Hispanic Origin

Asian/Pacific Islander; Hispanic; White Hispanic Origin FT PT RET Not Employed

Unknown/ Decline Unknown/ Decline

EMPLOYER OR NAME OF SCHOOL ADDRESS TELEPHONE # ARE YOU A STUDENT?

( )

Yes No Part time Full time

SPOUSE, PARENT OR GUARDIAN INFORMATION *(If under 18, name of parent with whom you reside)*

NAME: LAST FIRST MIDDLE INITIAL SEX BIRTHDATE

M F

ADDRESS: STREET CITY STATE ZIP TELEPHONE # RELATIONSHIP TO PATIENT

( )

Spouse Parent Other

SOCIAL SECURITY # EMPLOYER NAME AND ADDRESS EMPLOYER TELEPHONE #

( )

INSURANCE INFORMATION ****PLEASE HAVE CARDS READY FOR STAFF TO COPY****

NAME OF PRIMARY INSURANCE CO.

INSURED'S NAME (Subscriber of insurance) SUBSCRIBER'S BIRTHDATE

HOLDER'S RELATIONSHIP TO PATIENT: Circle one

Self Spouse Natural Child with financial responsibility Step Child

Natural Child without financial responsibility Adopted Child Foster Child

Significant Other Life Partner Grandchild Organ donor

Other :Specify:_____

ID # OR AGREEMENT # GROUP # EFFECTIVE DATE

AMOUNT OF CO-PAY FOR OFFICE VISITS and SPECIALIST'S VISITS:

NAME OF SECONDARY INSURANCE CO

INSURED'S NAME (Subscriber of insurance) SUBSRIBER'S BIRTHDATE

HOLDER'S RELATIONSHIP TO PATIENT: Circle one

Self Spouse Natural Child with financial responsibility Step Child

Natural Child without financial responsibility Adopted Child Foster Child

Significant Other Life Partner Grandchild Organ donor

Other Specify:_____

ID # OR AGREEMENT # GROUP # EFFECTIVE DATE

DO YOU HAVE OTHER INSURANCE THAT WILL PAY THIS ACCOUNT? o Automobile o Other _____

You are required to complete an additional form. o Workmen's Comp o None

Will patient be best served in a language other than spoken English? : ° No ° Yes If yes, please specify_____

EMERGENCY CONTACT

PLEASE NAME A PERSON *WHO DOES NOT LIVE WITH YOU* TO CONTACT IN CASE OF AN EMERGENCY OR IN THE EVENT WE ARE UNABLE TO REACH YOU.

NAME / RELATIONSHIP: TELEPHONE # - HOME ( )

TELEPHONE # - WORK ( )

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to either: Tri State Medical Group/ Tri State Pediatric Group/ Tri State OB/GYN/ Sewickley Valley Medical Group/ as noted above. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

SIGNED: _____ DATE: _____

PATIENT OR RESPONSIBLE PARTY

TURN OVER TO NEXT PAGE

PATIENT NAME: _____ D.O.B. _____

ASSIGNMENT OF BENEFITS

MEDICARE PATIENTS:

I request that payment of authorized Medical benefits be made either to me or on my behalf to the name of the provider of service and/or supplier for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related service.

We do accept Medicare assignment, however, you are responsible for your Medicare deductible. Many co-insurance plans do not cover the Medicare deductible and you will be billed. It is your responsibility to know if your co-insurance does not cover this. In addition, if the 20% after Medicare is not paid by your co-insurance, it is your responsibility to contact them regarding this. Please note: we will file your co-insurance one time only.

I have read the above and fully understand my financial obligation.

_____ _____ _____

Date Patient Signature HIC#

MEDIGAP PATIENTS:

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the name of the provider of service and/or supplier for any services furnished to me by that provider of service and/or supplier. I authorize any holder of Medicare information about me to release to _____ (Name of Medigap insurer) and its agents any information needed to determine these benefits payable for related service.

I have read the above and fully understand my financial obligation.

_____ _____ _____

Date Patient Signature HIC#

❑ **BLUE SHIELD PATIENTS**

We participate in a variety of Pennsylvania Blue Shield plans in addition to Blue Shield plans of other states. You will be billed for any applicable co-payments and deductibles. **I understand that payment for office visits is due in full at the time of the visit.**

❑ **COMMERCIAL HEALTH INSURANCE PATIENTS**

As a courtesy to our patients, when we have your complete insurance information, a claim is automatically submitted to your insurance carrier unless we are instructed otherwise. In some cases, you will receive payment. You are personally responsible for payment of the entire account. We will assist you; however, any questions related to delayed payment or denial should be directed to your insurance company and not to our office.

❑ **HMO AND PPO PATIENTS**

We participate in numerous HMO and PPO programs. Due to the varied guidelines defined by each plan, it is your responsibility to know your specific plan. Additionally, in certain programs, you will be responsible for any co-payments that apply.

❑ **SELF PAY PATIENTS**

Payment for services rendered is due at the time of service unless other arrangements have been made prior to your appointment. Your prompt payment is appreciated. We do not want your health care to be a financial hardship to you. If you have any difficulties, our billing department will help to establish a payment program to accommodate your needs.

I have read the item checked above and fully understand my financial obligation.

_____ _____

Date Patient Signature

MEDICAL HISTORY

Name _____ Birthdate _____ Today's Date _____

Address _____ Sex: M F Marital Status: S M D Sep W

_____ Spouse's Name _____

Phone _____ Work Phone _____ Emergency Contact _____

Occupation _____ Phone _____

ALLERGIES: (This is to Medications, Foods, X-Ray Dyes or Other Substances) YES ❑ NO ❑

If yes, PLEASE list the medicine, substance or dye and the reaction:

_____ _____ _____

_____ _____ _____

PREVENTION

Do you use tobacco? Yes _____ No _____

Cigarettes _____ Pipe _____ Chewing _____ Amount per day _____

Do you drink alcohol? Yes _____ No _____ Amount per day _____

Do you drink beverages with caffeine? Yes ___ No ___ Coffee ___ Tea ___ Cola ___ If yes,

How much per day: _____

Do you use drugs? (Marijuana, cocaine, crack, etc.) Yes ___ No ___ If yes, explain _____

_____

Do you regularly exercise? YES ___ NO ___

Do you wear seat belts? YES ___ NO ___ Use car seats for children? YES ___ NO ___

Do you wear a bike helmet? YES ___ NO ___

Are you sexually active? YES ___ NO ___ If yes, which type of birth control do you use?

Do you practice safe sex? YES ___ NO ___ _____

Have you ever engaged in any activity, which put you at risk for getting AIDS? YES ___ NO ___

Explain: _____

If you have a gun in your home, is it secured and stored out of the reach of children? YES ___ NO ___

Are you in a relationship in which you are afraid of physical harm by your partner? YES ___ NO ___

Have you ever worked with chemicals, paints, asbestos, or other hazardous material? YES ___ NO ___

Do you have a "living will"? YES ___ NO ___

Do you have a donor card? YES ___ NO ___

CURRENT MEDICATIONS: (List ALL Prescription, Over the Counter, Vitamins, Herbs, Etc.)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Patient Name _____ Birth Date _____ Marital Status M S W D

Address _____ Home Phone _____

_____ Sex M F Religion _____

Occupation _____ Employer _____

SS Number _____ Phone at Work _____

Spouse _____ Or Parents _____

Occupation of Spouse or Parents _____ Employer _____

Medicare Number _____

Name of Ins. Co. _____ ID # _____

Address _____

_____ Name of Subscriber _____

In Case of Emergency, Name of
Nearest Relative Not at Your Address _____

Address _____ Relationship _____ Phone _____

IMMUNIZATIONS			
DPT-DT - Initial Series			
Booster - DPT-DT			
Trivalent Oral Polio			
Booster - Polio			
MMR			
Measles (Rubeola)			
German Measles (Rubella)			
Mumps			
Influenza			
Pneumovax			
Hepatitis			
Other			
Mantoux			

ALLERGIC REACTIONS
substance/effect

PAST MEDICAL HISTORY

DATE	HOSPITAL	DOCTOR	DIAGNOSIS/SURGERY

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

PATIENT DECLINED ☐

PATIENT NAME:	DOB:	DATE:

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Please circle your answer.)

	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself-or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
ADD COLUMNS:				
TOTAL: Healthcare professional: Screening: 9 or <=Negative or 10 or >=Positive Follow Up: 5 or <=Negative or 6 or > =Positive				
10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____			

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HERITAGE VALLEY HEALTH SYSTEM

07192017

FAMILY HISTORY: **Has any member of your family ever had the following conditions? List only Mother, Father, Grandparents, Siblings or Children.**

	Which Family Member	Approximate Age
Cancer		
Heart Disease		
Hypertension		
Diabetes		
Mental Problems		
Depression/anxiety		
Addictions (drugs/alcohol)		
Glaucoma		
Strokes		
Asthma, COPD		
Bleeding Disorders		
Other (Any unusual medical problem or cause of death		

PLEASE LIST AND SUPPLY THE DATES OF:

Past medical history: _____ **Surgeries** _____

Hospitalizations other than surgery: _____

IMMUNIZATIONS: **Have you had any of the following immunizations?**

Hepatitis B Yes ____ No ____ Date of last _____ **Pneumonia** Yes ____ No ____ Date of last _____
Tetanus Yes ____ No ____ Date of last _____ **Flu shot** Yes ____ No ____ Date of last _____
TB (Mantoux) Yes ____ No ____ Date of last _____ **Other?** _____ Date of last _____

Do you wish to be tested for HIV? YES ____ NO ____

When was the last time you were seen by a doctor? _____

Dr. James K Tatum, HVMG

2299 Brodhead Road, Aliquippa PA 15001

724.378.8484

TOBACCO SCREENING

*Patient name:*_____ *DOB*_____

1. Do you have a history of **tobacco use?**

YES or NO

2. Have you used **tobacco** in the last **30 days?**

YES or NO

3. Have you used **smokeless tobacco** products in the last **30 days?**

YES or NO

HERITAGE VALLEY HEALTH SYSTEM
CORPORATE COMPLIANCE PROGRAM

Receipt of Notice of Privacy PracticesAcknowledgement Statement

I acknowledge I have received a copy of Heritage Valley Health Systems Notice of Privacy Practices for Protected Health Information.

_____
Patient Name *(please print)*

_____
Patient Signature

_____Date of Birth_____
Date

_____

In the event of the patients emergency condition, signature of person receiving Notice for patient.

****

Please check the appropriate boxes

- List the family members or other persons, if any, whom we may inform about your healthcare and payment related to your healthcare.

Name:_____Relationship:_____PhoneNumber:_____

Name:_____Relationship:_____PhoneNumber:_____

- List the family member, or other persons, if any, whom are authorized to pick up health care information such as medical records, prescriptions, supplies, test results, etc on your behalf.

Name:_____Relationship:_____PhoneNumber:_____

Name:_____Relationship:_____PhoneNumber:_____

Print the phone number(s) where you would like to receive calls about your appointments, lab and x-ray results.

_____May we leave a detailed message at this number ? ☐ Yes ☐ No

_____May we leave a detailed message at this number? ☐ Yes ☐ No