

Grand View Medical Practices OB/GYN Adult Health History Form

Last Dexascan (age 65+): _____

Have you ever had the HPV vaccine (Gardasil)? Yes No If so, When?: _____

Past Medical History: (Please check off all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Skin Condition |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> HIV | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Bowel Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Psychiatric Disease |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer: Type: _____ | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ulcer Disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Lung Disease | |
| <input type="checkbox"/> Other (explain): _____ | | |
| • _____ | | |
| • _____ | | |

Past Surgical History: (Please list all surgeries with approximate date)

Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____

Family History: (Please check all that apply)

Mother	Father	Sibling	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother	
							Alzheimer's
							Asthma
							Autoimmune Disease
							Aneurysm
							Bleeding/Clotting Disorder
							Brain Tumor
							Cancer (list type)
							Colon Polyps
							Diabetes
							Depression/Anxiety
							Glaucoma
							Heart Disease
							Lung Disease
							Multiple Sclerosis
							Stroke
							Seizures
							Other (explain)

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Social History:

Who lives in your home with you?: _____

Any children?: _____

Marital Status: _____

Have you ever smoked any tobacco products?: Circle One: Yes No

If so, how many cigarettes per day?: _____ How many years?: _____

Quit Date?: _____

Tobacco Type: Circle all that apply: Cigarettes Cigar Chew Snuff Vape

Do you drink any alcohol? Circle One: Yes No

How Much per week?: _____

Have you ever used any recreational drugs? Circle One: Yes No

If so, what kind? Circle all that apply:

Marijuana Crack/Cocaine Heroin Amphetamines Hallucinogens Tranquilizers
Sedatives Opiates Painkillers Club/Designer Drugs Inhalants IV Drugs
Methamphetamines Prescription Drugs

Quit Date?: _____

What is your occupation?: _____

How would you rate your diet?: Circle One: Good Fair Poor

Are you on a specific diet type?: Circle any that apply:

No Low Fat Low Sodium Low Carb Diabetic Gluten Free
Vegetarian Vegan Paleo

Would you like advice on your diet?: Circle One: Yes No

Do you drink any Caffeine?: Circle One: Yes No

How Much per day?: _____

Do you Exercise regularly?: Circle One: Yes No

How often per week?: _____

What type of exercise?: _____

Any Hobbies or Activities?: _____

Have you ever been sexually active?: Circle one: Yes No

Are you currently sexually active?: Yes No

Current number of Partners?: _____

Preferred Partner is/are/have been: Male Female Both

Contraception Type: Condoms Depo-Provera Diaphragm Foam
IUD Oral Contraceptive Pill Patch Ring Tubal Ligation
Vasectomy Abstinence Infertility Mini Pill Withdraw

Other: _____

Any Recent Travel? _____

GVH GRAND VIEW HEALTH

PATIENT INFORMATION	
Name (Last, First, Middle)	Employer Name
Date of Birth: Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk	Employer's Address
Address	Employer's Phone #
City State Zip	Employer Status <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Retired <input type="checkbox"/> Active Military <input type="checkbox"/> Self Employed <input type="checkbox"/> Unemployed
Email	Occupation
Primary Care Physician:	Pharmacy Name and Location
Referring Physician	
Communication Preferences	
<u>Phone Numbers</u>	
Cell:	Marital Status _____
Home:	Preferred Language _____
Work:	Interpreter Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No
Preferred Phone # <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	Ethnicity: <input type="checkbox"/> Non Hispanic <input type="checkbox"/> Other _____ <input type="checkbox"/> Hispanic <input type="checkbox"/> Unknown
OK to leave voice mail regarding appointment, clinical, or financial information? <input type="checkbox"/> Yes <input type="checkbox"/> No	Race: <input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other <input type="checkbox"/> Patient Declined
Emergency Contact	
Name (Last, First, Middle):	Permission to Disclose Healthcare Information <input type="checkbox"/> Yes <input type="checkbox"/> No
	Regarding Appointments? <input type="checkbox"/> Yes <input type="checkbox"/> No
Relationship to Patient:	Regarding Clinical Information? <input type="checkbox"/> Yes <input type="checkbox"/> No
Phone # <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	Regarding Financial Information? <input type="checkbox"/> Yes <input type="checkbox"/> No
Person Financially Responsible <input type="checkbox"/> check here if self	
Name (Last, First, Middle)	Relationship to Patient
Address	Home Phone
City State Zip	Cell Phone
PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Name	Insurance Name
Subscriber Name	Subscriber Name
Subscriber DOB	Subscriber DOB
Policy Number	Policy Number
Group Number	Group Number
Effective Date	Effective Date

Patient or Guardian Signature _____ Date _____





REQUEST FOR PAYMENT AND ASSIGNMENT OF BENEFITS

I, _____ (Print Name) request payment and authorize any healthcare benefits that are otherwise payable to me by any insurance provider, benefit plan or other third party payer, under the terms of the insurance policy with _____(Insurance Company) or benefit plan to be paid directly to Grand View Health for services and goods provided by Grand View Health.

- I may be responsible for payment in full of any amount due that is not covered or paid for by any insurance policy or benefit plan for services and goods provided by Grand View Health.
- In event that I fail to make full payment or fail to comply with other payment arrangements made with Grand View Health's approval, I understand appropriate collection measure may be initiated.
- If my account is referred to an attorney or agency for collections of any unpaid balances for which I am responsible, I understand that I will also be responsible for all collection costs, including reasonable attorney's fees and court costs.
- My obligations to pay may not be deferred for any reason, including pending legal actions against other parties to recover medical costs.
- That I am responsible to know and understand what services are covered under my insurance policy.

RELEASE OF INFORMATION

I authorize GVH and/or their agents:

- To release to my insurance provider, benefit plan, or other third party payer, or their agents, any medical or other information necessary to process related health claims, receive payment or to obtain authorization for services, supplies and equipment in accordance with HIPAA standards..
- To request and to receive directly, on my behalf, claims for benefits and/or appeals of any denied claims or authorization and to take action in my name against my insurance company, benefit plan or other third party payer, to receive any benefits that may be due or payable under the insurance policy or benefit plan.
- To give medical or other information to any healthcare practitioner furnishing health care services to me or receive information from them in accordance with HIPAA standards.

STATEMENT OF ASSISTANCE

I agree:

- To assist GVH in collections that may be due or payable under my insurance policy or benefit plan for the service, supplies and equipment provided.
- To provide any additional information needed to process the claim for payment.
- That a photocopy or other reproduction of this document shall be considered as valid as the original.

By signing below I am certifying that the information on this form is correct and current:

Signature of Patient or Person Authorized to Consent for Patient

Date

Signature of Witness

Date

If the patient is unable to sign upon arrival, state the reason: _____



GRAND VIEW HEALTH

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Sellersville, PA 18960
215-453-4000
www.gvh.org

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling the Privacy Officer at Grand View Health, on this organization's website, or by requesting one at this organization's offices.

Date

Signature

Print or Type Name

- As the representative of the above individual, I acknowledge receipt of the Notice on his or her behalf.

Signature

Relationship





Patient Portal Enrollment Form

Please complete the information below. A Grand View Health representative will set up your portal account and you will receive an email to the email address provided below with instructions to complete your enrollment within the next 2-3 business days.

I understand that patient information within the portal may include information relating to acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection, Behavioral Health services/psychiatric care, or treatment for alcohol and/or drug abuse.

Should you like to access patient information for someone other than yourself, please fill out an Authorization for Proxy Access to GVH Patient Portal form.

Patient Name _____

Address _____ City _____ State _____ Zip Code _____

Date of birth (month/day/year) ____/____/____

Phone Number: _____

Medical Record # (if available) _____

Email address _____

Verify Email address _____

Signature _____ Date _____

FOR STAFF USE ONLY

Patient name as shown in EMR: _____

Medical Record # as shown in EMR: _____

DOB as shown in EMR: _____

ID Verified by: _____

Enrollment completed by: _____

(Print Name)

- Patient Identification
- Photo ID
- POA Provided
- Office
- Patient Registration
- Health Information Management

Please present completed Patient Portal Enrollment Form to the Health Information Management Department with photo ID.

