HEALTH HISTORY

(Confidential)

Name ______________________________ Today's Date ______________

Age __________ Birthdate ______________ Date of last physical examination ______________

What is your reason for visit? ______________________________

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms
- ☐ Hips
- ☐ Back
- ☐ Legs
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period __________

Date of last Pap Smear __________

Have you had a mammogram? __________

Are you pregnant? __________

Number of children? __________

CONDITIONS Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS List medications you are currently taking	ALLERGIES To medications or substances
Pharmacy Name __________ Phone __________	

(All Information is strictly confidential)

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) If, your blood relatives had any of the following:	Disease	Relationship to you
Father						Arthritis, Gout	
Mother						Asthma, Hay Fever	
Brothers						Cancer	
						Chemical Dependency	
						Diabetes	
						Heart Disease, Strokes	
Sisters						High Blood Pressure	
						Kidney Disease	
						Tuberculosis	
						Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates: ______________________________

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

HEALTH HABITS Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Other	

OCCUPATIONAL CONCERNS
Check (✓) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

____________________________ __________________
Signature Date

____________________________ __________________
Reviewed By Date

Lincoln Internal Medicine
801 Sterling Parkway, Suite 120
Lincoln CA 95648
Tel: (916) 408-3773
Fax: (916) 408-3853
www.lincolnmed.com

Acknowledgement of Receipt of Practice Privacy Policy and Authorization for Use or Disclosure of Protected Health Information

______ **Please initial here to acknowledge that you have received a copy of Lincoln Internal Medicine's Privacy Policy.**

I authorize my physician and/or administrative and clinical staff to disclose information regarding my care and treatment at Lincoln Internal Medicine to:

____

This authorization shall be in force and effect until I inform Lincoln Internal Medicine that I wish to revoke the authorization. I understand that I may revoke this authorization by writing to the Privacy Officer at 801 Sterling Parkway, Suite 120, Lincoln CA 95648. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

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.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except when health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

____
Signature of Patient or Personal Representative

____
Date

____
Print Name of Patient or Personal Representative

____
Description of Personal Representative's Authority

This form does not constitute legal advice and is for educational purposes only. This form is based on current federal law and subject to change based on changes in federal law or subsequent interpretative guidance. This form is based on federal law and must be modified to reflect state law where that state law is more stringent than the federal law or other state law exceptions apply.

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MEDICATION SHEET

Date ____________________

Patient Name ____________________________________ **Date of Birth** ______________

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: doctor prescribed medications, over-the-counter medications (examples: aspirin, antacids), and supplements (examples: vitamins, ginseng, fish oil).

MEDICATION	STRENGTH	HOW DO I TAKE IT?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		

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MEDICATION SHEET

12.		
13.		
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27.		

LINCOLN INTERNAL MEDICINE

801 STERLING PARKWAY, STE 120
LINCOLN CA 95648
Tel: (916) 408-3773
Fax: (916) 408-3853
www.lincolnimed.com

PATIENT INFORMATION

☐ Male ☐ Female — Doctor: ______________________

Patient's Name: ______________________ Home/Cell Phone: ______________________

Address: ______________________

City: ______________________ State/Zip: ______________________

Patient's Email Address: ______________________

SSN: ______________________ Date of Birth: __________ Age: ______

Marital Status: ☐ S ☐ M ☐ W ☐ Div ☐ Sep

Employer: ______________________ Work Phone: ______________________

Employer's Address: ______________________

Spouse's Name: ______________________ Date of Birth: __________ SSN: __________

Person to notify in case of emergency (note: person should not live at same residence):

Name: ______________________ Relationship: ______________________

Address: ______________________ Phone: ______________________

INSURANCE INFORMATION

Primary Insurance

Name of Insurance: ______________________
Insurance ID#: ______________________
Group #: ______________________

Secondary Insurance

Name of Insurance: ______________________
Insurance ID#: ______________________
Group #: ______________________

How did you hear about our practice? ______________________

Date: ______________________ Signed: ______________________

Printed Name: ______________________

Compassionate Care. Expert Service. Healthcare You Can Trust.

Please review Lincoln Internal Medicine office policies below. Initial each box, print and sign at the bottom.

☐ **Prescription refill:** It is our policy that you should be responsible to know when your medications must be refilled at least a week before you run out. Medications are refilled only at the patient visit or when requested in advance through your pharmacy. This includes all mail-order prescriptions. We cannot take weekend, walk-in, after hours, or phone call refill requests.

☐ **Information:** you agree to provide your correct name, current and correct address, cellular or other phone number, email address, insurance information, Social Security number, driver's license, or picture identification at the time of registration or as requested by the practice at any time.

☐ **Financial responsibility/ Insurance copayments/ deductibles/ coinsurance:** by these initials and your signature below, you accept financial responsibility for all charges for services rendered to you. Insurance companies do not pay all fees and may exclude certain services from coverage. It is your responsibility to understand your insurance plan. All copayments, deductibles, coinsurance, or noncovered services are to be paid in a timely fashion according to office policies. If requested, and as a condition of service, you agree to sign an "advanced beneficiary notice" if we determine or question your insurance coverage.

☐ **Payment methods:** we accept cash, check, and several major credit cards: VISA, Master Card, American Express, and Discover.

☐ **Appointments:** We require a minimum of 24 hours (or the Friday before a Monday appointment) notice of cancellation as a courtesy to other patients seeking services. A pattern of non-cancelled missed appointments may result in discharge from the practice.

☐ **Patient Discharge:** The practice reserves the right to discharge a patient for any reason. Please note that discharges may occur for failure to meet your obligations under this document. In addition, because of care quality considerations, the practice may discharge you for failure to comply with treatment plan(s) as outlined by your provider.

I have read and understand all the terms of this policy and by my initials and my signature below, I attest that I fully understand each item and agree to the terms above.

Signature____ **Date** ____________________________

Printed Name____

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PATIENT RIGHTS

Lincoln Internal Medicine has adopted the following written policies concerning the rights and responsibilities of all patients.

PATIENTS HAVE THE RIGHT:

1. To considerate and respectful care; cultural, psychosocial, spiritual, personal values and beliefs will be respected. Patients with vision, speech, hearing, language and cognitive impairments have the right to effective communication.
2. To every consideration of his/her privacy concerning his/her medical care. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. The patient has the right to expect that all communications and records pertaining to his/her care will be treated as confidential. Those not directly involved in his/her care must have permission of the patient to be present. Disclosure of records is treated confidentially and except when required by law, patients are given the opportunity to approve or refuse their release.
3. To receive, to the degree known, complete information concerning their diagnosis, evaluation, treatment and prognosis.
4. To participate in discussions involving their health care.
5. To be informed of patient rights, Lincoln Internal Medicine's expectation of patient conduct and responsibilities, services available, provisions for after hours care, fees and payments policies.
6. To express suggestions to Lincoln Internal Medicine, to voice complaints, and have those complaints impartially investigated with a response in no more than seven business days. Complaints should be directed to the Office Manager.

PATIENT RESPONSIBILITIES

1. Bring your insurance card to each visit – notify receptionist if there are changes to home address, phone number or insurance.
2. All co-payments, deductibles and other patient portion due for non-covered benefits will be collected at the time of service.
3. We require at least 24 hours notice for an appointment cancellation.
   a. A patient may be discharged from the practice if proper notice is not given for cancellation of an appointment.
4. All visits (Coumadin Clinic, BP check, injections) to Lincoln Internal Medicine require an appointment.
5. Be respectful of other patients' privacy while checking in.
6. To refill a prescription that was prescribed to you by Lincoln Internal Medicine, please call your pharmacy. They will in turn call/fax our office to complete the refill process.
   a. Please allow 2-3 business days for prescription refills.
   b. If you need a refill on a prescription that was issued by another physician, an appointment may be necessary.
7. All referrals, once issued to you by our doctor, take 2-3 days business days to process.
   a. Authorizations for services may take an additional 3 business days to process.
8. Please allow 5 business days for results to be received and interpreted by your physician.
9. You may obtain a copy of your medical record upon written request.
   a. The charge for reproducing your medical record is .25 per page, clerical fees and postage.
10. There is a fee of $20 to the patient for completion of disability, DMV, EDD, etc. forms. This must be paid prior to the form being filled out.

________________________________ ________________________
Patient Signature Date

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Privacy Policy

Our practice policy is that all physicians and staff preserve the integrity and the confidentiality of the protected health information (PHI) of our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and protected health information to provide the highest quality medical care possible while protecting the protected health information and confidentiality of our patients.

Our practice and its physicians and staff will not use or disclose PHI for uses outside of treatment, payment or healthcare operations (TPO) without an authorization from the patient.

Our practice will use and disclose PHI to remind patients of their appointments within the minimum necessary standard.

We recognize that patients have a right to privacy. Our practice, and its physicians and staff respect the dignity of the patient at all times and treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.

Although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believes his/her information is inaccurate or incomplete.

We may permit access to medical records with a written request. The request must be approved by our practice. If we deny the request, then we must inform the patient that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the appeal.

We will provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.

Our practice will maintain a list of all disclosures of PHI for purposes other than TPO for each patient. We will provide this list to patients upon request, so long as their requests are in writing.

Our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.

All physicians and staff will adhere to this policy. Violations of this policy will not be tolerated by our practice and is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions.

We may change this privacy policy at any time. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.

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