UL Physicians

PATIENT INFORMATION

Today's Date: _____

Patient Name: _____
Last First Middle Maiden

DOB: _____ Social Security #: _____ Gender: ❒ Male ❒ Female

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

Primary Phone: _____ Work Phone: _____ Additional #: _____

Email Address: _____

Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated	**Employment:** ❒ Full Time ❒ Part Time ❒ Not employed ❒ Disabled ❒ Military Duty ❒ Retired	**Student:** ❒ Full Time ❒ Part Time ❒ Not a Student
Race: ❒ American Indian/ Alaskan Native ❒ Asian ❒ Black/African American ❒ Native Hawaiian ❒ More than one race ❒ Other Pacific Islander ❒ White ❒ Decline to Report	**Ethnicity:** ❒ Hispanic/Latino ❒ Non-Hispanic/ Non-Latino ❒ Decline to Report	**Primary Language:** ❒ English ❒ Spanish ❒ Chinese ❒ Russian Other: _____ **Do you need an interpreter?** ❒ Yes ❒ No

Emergency Contact Information

Name: _____ DOB: _____ Gender: ❒ Male ❒ Female
Last First Middle

Relationship to Patient: ❒ Father ❒ Mother ❒ Guardian ❒ Sibling ❒ Child ❒ Other

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

Primary Phone: _____ Work Phone: _____ Additional #: _____

OVER ⟶

UL Physicians

PATIENT INFORMATION

Insurance Information

Primary Insurance: _____ Policy/Member ID#: _____ Policy Group#: _____

Policyholder's Name: _____ Gender: ❒ Male ❒ Female
(As it appears on the card)

Policyholder's SSN: _____ Policyholder's DOB: _____

Provider listed on Card: _____ Primary Care Provider: _____

Patients Relationship to Subscriber: ❒ Self ❒ Spouse ❒ Child ❒ Other

Secondary Insurance: _____ Policy/Member ID#: _____ Policy Group#: _____

Policyholder's Name: _____ Gender: ❒ Male ❒ Female
(As it appears on the card)

Policyholder's SSN: _____ Policyholder's DOB: _____

Provider listed on Card: _____ Primary Care Provider: _____

Patients Relationship to Subscriber: ❒ Self ❒ Spouse ❒ Child ❒ Other

Responsible Party Information (complete if other than patient)

Name: _____ DOB: _____ Gender: ❒ Male ❒ Female
Last First Middle

Relationship to Patient: ❒ Father ❒ Mother ❒ Guardian ❒ Sibling ❒ Child ❒ Other

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

Primary Phone: _____ Work Phone: _____ Additional #: _____

I authorize the release of any medical or other information necessary to process his claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

Signature: _____ Date: _____
Patient / Legal Guardian

What Pharmacy do you use? _____

Pharmacy Location: _____

Do not write, stamp, punch holes or affix a sticker in this area.
To reproduce, follow the printing instructions. Do not fold this form.

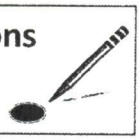
Direction of Feed

Patient History

Please answer every question

STAFF: *Responses in boxed bubbles and handwritten items must be entered* ***MANUALLY***.

Marking Instructions



PLEASE PRINT PATIENT'S LAST NAME

PATIENT'S FIRST NAME | MIDDLE INITIAL | PATIENT'S DATE OF BIRTH (Month / Day / Year)

SOCIAL HISTORY

TOBACCO USE

What is your smoking status? — current (every day) ◯ previous ◯ current (some days) ◯ never ◯

If you answer "never", skip ahead to "Does anyone in your household smoke?"

How many packs per day do you (or did you) smoke? — less than 1 ◯ 1-2 ◯ more than 2 ◯

How many years have you (or did you) smoke? — less than 5 ◯ 5 ◯ 10 ◯ 15 ◯ 20 ◯ 25 ◯ 30 ◯ 35 ◯ 40+ ◯

Does anyone in your household smoke? — yes ◯ no ◯

Do you use other tobacco products? — currently ◯ in the past ◯ never ◯

ALCOHOL USE

Do you consume alcohol? — currently ◯ in the past ◯ never ◯

Average number of drinks per week (now or in the past)? — 7 or less ◯ 8-14 ◯ 15+ ◯

OTHER

IV drug use or other recreational drug use? — currently ◯ in the past ◯ never ◯

Have you ever had a blood transfusion? — yes ◯ no ◯

How often do you exercise? (times per week) — occasionally ◯ 1-2 ◯ 5-6 ◯ 0 ◯ 3-4 ◯ 7 ◯

Do you always wear a seat belt? — yes ◯ no ◯

SURGICAL HISTORY

Please mark all surgeries you have had:

- ◯ **I HAVE HAD NO SURGERIES**
- ◯ Appendectomy
- ◯ Breast Augmentation
- ◯ Breast Lumpectomy
- ◯ Breast Reduction
- ◯ Carotid Artery
- ◯ Cataract
- ◯ Foot
- ◯ Gallbladder
- ◯ Heart Bypass
- ◯ Hysterectomy (due to cancer)
- ◯ Hysterectomy (not due to cancer)
- ◯ Inguinal Hernia
- ◯ Kidney Removal
- ◯ Knee
- ◯ Low Back Disc
- ◯ Lung
- ◯ Mastectomy
- ◯ Neck Disc
- ◯ Ovary Removal
- ◯ Pacemaker
- ◯ Prostate
- ◯ Shoulder
- ◯ Sinus
- ◯ Thyroid Removal
- ◯ Tonsillectomy
- ◯ Total Hip Replacement
- ◯ Total Knee Replacement
- ◯ Tubal Ligation
- ◯ Vasectomy
- ◯ Weight Loss

Cesarean Section — 1 ◯ 2 ◯ 3 or more ◯

Heart Valve Replacement — mitral ◯ aortic ◯ tricuspid ◯ unknown valve ◯

◯ Other Surgery (please specify): _____

OVER ⟶

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Direction of Feed

Patient History

Please answer every question

STAFF: *Responses in boxed bubbles and handwritten items must be entered* ***MANUALLY***.

YOUR MEDICAL HISTORY

Please indicate if YOU have a history of the following:

◯ **I HAVE NO SIGNIFICANT MEDICAL HISTORY**

PAST	CURRENT		PAST	CURRENT	
◯	◯	Alcohol Abuse	◯	◯	High Blood Pressure
◯	◯	Allergies / Sinus	◯	◯	High Cholesterol
◯	◯	Alzheimers	◯	◯	HIV / AIDS
◯	◯	Anemia	◯	◯	Hypothyroid (Low Thyroid)
◯	◯	Anxiety	◯	◯	Irritable Bowel Syndrome (IBS)
◯	◯	Arthritis	◯	◯	Kidney Stones
◯	◯	Asthma	◯	◯	Liver Cancer
◯	◯	Birth Defects	◯	◯	Lung Cancer
◯	◯	Bleeding Disease	◯	◯	Lupus
◯	◯	Blood Clots	◯	◯	Migraines
◯	◯	Breast Cancer	◯	◯	Multiple Sclerosis
◯	◯	Bipolar Disorder	◯	◯	Osteoporosis
◯	◯	Cataracts	◯	◯	Parkinson's Disease
◯	◯	Colon Cancer	◯	◯	Prostate Cancer
◯	◯	Congestive Heart Failure	◯	◯	Prostate Problems
◯	◯	COPD / Emphysema	◯	◯	Reflux / GERD
◯	◯	Coronary Artery Disease	◯	◯	Rheumatic Fever
◯	◯	Crohn's Disease	◯	◯	Rheumatoid Arthritis
◯	◯	Depression	◯	◯	Seizures / Convulsions
◯	◯	Diabetes Type 1	◯	◯	Sexually Transmitted Disease
◯	◯	Diabetes Type 2 (adult onset)	◯	◯	Sleep Apnea
◯	◯	Gout	◯	◯	Stomach Ulcer
◯	◯	Heart Attack	◯	◯	Stroke / CVA of the Brain
◯	◯	Hepatitis B	◯	◯	Suicide Attempt
◯	◯	Hepatitis C	◯	◯	Tuberculosis (TB)

◯ Other Disease, Cancer or Significant Medical Illness (please specify):

_____

FAMILY MEDICAL HISTORY

◯ **ADOPTED**

◯ **FAMILY HISTORY UNKNOWN**

◯ **NO SIGNIFICANT FAMILY MEDICAL HISTORY**

◯ **Mother**, **Grandmother**, or **Sister** developed Heart Disease before the age of **65**.

◯ **Father**, **Grandfather**, or **Brother** developed Heart Disease before the age of **55**.

Please indicate which family member(s) have had these illnesses:

	Father	Mother	Grandmother (Mother's side)	Grandfather (Mother's side)	Grandmother (Father's side)	Grandfather (Father's side)	Brother	Sister
Alcohol Abuse	◯	◯	◯	◯	◯	◯	◯	◯
Anemia	◯	◯	◯	◯	◯	◯	◯	◯
Arthritis	◯	◯	◯	◯	◯	◯	◯	◯
Asthma	◯	◯	◯	◯	◯	◯	◯	◯
Bipolar Disorder	◯	◯	◯	◯	◯	◯	◯	◯
Bleeding Disease	◯	◯	◯	◯	◯	◯	◯	◯
Breast Cancer	◯	◯	◯	◯	◯	◯	◯	◯
Colon Cancer	◯	◯	◯	◯	◯	◯	◯	◯
COPD / Emphysema	◯	◯	◯	◯	◯	◯	◯	◯
Depression	◯	◯	◯	◯	◯	◯	◯	◯
Diabetes Type 1	◯	◯	◯	◯	◯	◯	◯	◯
Diabetes Type 2 (adult onset)	◯	◯	◯	◯	◯	◯	◯	◯
High Blood Pressure	◯	◯	◯	◯	◯	◯	◯	◯
High Cholesterol	◯	◯	◯	◯	◯	◯	◯	◯
Osteoporosis	◯	◯	◯	◯	◯	◯	◯	◯
Seizures / Convulsions	◯	◯	◯	◯	◯	◯	◯	◯
Stroke / CVA of the Brain	◯	◯	◯	◯	◯	◯	◯	◯
Lung Cancer	◯	◯	◯	◯	◯	◯	◯	◯

◯ Other Family Medical History (specify illness & family member):

_____

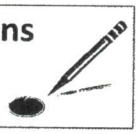
Specialty: General Surgery
Visit Types: New pt visit
Est pt visit

General Surgery Review of Systems

Please answer every question

Compatible Note Forms:
CHI Adult Female ROS – Gen Surg
CHI Adult Male ROS – Gen Surg

Marking Instructions



PLEASE PRINT PATIENT'S LAST NAME

PATIENT'S FIRST NAME | MIDDLE INITIAL | PATIENT'S DATE OF BIRTH (Month / Day / Year)

Please mark all symptoms you are CURRENTLY experiencing.

Mark all that apply. If you have no symptoms in a category, please mark "NONE."

CONSTITUTIONAL	fever ◯ difficulty sleeping ◯ fatigue ◯	chills ◯ weight loss ◯ weight gain ◯	**NONE** ◯
EYES		vision problems ◯	**NONE** ◯

please fold on dotted line

EAR / NOSE / THROAT	sinus problems ◯	loss of hearing ◯	**NONE** ◯
CARDIOVASCULAR	chest pain ◯ blood clots ◯ ankle swelling ◯	anemia ◯ phlebitis ◯ bleeding problems ◯	**NONE** ◯
RESPIRATORY	shortness of breath ◯	cough ◯ asthma ◯	**NONE** ◯
GASTROINTESTINAL	change in bowel habits ◯ nausea ◯ vomiting ◯ blood in stool ◯ hemorrhoids ◯	peptic ulcer ◯ difficulty or discomfort in swallowing ◯ constipation ◯ colitis ◯ hiatal hernia ◯ diarrhea ◯	**NONE** ◯
GENITOURINARY		painful urination ◯	**NONE** ◯
NEUROLOGICAL	headache ◯	seizures ◯	**NONE** ◯

please fold on dotted line

MUSCULOSKELETAL	joint pain ◯	back pain ◯ arthritis ◯	**NONE** ◯
PSYCHIATRIC	anxiety ◯	depression ◯ chemical dependency ◯	**NONE** ◯

OVER →

For technical support,
please contact PatientLink at
Support@MyPatientLink.com.

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GENERAL CONSENT FORM

PATIENT NAME: Date of Birth:

Payment. I authorize University of Louisville Physicians, Inc. (UofL Physicians) to submit claims on my behalf directly to Medicare/Medicaid/my private health insurance carrier. This means that UofL Physicians will direct payment for supplies and services provided. Lab work and diagnostics are performed by a third-party vendor and they will bill separately for these services. I understand that I am financially responsible to the provider(s) for the charges not paid or payable. I authorize you to release any information necessary to insurance carriers regarding illnesses and treatment to process claims.

Consent for Treatment. I consent for UofL Physicians to administer treatments, tests and/or diagnostic tests to treat my/the patient's injury/illness on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment I/the patient receives. In compliance with state law, as part of the care to be given a test may be performed for human immunodeficiency virus infection (HIV/AIDS), hepatitis, or other blood-borne infectious or communicable diseases if the doctor, APRN, or Physician Assistant orders the test for diagnostic purposes because of my/the patient's medical history, symptoms, or conditions.

Electronic Prescription. I understand UofL Physicians utilizes electronic prescribing technology and participates with SureScripts. SureScripts operates the Pharmacy Health Information Exchange, which facilitates the electronic transmission of prescription information between providers and pharmacists. SureScripts also provides prescription data on any medications, known as medication history, which are prescribed to me/the patient.

Cell Phone Calls/Text and Emails. As a service to our patients, we provide a courtesy appointment reminder calls/text and possibly other important calls that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number. By providing your email address you acknowledge that you may receive health care surveys and other health care related communications. You understand this is not to be used for provider communication and that email is not secure and can be intercepted and used by unauthorized persons.

Involvement of Others in Care. I authorize UofL Physicians to provide and discuss my/the patient's care and medical needs with the following persons:

Name	Date of Birth	Relationship	Phone

Patient Rights and Responsibilities

I acknowledge receipt of the Patient Rights and Responsibilities Accept ☐ Declined ☐

Notice of Privacy Practices

I acknowledge receipt of the Notice of Privacy Practices Accept ☐ Declined ☐

Minor Patient Photograph

I consent for UofL Physicians to photograph the patient for identification purposes only ☐ Declined ☐

I certify that I have read and understand the terms of this consent as noted above.

If Parent/Legal Guardian/Legal Authorized Representative, Print Name

Signature

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KASPER CONSENT AND AUTHORIZATION
FOR TREATMENT WITH CONTROLLED SUBSTANCES/STIMULANTS

I/the patient understand and acknowledge that, to the extent medically necessary, I/the patient may be prescribed a controlled substance, which may/may not contain Hydrocodone, while receiving medical care and treatment in order to manage complaints of pain or other medical conditions. I have been fully informed of the risks, alternatives and possible consequences involved in the use of controlled substances.

I understand that this agreement is contingent on compliance with ALL of the following patient and physician terms:

1. I understand that as required by KRS 218A a KASPER report must be obtained and reviewed by the provider(s) prior to dispensing all Schedule II drugs or Schedule III drugs with hydrocodone and every 90 days thereafter. KASPER tracks all controlled prescriptions written in the State of Kentucky.

2. I understand that I agree to receive stimulant medication prescriptions ONLY from the provider(s) in our practice.

3. I understand that a scheduled appointment may be required with the provider(s) prior to receiving any refills.

4. I understand this practice will not fill controlled substances or stimulants after hours, on holidays or weekends by the on-call provider.

5. I understand that my prescribing provider and/or staff may communicate and collaborate with any other health care provider(s) currently involved in my care, as well as, those previously involved in my care.

6. I understand that I must notify the provider(s) about any medication side effects I may experience.

7. I understand that if a serious side effect issue including withdrawal occurs after hours, on a holiday, or during the weekend, that I should immediately seek emergency assistance from the nearest emergency room.

8. I understand that I must take the medication as prescribed and I CANNOT change dosage amounts or alter the time schedule of the prescribed medication without being directed to do so by my provider(s).

9. I understand that these medication(s) must be kept in a safe place at all times and that I am responsible for the security of my medications. It has been thoroughly explained to me that the policy does not allow for replacement of misplaced, spilled, inaccessible, or lost medication(s) or prescription(s).

10. I understand that if my medication(s) or prescription(s) is/are stolen that I must deliver a police report to my provider(s) and the provider(s) will contact the police department for verification. A second event such as above may lead to termination of this contract.

11. I understand that if it appears to my prescribing provider(s) there are no demonstrable benefits to my daily function, academic performance, or quality of life from the medication(s), alternative medications, discontinuing or taper me off all stimulant medication(s) may be prescribed.

12. I will not hold my physician liable for problems caused by the discontinuation of medication(s).

13. I understand that I must submit to urine and/or blood tests to confirm the presence of the prescribed medications and to detect the use of non-prescribed medications or drugs at any time and without prior warning. If I test positive for non-prescribed medications or illegal substance(s), such as marijuana, speed, cocaine, etc. my treatment for chronic pain may be terminated. Failure to submit to drug testing will terminate this agreement.

14. I agree to actively participate in all aspects of the treatment plan recommended by my provider(s) to achieve increased function and improved quality of life. Failure to participate in all aspects of the treatment plan will result in termination of this agreement.

15. I understand that I must inform any provider(s) who may treat me for any other medical problem(s) that I am enrolled in a treatment program and that failing to do so is medically dangerous.

16. I agree that I am to fill all of my prescriptions at a pharmacy located within my state of residency.

17. I agree to notify this office with the name of the prescribing provider(s) or facility and the pharmacy filling any stimulants or controlled substances which are prescribed in the event of an emergency.

18. I agree to not share, sell or exchange my medication with anyone else.

19. I understand that each prescription is for a specific number of pills designated to last a certain amount of time and will not be filled early.

20. I understand that this office may contact police or other governmental agencies as deemed necessary.

21. I understand that my provider(s) or designee may contact other pharmacies in the management of my condition

22. I understand that the prescribing provider(s) can stop treatment with if I am determined to be giving away, selling or misusing the medication, failing to keep scheduled appointments or attempting to obtain controlled medications after hours, early refills, from other providers, facilities or any other sources

23. I understand that I must adhere to the advice of the prescribing provider(s) regarding the operation of motor vehicles while using controlled medications

24. I understand that any alteration of controlled substances prescriptions will be reported to the police for prosecution and that I will be discharged from the practice.

I certify that:

1. I am not currently using illegal drugs or abusing prescription medication(s) and I am not undergoing treatment for substance dependence (addiction) or abuse.

2. I have read and entered into this Agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.

3. I have never been involved in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc...)

4. I understand there is no guarantee or assurance that has been made as to the results that may be obtained when utilizing these medications for my condition.

5. I have reviewed the side effects of the medication(s) that may be used in the treatment of my condition. I fully understand the explanations regarding the benefits and the risks of this medication(s) and I agree to the use of these medication(s) in the treatment of my condition.

6. I am not pregnant and that I will notify this office should I become or intend to become pregnant.

7. I understand the potential benefits and the possible side effects/risks involved in using these medications.
   Acknowledgement

I have read the conditions and terms stated above and have had all of my questions regarding these conditions and terms explained to my satisfaction. I have met the conditions and agree to honor all of the terms of this agreement. I also understand that if I violate any of the terms of this agreement, it is cause for the provider(s) to refuse further prescriptions or treatment. I have been provided a copy of this contract.

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Patient/Parent/Legal Guardian Signature

If Parent/Legal Guardian, Print Name

COMP-02
Revised July 9, 2013