Healthonomic Primary Care

Maria Lentzou, M.D.
Leynard Martinez, M.D.
Moira McQuillan, M.D.
Ryan Kim, NP
Hannah Mehochko, NP
Tel 708-671-1500, Fax 708-671-1535

HIPAA Release of Information Authorization Form

I. Purpose of this form:

A federal law known as the Health Insurance Portability and Accountability Act (HIPAA) protects how your health information is used. HIPAA does not allow your health information to be used or released for certain purposes without your written permission. Health information protected under the law includes: medical and dental records, bills or other payment records for health care received, tissue samples, X-Rays, laboratory results and other health information that identifies you. State laws also protect how your health information may be used.

By signing this form, you are allowing your health care providers at Healthonomic Primary Care to release your health information for the uses described below and also described in the information consent. You will be given a signed copy of this authorization.

II. Healthcare Providers Covered by this Authorization:

This authorization permits the following healthcare providers to release your health information for health care:

NOTE: *Check* ***ALL*** *boxes that apply*

☐ Prescription Monitoring Program of Illinois
☐ All health care providers with health information about me
☐ Palos Community Hospital
☐ Advocate Christ Hospital and Medical Center
☐ Other: _____(please specify)

III. Agreement:

I have read (or someone has read to me) the information provided above. I have been given the opportunity to ask questions and all of my questions have been answered to my satisfaction. By signing below, I agree that my health information may be used as described in this form.

_____

Name of Patient **Signature** **Date Signed**

If individual is unable to sign this Authorization, please complete the information below

_____

Name of Legal Guardian / Personal Representative **Signature** **Legal Relationship** **Date Signed**

Healthonomic Primary Care Patient Registration Form

Today's Date: PCP

PATIENT INFORMATION			
Last Name:		First Name:	MI:
Date of Birth: / /	Gender: M / F	Marital Status: Single / Married / Divorced / Separated / Wid	
Ethnicity: Caucasian / African American / Hispanic / Asian / Other:			Preferred Language:
Street address:			Home Phone:
City:	State:	Zip:	Cell Phone:
E-mail address:		Social Security No.:	
How did you hear about us?		Occupation:	

IN CASE OF EMERGENCY	
Name:	Relationship
Address:	Cell Phone:

Pharmacy Information: Please list the local and mail order pharmacies where you get your prescriptions filled.

Pharmacy	Address, City, State	Phone Number	Fax Number

Please list the doctors and providers who are involved in your care

Name of doctor/provider	Reason for Care	Date last seen	Phone number

COMMUNICATION AUTHORIZATION

Please checkmark in which way we may contact you to discuss your healthcare concerns

□ Phone, may we leave detailed voicemail? Yes No □ Fax □ In person

□ Mail □ Patient portal messenger

Please indicate below the names and relationship of any individual the staff of Healthonomic Primary Care may discuss your healthcare issues with. This authorization includes information communicated via phone, mail, fax, or in person.

Name	Relationship	Phone Number

For patients with a guardian, please provide the guardian's name and authorization/relationship.

Name: Authorization/Relationship:

Please list medicines you+A1:G37 are taking. Include all prescriptions, non-prescription, and over-the-counter (OTC) medicines- including inhalers, vitamins, herbs, and supplements.			
Medicine Name	Strength	Dose	Who ordered this medicine?

Please list any allergies:

Medical/Family History: Please check the appropriate boxes

Disease	Self	Father	Mother	Brother/Sister	Children	Grandparents
Cancer	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐
Asthma/COPD	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Alzheimer's Dementia	☐	☐	☐	☐	☐	☐
Parkinson's	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐

Please specify:

Please list any surgeries or procedures, along with date

Preventative Health

Preventative Service	Date last received
Mammogram	
Pap test +/- HPV test	
Bone density scan	
Colonoscopy	
Prostate Cancer Screening	
Immunizations	
Flu	
Pneumococcal	

Review of Symptoms		
General	**Gastrointestinal**	**Women Only**
□ Unintentional weight gain/loss	□ Abdominal pain	□ Last menstrual cycle _____
□ Poor sleep	□ Rectal bleeding or blood in stools	□ Bleeding between periods
□ Fatigue	□ Change in bowel habits	□ Abnormal PAP smear
□ Headache	□ Constipation	□ Heavy menses
□ Depression/Anxiety	□ Diarrhea	**Men Only**
Cardiovascular	□ Nausea	□ Erectile Dysfunction
□ High blood Pressure	□ Heartburn	□ High PSA
□ Chest Pain	□ Vomiting	**Genitourinary**
□ Palpitations	**Neurologic**	□ Blood in urine
□ Syncope	□ Blackouts or loss of consciousness	□ Frequent or painful urination
Pulmonary/Lungs	□ Tingling/Numbness	□ Urine urgency
□ Shortness of breath	**Musculoskeletal**	□ Urine retention
□ Persistent Cough	□ Back pain	□ Nocturia
□ Coughing up blood	□ Neck pain	**Skin**
□ Wheezing	□ Joint pain: _____	□ Easy bruising
□ Trouble breathing		□ Change in moles
□ Snoring		

Other, please specify: _____

Please check appropriate boxes or fill in the blanks

In the past 2 weeks, how often have you been bothered by any of the following:	Not at all	Several days	More than half the days	Nearly every day
Little interest of pleasure in doing things?	□	□	□	□
Feeling down, depressed or hopeless?	□	□	□	□
Trouble falling or staying asleep, or sleeping too much?	□	□	□	□
Feeling tired or having little energy	□	□	□	□
Poor appetite or overeating	□	□	□	□
Feeling bad about yourself- or that you are a failure or have let your family down	□	□	□	□
Trouble concentrating on things, such as reading the newspaper or watching television	□	□	□	□
Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual.	□	□	□	□
Thoughts that you would be better off dead, or hurting yourself in some way?	□	□	□	□

TOBACCO					
Are you now or have you ever used tobacco?	Never		Former		Current
If current, for how many years and how many packs per day	Packs per day:		Number of years		
If current, are you thinking of quitting?	Yes, ready to quit		Thinking about quitting		Not ready to quit
If former, when did you quit?	Date:				
ALCOHOL					
Did you have a drink of alcohol in the past year?	Yes				No
If yes, how often did you have a drink containing alcohol in the past year	Monthly or less	2-4 times a month	2-3 times per week	4 or more times a week	
If yes, how many drinks did you have on a typical day when you were drinking in the past year?	1-2	3 - 4	5 - 6	7 - 9	10+
If yes, how often did you have 6 or more drinks on one occasion in the past year?	Never	Less than monthly	Weekly	Daily or almost daily	
History of drug use? Yes No	If yes, please specify: _____				
NUTRITION					
How well do you eat?	Healthy	Want to change habits	Not interested in changing habits	Unsure	
How many servings of fruits and vegetables do you eat	5 or more a day	3-4 times a day		Less than 2 a day	
How many times a week do you eat pastries or chips?	5 or more a week	3-4 times a week		Less than 2 times a week	
EXERCISE					
What type of exercise do you do regularly? Please circle all that apply	Biking Swimming Other:_____	Treadmill Running	Sports Walking	Pilates Yoga	
How many times a week and minutes per session of you exercise? Please circle	1-2 less than 30 minutes	3-4 30-60 minutes	5-6	Everyday More than 60 minutes	

HEALTH LITERACY

This is a 7-item word recognition test to provide clinicians with a valid quick assessment of patient health literacy. This is a requirement through our partnership with Advocate Medical Group. Please check off each word that you are familiar with.

- □ Osteoporosis
- □ Antibiotics
- □ Hypertension
- □ Cholesterol
- □ Jaundice
- □ Rectal
- □ Anemia

The above information is true to the best of my knowledge. I authorize insurance benefits be paid directly to the physician. I understand that I am financially responsible for my balance. I also authorize Healthonomic Primary Care or insurance company to release any information required to process my claims.

Patient/Guardian signature:_____ Date: _____