Patient Information

Name: _____
Last First MI

Email address: _____

☐ I wish to opt out of any clinic updates via email. This includes: newsletters, deals, coupons, and promotions.

Street Address: _____ City _____ State _____ Zip _____

PO Box: _____

Phone # (H)_____ (W) _____ (Other) _____

Can we call you at work? ❑ Yes ❑ No

Date of Birth: _____ Sex: ❑ Male ❑ Female **SS#:** _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Race ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Latin American ❑ Other ____

Ethnicity ❑ Hispanic ❑ Latino ❑ Non-Hispanic / Non-Latino

Military History: ❑Active ❑ Veteran ❑ N/A

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

How did you hear about our practice? _____

If you heard from a friend, who? _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

Phone #: (H) _____ (W) _____

SIGNATURE (X) _____ **DATE:**_____

Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The treating medical provider, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the medical provider. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. Any prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

Sign here: X_____I have read and understand the above consent form.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Northwoods Family Physical Medicine.

(Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

I acknowledge that it is the policy of Northwoods Family Physical Medicine to leave reminder messages on voicemail/answering machines, or with another person in the household. I may make a request of an alternative means of communication (within reason) in writing.

May we discuss your medical condition with any member of your family?	YES	NO
May we discuss your billing information with any member of your family?	YES	NO

If YES, please name the members allowed:

X_____ _____
Signature of Patient/Guardian Date

X_____ _____
Witness (Office Staff) Date

History of Present Illness – PRP Procedures

Do you currently have, or have been diagnosed with, or have had in the past, any of the following:

_____ Platelet dysfunction syndrome

_____ Critical thrombocytopenia

_____ Hemodynamic instability

_____ Septicemia

_____ Local infection at the site of the procedure(s)

_____ Areas of active inflammation or infection (cysts, pimples, rash)

_____ Sexually transmitted disease or blood borne infection

_____ Excessively sensitive skin, healing problems, dermatitis or inflammatory Rosacea

_____ Systemic use of corticosteroids within 2 weeks

_____ Corticosteroid injection at treatment site within 1 month

_____ Cancer – Type:_____

_____ History of allergies, rashes or other skin reactions that may be sensitive to treatment

_____ Active or past vaginal/uterine or other female related problems

_____ Have you had a normal gynecological exam within the last year and have not had any gynecological/female issues since?

_____ Active or past bladder/prostate/penile or other male related problems

Name_____