



MEDICATION

LIST ALLERGIES

* Height, _____ Weight _____ Shoe Size, _____

*Have you Had heart grafts, or joint replacements Yes/ No

Other medical information I need to know _____

HEALTH HISTORY Insulin diabetic: __ (A1C __) Rheumatoid Arthritis__ Osteoarthritis __
Hypertension__ Anemia __ location/on chemo/remission Cardiac disease __ Liver
disease __ Gout__ Neuropathy _____ Phlebitis Fainting history _____

Any Personal concerns or fears i.e. shots or sedation _____

SURGERIES/HOSPITALIZATIONS AUTHORIZATION FOR RELEASE OF INFORMATION I hereby authorize Dr. Bembynista to use or disclose my personal health information as described below. I understand that, if the organization authorized to receive my PHI is not a health plan or health care provider. The released PHI may no longer be protected by federal privacy regulation. Our Notice of Privacy Practices provides detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practice. It is available on request.

PATIENT AUTHORIZES COMMUNICATION WITH FAMILY/FRIENDS REGARDING YOUR CARE AND TEST RESULTS. NAME _____ PH _____ REL. _____

PATIENT AUTHORIZES COMMUNICATION WITH FAMILY/FRIENDS REGARDING YOUR ACCOUNTING & BILLING NAME _____ PH _____ REL _____

Appointment reminder OPT IN _____ OPT OUT _____

PATIENT AUTHORIZES COMMUNICATION WITH PRIMARY CARE PHYSICIAN OR OTHER PHYSICIAN NAME _____

. *Signature _____ (Patient/Guardian) Date. _____

