# PATIENT INFORMATION

NAME _____ DATE _____

ADDRESS _____ SOC. SEC. # _____

CITY _____ STATE ____ ZIP _____ HOME PHONE _____

E-MAIL ADDRESS:_____ CELL PHONE _____

AGE ___ BIRTHDATE _____ SEX ___ MARRIED __ SINGLE __ WIDOWED __ DIVORCED ___

REFERRED BY _____ ADDRESS _____

HAVE YOU BEEN SEEN BY DR. BAKER BEFORE? _____ WHEN? _____

SPOUSE OR NEXT OF KIN: (EMERGENCY CONTACT)

NAME _____ TELEPHONE _____

ADDRESS _____ RELATIONSHIP _____

YOUR EMPLOYER:

NAME _____ TELEPHONE _____

ADDRESS _____ OCCUPATION _____

SPOUSE'S EMPLOYER:

NAME _____ TELEPHONE _____

ADDRESS _____ OCCUPATION _____

REASON FOR APPOINTMENT _____

PATIENT SIGNATURE _____

## CONSENT TO TAKING OF PHOTOGRAPHS

I understand that during my initial appointment, in connection with the medical services which I am receiving from James L. Baker, Jr., M.D., P.A., I consent that photographs may be taken of my body under the following conditions: (1) The photographs shall be taken by my physician or a competent photographer approved by my physician. (2) The photographs shall be used for medical records only, unless in the judgment of my physician, medical education or science will be benefited by their use. In that event, I agree that they may be used for such professional medical purposes.

_____
(Patient Signature)

_____ _____
(Witness Signature) (Parent or Legal Guardian Signature)

**FOR THE COMFORT, SAFETY AND RELAXATION OF ALL PATIENTS, WE REQUEST THAT ONLY CHILDREN AGE 12 AND OLDER ATTEND YOUR APPOINTMENT.**

**THANK YOU FOR YOUR CONSIDERATION AND UNDERSTANDING.**

**PATIENT MEDICAL HISTORY** ***(PLEASE PRINT)***

1. Please list any operations you have had and the dates: _____

_____

_____

_____

2. Please list any major illnesses you have had in your life and the dates:

_____

3. Your height: _____ Weight: _____ Age: _____ Number of Pregnancies: _____ Number of Children: ____

4. How many drinks do you have in an average week? _____

5. What is the name & phone number of your family physician? _____

6. What is the name & phone number of your pharmacy? _____

7. LIST **ANY** MEDICATIONS, PILLS OR INJECTIONS YOU TAKE WITH THE DOSAGE (Aspirin, Birth Control, Blood Pressure, Herbal Supplements, etc.): _____

_____

8. ARE YOU **ALLERGIC** TO ANY MEDICATIONS? IF SO, WHAT? _____

_____

9. PLEASE MARK (**X**) YES OR NO TO THE FOLLOWING QUESTIONS AND ANSWER WHERE APPLICABLE:

| YES | NO | | |
|---|---|---|---|
| ___ | ___ | 8. | Have you ever had any problems with a general anesthetic? What? _____ |
| ___ | ___ | 9. | Have you ever had any problems with a spinal anesthetic? What? _____ |
| ___ | ___ | 10. | Have any relatives had problems with anesthetics? (High fever, etc.) What? _____ |
| ___ | ___ | 11. | Have you ever had high or low blood pressure? (**Circle** which one) |
| ___ | ___ | 12. | Have you ever had trouble with your heart? What? _____ |
| ___ | ___ | 13. | Have you ever had a heart attack? When? _____ Stroke? When? _____ |
| ___ | ___ | 14. | Have you ever had angina chest pains? If so, when & how often? _____ |
| ___ | ___ | 15. | Do your feet or ankles swell? |
| ___ | ___ | 16. | Do you have any problems with your breathing or lungs (**Circle** all that apply): Asthma Wheezing Emphysema COPD Excessive Cough |
| ___ | ___ | 17. | Do you smoke? If so, how much _____ for how long _____? |
| ___ | ___ | 18. | Do you have any: loose teeth, false teeth, dentures, caps or bridges? (**Circle** all that apply) |
| ___ | ___ | 19. | Do you wear contact lenses? (If so, please remove before surgery) |
| ___ | ___ | 20. | Do you have **any** body piercings? (If so, they **MUST** be removed before surgery) |
| ___ | ___ | 21. | Have you ever had any problems with your kidneys or liver? What? _____ |
| ___ | ___ | 22. | Have you ever had yellow jaundice or Hepatitis A, B or C ? (**Circle** all that apply) |
| ___ | ___ | 23. | Do you have (**circle** all that apply): diabetes, arthritis, hiatal hernia, frequent heartburn, epilepsy, seizures, fainting spells? |
| ___ | ___ | 24. | Have you ever had problems with excessive bleeding or frequent black and blue marks with minimal trauma? |
| ___ | ___ | 25. | Have you been on any blood thinning medications, such as Aspirin, Ibuprofen, Coumadin, Heparin, Plavix or Lovenox in the past 12 months? (**Circle** all that apply) |
| ___ | ___ | 26. | Do you or anyone in your family have Multiple Sclerosis? Who? _____ |
| ___ | ___ | 27. | Do you take any medications, injections or pills for: Blood Pressure, Heart, Lungs, Diabetes, or Kidneys (**Circle** all that apply) |
| ___ | ___ | 28. | Have you taken Prednisone, Steroids or ACTH in the past six months? (If yes, **circle**) |
| ___ | ___ | 29. | Have you or anyone in your family had a cold or flu in the last two weeks? (If yes, **circle**) |

What are your expectations from the surgery you desire? _____

_____

Do you have any questions for the surgeon or anesthesiologist? _____

_____

**Name (PRINT)**_____ **DOB** _____ **Date** _____

**AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPTIONS**

I hereby authorize the release or use of my protected health information ("PHI") and medical record information by James L. Baker, Jr., M.D. ("the Practice") in order to carry out treatment, payment or health care options. These disclosures may be done by mail, phone, fax or electronic transmission.

When allowing a third party (other than Dr. Baker or his staff) to be in the exam room with you while one of them is examining you or discussing your care/treatment/or medical condition, by signing this Consent form **you are consenting** to the disclosure of your PHI (protected health information) to that third party.

You retain the right to request that we further restrict how your PHI (protected health information) is released or used to carry out treatment, payment or health care options. Our practice is not required to agree to such requested restrictions. However, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

**I acknowledge and agree that the Practice may disclose my PHI (protected health information) and medical record information to the following individuals: (please initial line and write {print} in name of individual)**

_____ Spouse_____ _____ Parent_____

_____ Child_____ _____ Legal Guardian_____

_____ Other_____ _____ Other_____

I agree that the Practice may also disclose the following types of information contained in my medical record **(please initial the appropriate categories listed below):**

_____ HIV/AIDS Information ____ Sexually Transmitted Disease Information _____ Substance Abuse Information

_____ Mental Health Information _____ Pregnancy Information (if Patient is under the age of eighteen "18")

I agree and consent to the Practice releasing information to me in the following alternative manners **(please initial the appropriate spaces below):**

_____ Via regular mail (address): _____

_____ Via home answering machine, which is: _____

_____ Via my cellular telephone, which is: _____

_____ Via my e-mail address, which is: _____

_____ Via work voice mail, which is: _____

_____ Via fax to my designated fax, which is: _____

At all times, you retain the right to revoke this consent. Such revocation must be submitted to the Practice **in writing**. The revocation shall be effective except to the extent that the Practice has already taken action based on your prior Consent.

**The Practice may refuse to treat you if you (or an authorized representative) do not sign this Consent Form.** If you (or authorized representative) sign this Consent and then revoke it, the Practice has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

**I have read and understand the information in this consent. I am the patient or the authorized party to act on behalf of the patient to sign this document verifying consent to the above terms.**

***By signing below, I acknowledge and agree to the above conditions.***

_____ _____ _____

Signature of Patient or Authorized Representative Date Time

If Representative, explain relationship to patient: _____