Ball Memorial Hospital Physicians
Family Medicine Residency Center

REQUEST FOR CARE FORM

Date: _____

Patient's Legal Name: _____ (Last) _____ (First) _____ (MI) DOB: _____ Gender: M F

SSN: ___ - ___ - ____

_____ (Address) _____ (Apt/Suite) _____ (City) _____ (Zip Code)

Ph#: _____ Alt #: _____ Marital Status: Single Married Separated Divorced Widowed

Next of Kin/Guarantor (Responsible Party): _____

_____ (Emergency Contact Name) _____ (DOB) _____ (Relationship) _____ (Phone)

List Medical Problems: _____

List All Medications: _____

Insurance: _____ ID/Policy #: _____

Insured Name: _____ Employer: _____

Employment Status: _____ FT _____ PT _____ Student _____ Retired _____ Other

Physician Requested: _____

Who referred you to our clinic? _____

Have you seen a physician in this clinic before? Y or N If yes, who? _____

Do you have family members that currently see a physician in the clinic? Y or N If yes, who? _____

Have you seen another physician in the community? Y or N If yes, who? _____

_____ (Applicant Signature) _____ (Date)

Office Use Only

OA Review Date: _____ Physician Acceptance _____ Initials _____

PM Review Date: _____ Comments: _____ Initials _____

Patient Informed: Y or N Date/Time: _____ Initials _____

DO NOT SCAN INTO MEDICAL RECORD

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Indiana University Health

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

PATIENT INFORMATION

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____ Phone _____

Clinic/Hospital/Health Care Provider:

(Who has the information you want released? Please list the specific Hospital and/or clinic.)

Name _____

Address _____

City _____ State _____ Zip _____

Receiving Party:

Choose One:

☐ Me ☐ Other

(Where do you want the information sent? Who may have the information?)

Name _____

Address _____

City _____ State _____ Zip _____

Phone Number _____ Fax Number _____

Information to be Released:

(What do you want sent or released? Check the appropriate box.)

Date(s) of Service: From ____/____/____ To ____/____/____

☐ Physician Office Medical Records
☐ Hospital Medical Records
☐ Billing Records
☐ Copies of Films/Images

Only record types checked below:

☐ Discharge summary/note
☐ History & Physical Exam
☐ Operative report
☐ Consultations
☐ Radiology reports
☐ Rehab records (PT/OT/ST)
☐ Laboratory reports
☐ Progress Notes
☐ Emergency record(s)
☐ Immunization/allergy record
☐ Pathology reports
☐ Other records (Specify record types(s)) _____

Special Authorization Section

(Per IC-16-39-2 this special authorization is valid for 180 days.)

State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

Alcohol, Drug, or Substance Abuse Records	☐ Yes	☐ No
HIV Testing and Results	☐ Yes	☐ No
Mental Health Records	☐ Yes	☐ No
Psychotherapy Records	☐ Yes	☐ No
Genetic Records	☐ Yes	☐ No

Release Instructions:

(How and When do you want the information?)

Release Method/Format requested: (check one)

☐ Electronic Access – E-mail address _____
☐ Paper ☐ CD/DVD ☐ Fax (patient care only)

Date information is needed _____ NOTE: Please allow 30 days for processing

Purpose of Release:

(Why is it needed?)

☐ Personal use*
☐ Continuing Care
☐ Transfer of care
☐ Insurance application*
☐ Insurance payment/claim
☐ Litigation/legal*
☐ Social Security appeal
☐ Social Security Disability Determination*
☐ Other* _____

*Fees may be charged in accordance with IN Statute 760 IAC 1-71-3 and Federal Rule 45 C.F.R. §164.524

- This authorization will expire in 60 days from the date signed unless otherwise specified _____
- I understand that I have the right to revoke this authorization at any time. In order to revoke this authorization, I must do so in writing and present my written revocation to the above named authorized entity. The revocation will not apply to information that has already been released in response to this authorization.
- I understand that I am not required to sign this Authorization in order to receive health care treatment.
- IUH's records may include records that it received from other organizations. If these records have been used by IUH, and filed in the record IUH maintains about you, these records may be released with your IUH records.
- IUH cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release IUH from any and all liability resulting from a redisclosure by the recipient.

Your signature indicates that you have read and understand this form, and you authorize release of your information as described above.

_____ _____
Patient/Legal Guardian Signature Date

_____
Authority to act on behalf of patient (Attach documentation)

TO BE COMPLETED BY HOSPITAL STAFF:

Initials of person releasing information ____ Date _____

Photo ID/Signature verified (if not currently admitted) _____

Medical Record Number _____

Patient Encounter Number _____

Ball Memorial Physicians

IU Health Family Medicine Residency Center
New Patient Intake Form

We would like to welcome you as a new patient to our medical home. As your medical home, it is our responsibility and pleasure to coordinate all your health care and provide you with excellent service. We will review our Medial Home Booklet with you to further explain our goals for your care at your intake appointment. Please bring this completed form to your intake appointment scheduled on _____.

Please be sure to bring any insurance information and all your medications in the original package.

Name_____ **DOB**_____/_____/_____

Previous Physician: _____ Your pharmacy:_ _____

Patient Health History

Other Doctors You See:

Name	Reason

Allergies

☐ **Check here if you have No Known Drug Allergies**

Penicillin	☐ Yes	☐ No	Reaction:	
Sulfa	☐ Yes	☐ No	Reaction:	
Codeine	☐ Yes	☐ No	Reaction:	
IVP Dye	☐ Yes	☐ No	Reaction:	
Seafood	☐ Yes	☐ No	Reaction:	
Latex	☐ Yes	☐ No	Reaction:	
Aspirin	☐ Yes	☐ No	Reaction:	
Tape	☐ Yes	☐ No	Reaction:	
Eggs	☐ Yes	☐ No	Reaction:	

Other: _____

Family History

Mother: ☐ Living Age: _____ Health problems: _____
☐ Deceased Age: _____ Cause of death: _____

Father: ☐ Living Age: _____ Health problems: _____
☐ Deceased Age: _____ Cause of death: _____

Bother(s): ☐ # Living _____ Health problems: _____
☐ # Deceased _____ Cause of death: _____

Sister(s): ☐ # Living _____ Health problems: _____
☐ # Deceased _____ Cause of death: _____

Prior Medical Problems (please circle all that apply)

Alzheimer's
Anemia
Anxiety
Arthritis/joint pain
Asthma
Blood clots/DVT
Bronchitis
Cancer – type/location:
_____
_____
Cataracts
Chronic Pain
COPD/Emphysema
Crohns disease
Depression
Diabetes (I or II)
Diverticulitis
Eating Disorder
Fibromyalgia
GERD (heartburn)
Glaucoma
Headaches/Migraines
Hearing loss
Heart Arrhythmia
Heart attack
Heart failure (CHF)
Heart valve disease
Hepatitis
High blood pressure
High Cholesterol
Irritable bowel
Kidney disease
Memory loss
Mitral valve prolapse
Muscle weakness
Obesity
Osteopenia
Osteoporosis
Palpitations
Parkinson's
Pneumonia
Polycystic ovaries
Prostate problems
Seizures
Sleep apnea
STD's
Stomach ulcers
Stroke
Thyroid Problems
Ulcerative colitis
Vertigo
Vision loss
Weight loss
Wheezing

Other mental health problems not listed above: _____

_____

Other medical problems not listed above: _____

_____

Prior Surgeries or Procedures (please write the year of the procedure):

Tubal/Vasectomy	_____	D&C	_____	Appendectomy	_____
Hysterectomy	_____	Removal of tube/ovary	_____	Gallbladder	_____
Hernia Surgery	_____	Bladder surgery	_____	Wisdom Teeth Extraction	_____
Tonsillectomy	_____	Head/Neck Surgery	_____	Back/Joint Surgery	_____
Breast Biopsy	_____	Mastectomy/Lumpectomy	_____	Prostate Surgery	_____

Other surgeries not listed above: _____

_____

Pregnancy History

Total # of Pregnancies: _____ **Total # of Living Children:** _____ **Total # of Miscarriages/Abortions:** _____

Total # of Ectopic Pregnancies: _____

DOB	Type of Delivery*	Baby's Weight	Epidural Y or N	Gestational Age Male/Female	Length of Labor	Complications	Hospital/Doctor
				/M or F			
				/M or F			
				/M or F			
				/M or F			
				/M or F			
				/M or F			

*Vaginal Birth, Natural Birth, Scheduled Cesarean, Unplanned Cesarean, Vaginal Birth after C-Section, Scheduled Induction

Social History

Please circle answer

Gender Identity: Man Woman Trans Man Trans Woman Other: _____

Relationship Status: Single Married Widowed Divorced/Separated Domestic Partnership

Do you have children? Yes No

Smoker: Never Past Present Types(s): _____

Alcohol: Never Occasional Daily # of drinks/day: _____

Drug Use: Never Past Present Types(s): _____

Exercise: Never Occasionally Regularly Type and Frequency: _____

Employment: Working Retired Unemployed Disabled Student Other

Job Title/Profession: _____

- Do you have sleeping difficulties? YES NO
- Do you feel safe at home? YES NO
- Do you have a good support system? YES NO
- Do you have significant stress? YES NO
- Do you have a safe place to go? YES NO
- Have you felt threatened, controlled by, or afraid of a partner, family member or caregiver? YES NO
- Have you ever binged, purged, or restricted your food intake? YES NO

Cultural/Learning Beliefs

Do you have any cultural or religious beliefs that may impact your medical care?			YES	NO
If yes, please explain:				
What is your preferred leaning style?				
Written material	Hands on	Face to Face	Group Education	One on one education
Other:				

Preferred language: _____

Do you have any learning disabilities or problems understanding information that we should take into account in your care? (This can include trouble with reading) Please explain.

_____

_____

_____

Gynecologic History

Age at time of first period? _____ Date your most recent period began? ___/___/_____

Date of period just before the one listed above: ___/___/_____

How many days does your typical period last? _____

How many days from the start of one period until the start of the next? _____

Would you say your period bleeding is? ☐ Heavy ☐ Medium ☐ Light

When was your last Pap smear? _____ Results: ☐ Normal ☐ Abnormal

Age at time of menopause? _____

Have you had a hysterectomy? YES NO

If yes, why was it performed? _____

What do you use to prevent pregnancy?

☐ Pills ☐ Patches ☐ Vaginal Ring
☐ Depo-Provera ☐ Condom ☐ Tubal ☐ Vasectomy
☐ IUD ☐ Spermicida ☐ NFP ☐ Nothing

Sexual History

How do you identify?

☐ straight ☐ gay ☐ asexual ☐ bisexual ☐ other: _____

Gender of current sexual partners?

☐ Man ☐ Woman ☐ Trans Man ☐ Trans Woman ☐ other: _____

Gender of past sexual partners?

☐ Man ☐ Woman ☐ Trans Man ☐ Trans Woman ☐ other: _____

Please check any of the following infections you have had:

☐ Syphilis ☐ Chlamydia ☐ Herpes ☐ Genital Warts ☐ Trichomonas
☐ Gonorrhea ☐ Crabs ☐ Yeast Infections ☐ Bacterial Vaginosis
☐ Pelvic Inflammatory Disease

Have you been tested for HIV? ☐ YES ☐ NO If yes, when: _____ Result: _____

For each of those circled above, please provide above information:

Date diagnosed: _____ Treated? ☐ YES ☐ NO

Partner informed? ☐ YES ☐ NO Need help telling partner? ☐ YES ☐ NO

Partner treated? ☐ YES ☐ NO

Date diagnosed: _____ Treated? ☐ YES ☐ NO

Partner informed? ☐ YES ☐ NO Need help telling partner? ☐ YES ☐ NO

Partner treated? ☐ YES ☐ NO

In the last 90 days, have you ever had sex in exchange for money or drugs? ☐ YES ☐ NO

In the last 90 days, have you ever had sex under the influence of drugs or alcohol? ☐ YES ☐ NO

Medications

☐ **No** prescription or non-prescription medications

Please list your *prescription & non-prescription* medications. Please include any vitamins, dietary supplements, herbal medicines, and over-the-counter medications. If you need additional space, please use the attached sheet.

Medication Name	Dosage	Frequency	Why do you take this medication?

Health Maintenance and Immunizations

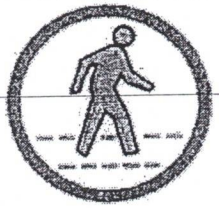
Please indicate the date when you most recently had the following along with results:

Test/Exam	Date (Month/Year)	Normal/Abnormal
Tetanus booster vaccine		
Colonoscopy		
Pneumonia vaccine		
Influenza vaccine		
Zostavax (shingles) vaccine		
For Women:		
Mammogram		
Bone density test (DEXA)		
For Men:		
PSA (prostate test)		
Prostate exam		

Is there anything you would like to do to improve your health (please circle):

Eat a Healthy Diet

Limit Alcohol

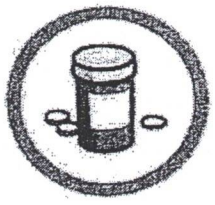


Be Physically Active

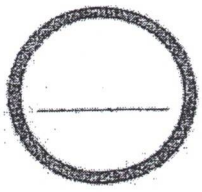
Monitor My Blood Sugar and Blood Pressure

Stop Smoking

Cope with Stress



Take My Medicine



Other