Adult Health History Form

Bowling Green Medical Group
A Cheerful Heart is Good Medicine

Welcome — it is our privilege to serve as your health care provider. We believe that the best care begins with truly understanding you as a whole person. **Your honest and complete health history** helps us deliver safe, personalized care tailored just for you. Everything you share will remain confidential and will be used only to help us provide the best care possible. Thank you for trusting us with your health — we are honored to be part of your care journey. *Please fill out every question to the best of your ability, taking your best guess if you cannot remember specifics.*

Name: _____ Date of Birth: ___ / ___ / ___ Date Completed: ___ / ___ / ___

Current Mood/Health: *Answer the following questions about your mood and overall health in the past month:*

Have you had little interest or pleasure in doing things?
☐ Yes ☐ No

Have you felt down, depressed or hopeless?
☐ Yes ☐ No

How would you rate your overall health?
☐ Great! ☐ Good ☐ Fair ☐ Poor

Review of Systems: *Which of the following are you currently experiencing? If multiple, circle current symptom.*

- ☐ Fever
- ☐ Weight change
- ☐ Fatigue/Weakness
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Palpitations
- ☐ Swelling in legs
- ☐ Cough/wheezing
- ☐ Heart burn
- ☐ Nausea/Vomiting
- ☐ Constipation/Diarrhea
- ☐ Blood in urine/bowel
- ☐ Frequent/painful urination
- ☐ Vaginal discharge
- ☐ Joint pain
- ☐ Muscle aches
- ☐ Back pain
- ☐ Headache
- ☐ Dizziness
- ☐ Anxiety/Depression
- ☐ Rash/itching
- ☐ Memory changes
- ☐ Numbness/tingling

Current Medications: *(Include prescriptions, over the counter, vitamins and herbal products)*

Medication	Dose	Frequency	Reason/Diagnosis

Past Medical History: *(Check all that apply; if you see a specialist for this issue, fill in ◈ symbol)*

- ◈ ☐ High blood pressure
- ◈ ☐ High cholesterol
- ◈ ☐ Heart Disease
- ◈ ☐ Stroke/TIA
- ◈ ☐ Diabetes
- ◈ ☐ Asthma/COPD
- ◈ ☐ Cancer: _____
- ◈ ☐ Arthritis
- ◈ ☐ Depression/Anxiety
- ◈ ☐ ADHD
- ◈ ☐ Insomnia/Sleep Apnea
- ◈ ☐ Migraine
- ◈ ☐ Liver disease
- ◈ ☐ Kidney disease
- ◈ ☐ Thyroid disease
- ◈ ☐ GI disease
- ◈ ☐ Skin disease
- ◈ ☐ Other: _____

Allergies: ☐ No Known Allergies ☐ Allergies to medications/food/other *(list and describe reaction)*

Medications/Rxn	Food/Rxn	Other
		☐ Seasonal and Environmental

Surgical/Hospitalization History:

Procedure/Reason	Date	Hospital/Location	Stayed Over Night?

Family History: *(Complete to the best of your ability, as this can help with insurance coverage in the future; place a check mark or x if relation has medical history of this issue; provide additional details if possible.)*

Condition	Mother	Father	Sibling	Children	Aunt/Uncle	Grandparent
High Blood Pressure						
High Cholesterol						
Heart Disease/CVA						
Stroke/TIA						
Diabetes						
Mental Health Disorder						
Substance Abuse						
Cancer						

Social History: How is your diet? ☐ Great ☐ Good ☐ Fair ☐ Poor Happy with your weight? ☐ Yes ☐ No

Tobacco Use:
☐ Never ☐ Former ☐ Current
#/day: _____ #Years: _____
Date/Age of start: _____
☐ Cigarettes ☐ Vape ☐ Chew
☐Other: _____
Interested in quitting: ☐ Y ☐ N

Current Recreational Drug Use? ☐ Marijuana
☐ Other: _____

Current Caffeine Use?
☐ None ☐ Coffee ☐ Tea
☐ Soda ☐ Energy Drink
Drink/day: _____

Sexual Activity in Past 12 months? ☐ Yes ☐ No
Gender of Partner: ☐ Male ☐ Female ☐ Both
#Partners: _____ New partner? ☐ Yes ☐ No
Protection: ☐ Yes ☐ No
STD History? ☐ Yes ☐ No
Desire STD Screen? ☐ Yes ☐ No
History of SA/Abuse: ☐ Yes ☐ No

Alcohol use in past 12 months? ☐ Yes ☐ No If yes, you generally drink? ☐ Beer ☐ Wine ☐ Liquor: _____
How often do you drink? ☐ Less than monthly ☐ 2-4/month ☐ 2-3/week ☐ Daily or close to it
How many drinks do you typically have on a day when you are drinking? ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7 -9
How often did you have 6 or more drinks? ☐ Less than monthly ☐ 2-4/month ☐ 2-3/week ☐ Daily or close to it
Is your alcohol consumption a concern to yourself or others? ☐ Yes ☐ No

Education: ☐ GED ☐ HS Diploma ☐ Associate/Prof. Certification ☐ Bachelors ☐ Masters ☐ Doctorate

Household: ☐ Single ☐ Married
☐ Divorced ☐ Other: _____
Adults: _____ # Children: _____
Religious? ☐ Yes _____ ☐ No

Employment: ☐ None ☐ Full-time
☐ Part-time ☐ Disabled ☐ SAHM
Occupation: _____
Employer: _____

Exercise Regularly: ☐ Y ☐ N
Frequency: _____ days/week
Duration: _____ min/day
Type: _____

Immunization and Health Screening History: *Date of most recent record of vaccine or health screen, and state if results were abnormal (Ab) or normal (N).*

Flu	_____	COVID-19	_____	Hep A	_____	Lipid panel: _____	☐ Ab	☐ N
HPV	_____	Pneumonia	_____	Hep B	_____	Colonoscopy: _____	☐ Ab	☐ N
MMR	_____	Tetanus	_____	Chx Pox	_____	Bone Density: _____	☐ Ab	☐ N

Gender Specific Health History: *Date of most recent exam/lab if applicable.*

Female

Age: 1st period? _____ Menopause? _____
#Live Births _____ #Miscarriage _____
#Abortions _____
LMP Date _____ / _____ / _____

Mammogram: _____ ☐ Ab ☐ N

Pap/Pelvic: _____ ☐ Ab ☐ N

Male

Prostate: _____

PSA: _____ ☐ Ab ☐ N

New Patient Registration

PATIENT INFORMATION

Name (Last, First, MI):_____ DOB:_____ Sex (M/F):_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Phone:_____ SSN#:_____

Marital Status (Circle One): Married Divorced Single Widow Ethnicity:_____

Race:_____ E-Mail:_____ Pharmacy:_____

How may we contact you with test results or follow up appointments? (Please Circle): Phone Mail Patient Portal

How did you hear about us (Circle): Radio TV Newspaper Friend Physician Referral Internet Other

Employer's Name:_____ Phone Number:_____

_____ _____ Zip:_____

In case of emergency contact:_____ Relationship:_____

_____ _____ _____ _____

Phone:_____ Phone:_____ _____

RESPONSIBLE PARTY (If other than patient)

Name (Last, First, MI):_____ DOB:_____ Sex (M/F):_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Phone:_____ SSN#:_____

Marital Status (Circle One): Married Divorced Single Widow Ethnicity:_____

Race:_____ E-Mail:_____ Relationship to Patient:_____

Employer's Name:_____ Phone Number:_____

_____ _____ _____ _____

INSURED'S INFORMATION

Primary Ins Co:_____ Secondary Ins Co:_____

Name (Last, First, MI):_____ DOB:_____ Sex (M/F):_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Phone:_____ SSN#:_____

E-Mail:_____ Employer's Name:_____

→ PLEASE SIGN THE LINE BELOW ←

_____ _____

Signature of Patient or Patient Representative

_____ _____

Date

Bowling Green Medical Group

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AUTHORIZATION OF TREATMENT/ ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/PRIVACY NOTICE

CONSENT FOR TREATMENT: By this document, I do hereby request and authorize Bowling Green Medical Group (BGMG), its medical practices and providers including physicians, technicians, nurses, and other qualified personnel to perform evaluation and treatment services and procedures as may be necessary in accordance with the judgment of the attending medical practitioner(s). I acknowledge that no guarantee can be made to anyone concerning the results of treatments, examinations or procedures.

PRIVACY NOTICE: I acknowledge receipt of the Health Information Privacy Notice for BGMG on or after 11/30/18.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I request that payment of authorized medical benefits is made on my behalf directly to the BGMG provider of service(s) furnished to me. I authorize BGMG to release any medical information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards. I authorize payment of service(s), otherwise payable to me under the terms of my private, group employer's or group health insurance plan, directly to BGMG, I hereby authorize that photocopies of this form and others to be valid as the original.

PAYMENT GUARANTEE: I do hereby guarantee payment of all fees and charges related to all services and durable goods provided to me through BGMG medical practices and providers from my first date of examination or treatment. I agree to make full payment immediately upon receipt of a BGMG billing statement whether it is an interim or final bill. In the event, that I fail to make full payment or fail to comply with other payment arrangements made with BGMG's approval, I understand that appropriate collection measures may be initiated and discharge from the practice could result.

ELECTRONIC HEALTH RECORD: Healthcare providers require access to patient medical information whenever or wherever a patient presents for care to assure safety, quality and to coordinate patient care across the provider network, avoiding duplication of services. BGMG has a system-wide electronic medical record that is available to caregivers on a "need to know" basis, to share information about patient care provided in the hospital, outpatient or physician office settings. Confidentiality of records including those reflecting treatment for behavioral health issues, HIV/AIDS or drug or alcohol problems is maintained per relevant government and regulatory standards. Patient care summaries are automatically sent to designated BGMG and other community primary care/family/referring physicians, as well as, to physicians who are consulted by the attending physician for coordination of care. BGMG and/or the attending physician can furnish and release to federal and state healthcare oversight agencies, or upon written request, to all insurance companies or their representatives any information with respect to treatment of the patient herein named including copies for the medical record.

ELECTRONIC PRESCRIBING: I understand that BGMG medical practices and office may use an electronic prescription system which allows prescriptions and related information to be electronically sent between BGMG providers and my pharmacy. I have been informed and understand the BGMG providers using the electronic prescribing system will be able to see information about my medications I am already taking, including those prescribed by other providers. I give my consent to my BGMG providers to see this health information.

IMMUNIZATIN REGISTRY: I understand that BGMG participates in the Missouri Department of Health's statewide immunization registry that collects vaccination history and information to serve the public health goal of preventing the spread of vaccine preventable diseases. The registry complies with federal health information privacy laws.

PERMISION TO FAX CHILDHOOD IMMUZATION RECORD TO SCHOOLS: I do hereby grant permission for BGMG to send or fax childhood immunization records to schools, upon request.

RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES: I have been made aware and understand that all BGMG medical practices and offices provide no facilities for safekeeping of valuables. I do hereby release BGMG from any responsibility due to loss or damage of any valuables that I, or anyone accompanying me, may bring to an BGMG medical practice, office or facility.

I, or my legal representative, certify that I have read this document, that is has been fully explained to me and that I understand its contents, and hereby agree to all terms and conditions set forth above and acknowledge the receipt of a copy if requested. By signing below, I acknowledge that I have received a copy of my patient rights.

Signature of Patient or Parent/Legal Guardian/Authorized Representative

Date of Signing

Bowling Green
Medical Group
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HIPAA Privacy and Release of Information Authorization

I, the undersigned patient or patient representative, hereby authorize the Bowling Green Medical Group (BGMG) and its affiliates, its employees and agents, o use and disclose protected health information (e.g. information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified herein may be subject to re-disclosure by such persons/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to BGMG. However, this authorization may not be revoked if its employees or agents have taken action on the authorization prior to receiving my written notice. I also understand that I have a right to a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of the practices: Privacy Practices, Release of Billing Information Policy, Assignment of Benefits Policy and grant the practice Medication History Authority.

If applicable, legal representatives, by signing this form I represent that I am the legal representative of the member identified below and will provide written proof (e.g. Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the members behalf with respect to the authorization form.

_____ _____

Date

_____

Patient, Parent or Legal Guardian Signature

I authorize the following person(s) to obtain my health information by verbal or written communication from BGMG. I understand that if I do not list anyone, no one but myself may be spoken to regarding my health.

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

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Appointment Cancellation/No-Show Policy

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 24 hours in advance.

Our providers and staff want to be available for your needs and for the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen.

Circumstances have caused us to enforce a policy of charging for no-show appointments, and those appointments not cancelled within 24 hours. As of June 10th, 2019, there will be a fee of $60.00 assessed if we do not receive a call to cancel an appointment. You will be given one (1) warning before fees are assessed. If you are more than 15 minutes late to an appointment, it will need to be rescheduled to a different date/time.

After a warning and four (4) missed visits you will be discharged from this clinic.

Thank you for being a valued patient and for your understanding and cooperation as we institute this policy. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

The Staff of Bowling Green Medical Group

_____ _____

Patient/Parent Guarding Signature Date

MEDICAL RECORDS REQUEST/AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

I authorize the use of disclosure of my health information as described below. I understand this authorization is voluntary. I understand if the organization authorized to receive the information is not a health plan or health care provider, the release of information may no longer be protected by federal privacy regulations.

Date of Request:_____

Name of Patient:_____ DOB:_____

I HEREBY AUTHORIZE BOWLING GREEN MEDICAL GROUP, LLC LOCATED AT:

905 Hwy 161, Bowling Green MO 63334 Phone: (573) 324-3333 Fax: (833) 996-3335 TO:

_____ Release To: _____ Obtain From:

_____

_____

(Provider, Hospital, Medical Clinic, etc)

Information to be released:

- Inpatient, Admit/Discharge Date(s)_____
- Outpatient/Emergency Date(s)_____
- Physician Clinic Date(s)_____
- Other_____

ATTN PROVIDERS:
PLEASE NO DISCS
THANK YOU!

Patient information is needed for:

____ Continuing Medical Care
____ Legal Use
____ School
____ Military
____ Insurance
____ Social Security/Disability

I understand the information to be released may include but is not limited to: History, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease including HIV and AIDS I understand that this authorization may be revoked by the person giving authorization by a written and dated notice, except to the extent that disclosure of information has been made prior to receipt of the revocation. **I understand that I may be charged for copies of my medical records.** I understand that if I refuse to disclose all or some healthcare information this may result in improper diagnosis or treatment, denial of coverage or claim for health benefits or other insurance, or other adverse consequences. I understand I may have a copy of this release form upon request.

_____

Signature of Patient or Patient's Representative Date

PLEASE SIGN THIS DOCUMENT ONLY, OUR OFFICE STAFF WILL COMPLETE THE REST
WE WILL KEEP ON FILE UP TO ONE YEAR FOR FURTURE MEDICAL RECORDS REQUESTS
(Hospitalization, ER, Urgent Care, etc.)