Laura Chamberlain MSN, NP-C
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MILLCREEK Primary Care Palliative Care
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NEW PATIENT INFORMATION SHEET: Assisted Living Facility Patients

Patient Name:_____ DOB:_____

Name of Assisted Living Facility:_____

Primary Medical (Emergency) Contact Name:_____ Relationship:_____

Phone #:_____ Email:_____

Financial Responsible Name:_____ Relationship:_____

Phone #:_____ Address:_____

OR ☐ Same as Medical Contact

Insurance Information: Please provide copy of cards

Primary Insurance: _____ ID#_____

Secondary Insurance: _____ ID#_____

MEDICAL CONTACTS

Previous Primary Care Provider:_____

Other Physicians involved in care: _____

ADVANCED DIRECTIVES

Code Status (circle): DNR (Do not Resuscitate) Full Code

Physician Order for Life Sustaining Treatment (POLST) form done (circle): yes no

SOCIAL HISTORY
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Do you use tobacco? ☐ Never ☐ Quit Date: _____ ☐ Smoke (_____packs per day) ☐ Chew
Do you drink alcohol? ☐ Never ☐ Quit Date: _____ ☐ rarely ☐ daily ☐weekly ☐special occasions

SURGICAL HISTORY:	
Type of Surgery:	**Year of Surgery**

Medications: PLEASE ATTACH A LIST

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ALLERGIES: please list type of reaction for each allergy NO ALLERGIES _____

Food Allergies: _____Environmental Allergies: _____

Medication Allergies: _____

Family History: (please put an "x" in the appropriate box)

Arthritis	□ Mother □ Father	□ Sibling □ Children	□ Grandparent □ Aunt/Uncle
Cancer (which type?):_____	□ Mother □ Father	□ Sibling □ Children	□ Grandparent □ Aunt/Uncle
Diabetes	□ Mother □ Father	□ Sibling □ Children	□ Grandparent □ Aunt/Uncle
Heart Disease	□ Mother □ Father	□ Sibling □ Children	□ Grandparent □ Aunt/Uncle
High Blood Pressure	□ Mother □ Father	□ Sibling □ Children	□ Grandparent □ Aunt/Uncle
High Cholesterol	□ Mother □ Father	□ Sibling □ Children	□ Grandparent □ Aunt/Uncle
Stroke	□ Mother □ Father	□ Sibling □ Children	□ Grandparent □ Aunt/Uncle
Thyroid Problems	□ Mother □ Father	□ Sibling □ Children	□ Grandparent □ Aunt/Uncle
Obesity	□ Mother □ Father	□ Sibling □ Children	□ Grandparent □ Aunt/Uncle
Liver problems	□ Mother □ Father	□ Sibling □ Children	□ Grandparent □ Aunt/Uncle
Kidney Problems	□ Mother □ Father	□ Sibling □ Children	□ Grandparent □ Aunt/Uncle
Depression/Anxiety	□ Mother □ Father	□ Sibling □ Children	□ Grandparent □ Aunt/Uncle
Blood Disorders	□ Mother □ Father	□ Sibling □ Children	□ Grandparent □ Aunt/Uncle

MEDICAL HISTORY: Have you ever had any of the following? (check ALL THAT APPLY) □ NONE

□ Allergies	□ Cardiac arrest	□ Fibromyalgia	□ Liver problems
□ Alzheimer's	□ Chest pain	□ Heartburn or reflux	□ Migraines/headaches
□ Anemia	□ Congestive heart failure	□ High cholesterol	□ Nerve pain
□ Anxiety	□ Constipation	□ Hypertension	□ Osteoporosis
□ Arthritis	□ Coronary artery disease	□ Hypothyroidism	□ Overactive Bladder
□ Atrial fibrillation	□ Pulmonary disease	□ Heart disease	□ Pulmonary embolism
□ Asthma	□ Dementia	□ Incontinence	□ Seizures
□ Back Pain	□ Depression	Urinary or Bladder	□ Stroke
□ Bleeding problems	□ Diabetes	□ Insomnia	□ Other: _____
□ Cancer (type?)	□ DVT (blood clot in leg)	□ Irritable bowel syndrome	_____
_____	□ Enlarged prostate	□ Kidney problems	

Immunizations: □ Influenza □ Pneumonia □ Shingles

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Please list any hospitalizations and include approximate dates and reason for hospitalization:

_____

_____

_____

HEIGHT: _____ WEIGHT:_____

REVIEW OF SYSTEMS: (patient checklist)

Instructions: Circle all symptoms that currently bother you

General: fever, chills, feeling flu-like, fatigue, changes in energy levels, unintended weight loss or weight gain in the last 12 months, difficulty sleeping.

Diet: changes in appetite (more hungry/less hungry)

Skin, Hair, Nails: rashes, itching, changes in skin color, changes in nails

Head & Neck: headaches, dizziness, head injuries, loss of consciousness

Eyes: blurring, visual changes, change in prescription glasses

Ears: hearing loss, ringing in the ears, sensation of the room spinning/ of spinning inside your body

Nose: congestion, nose bleeds, post-nasal drip

Throat & Mouth: hoarseness, sore throat, bleeding gums, ulcers, tooth problems, bad breath, difficulty swallowing

Gastrointestinal: heartburn, nausea, vomiting, constipation, diarrhea

Lymph Nodes: tenderness or enlargement in nodes of neck or groin area

Endocrine: heat or cold intolerance, excessive urination, excessive thirst, hair changes

Chest & Lungs: cough, sputum, shortness of breath

Cardiovascular: chest pain, palpitations, edema, difficulty breathing while lying down

Hematology: anemia, easy bruising, blood in stool (bright red or black tarry)

Genitourinary: painful urination, flank (mid-back) pain, urine urgency or frequency, excessive night time urination, blood in urine, urine dribbling, unexpected and unintended loss of bladder control or bowel control.

Musculoskeletal: joint pain, heat in joint, redness or swelling, excessive muscle aches, falls in the past year

Neurological: fainting, weakness, loss of coordination, seizures, migraine headaches, loss of consciousness, tremors

Mental Status: memory loss, depression, anxiety, agitation, suicidal thoughts

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CONSENT AND CONDITIONS OF SERVICE

As either the patient or the legally authorized representative of the patient, the following consents, understandings, and agreements are made on my own behalf, or on behalf of the patient in partial consideration of the health care services to be provided to the patient by Millcreek Primary and Palliative Care; to provide health care services to patient and to administer medical orders for the benefit of the patient for this visit and any subsequent visits. It is understood that this consent may be revoked *in writing* at any time.

The patient agrees to pay for all health care services from Millcreek Primary and Palliative Care including, but not limited to, any amounts not paid by any insurance company or other third party payer. The patient remains responsible for all co-payments, deductibles, co-insurance, and non-covered services regardless of amount paid by insurance or third party payer. Millcreek Primary and Palliative Care will make every effort to identify services that are potentially not covered by my insurance, but cannot be held responsible for coverage decisions by insurance plans. In addition, the patient will make Millcreek Primary and Palliative Care aware of any changes in health insurance coverage.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, the undersigned, authorize Millcreek Primary and Palliative Care to release any medical information including, but not limited to, diagnosis, x-rays, test results, reports, and records pertaining to any treatment or examination rendered to myself, or to the patient, if acting as the legally authorized representative of the patient. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, and/or legal. I further understand that this information may be released to the Centers for Medicare and Medicaid, or insurance companies and its agents to determine benefits payable for related services.
By signing below I am assigning my health insurance benefits to be paid to Millcreek Primary and Palliative Care for the service rendered.

ACKNOWLEDGEMENT OF REVIEW/RECEIPT OF PRIVACY PRACTICES

I understand that Millcreek Primary and Palliative Care takes every precaution to safeguard my *"Protected Health Information" (PHI)*. Those safeguards include password protection and/or encryption of electronically stored data and storage of written records behind locks. Millcreek Primary and Palliative Care will not share medical information with people or agencies not involved in your care.
By signing this acknowledgment I am consenting to Millcreek Primary and Palliative Care use and disclosure of my *PHI* to carry out treatments, payment, and health care operations. If I do not sign this consent, or later revoke it, Millcreek Primary and Palliative Care may decline to provide treatment to myself, or to the patient, if acting as the legally authorized representative of the patient.

I have read and understand these 3 sections and intend it be legally binding:

_____ _____
Signature of Patient or Legally Authorized Representative Date

_____
Printed Name (if other than patient)

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REQUEST FOR MEDICAL RECORDS

Please sign at the bottom so we can get medical records if needed

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name:	Date of Birth:	Social Security #:
Previous Medical Provider or Entity to release records:	Office Phone #:	Office Fax #:

I request and authorize you to release healthcare information to Millcreek Primary and Palliative Care

Please provide the following:

Copy of the last 3 office visits
Copy of the most recent history and physical
Copy of current and past diagnoses/problem list
Copy of labs or tests done in the last year

Patient/Representative Signature:	Date Signed:

Representative Name (if applicable): _____

Please provide any additional information you would like the NP to know:_____

_____

_____

_____

_____