



| OFFICE USE ONLY | | |
|-----------------|-----------|--------|
| Date | Account # | Doctor |

| PATIENT INFORMATION | | | | | | | |
|---|------------------------|------|--|------------------|---------------|---|--------|
| First Name (Legal) | Middle Initial | Last | Previous Name | Age | Date of Birth | Sex | Mar St |
| Address: Street | | | Apt. # | Patient Employer | | | |
| City | State | Zip | Patient's Cell Phone | | | | |
| Phone Number | Social Security Number | | Employer Address | | | | |
| This phone # will be used for appt. reminders | | | Employer City/State/Zip | | | | |
| In Case of Emergency (Friend or Relative who does not live with you) Name and Relationship | | | Employer Phone | | | | |
| Phone # | | | Spouse's Name/Parents Name (if under 18) | | | Spouse/Parent Employer Name | |
| | | | Spouse/Parent Employer Phone # | | | Student Status part-time _____ full-time _____ | |

| BILLING INFORMATION | | | |
|--|-------|------------------------------|--|
| Responsible Party/Custodial Parent (If same as above, skip to insurance information) | | Phone Number | Relationship to Patient <input type="checkbox"/> (1) Self <input type="checkbox"/> (2) Spouse <input type="checkbox"/> (3) Child <input type="checkbox"/> (9) Other |
| Address - Street | | Responsible Party's Employer | Phone Number |
| City | State | Zip | Patient Work Phone |
| | | | Patient Cell Phone |

| PRIMARY INSURANCE | |
|-------------------------------|-------------------------------|
| Ins. Company Name & Address | |
| Effective Date | Expiration Date |
| Policy Holder's Name | Relationship to Patient |
| Policy Number | Group Number |
| Policy Holder's SS Number | Policy Holder's Date of Birth |
| Policy Holder's Employer Name | |
| Phone Number | |

| WORKERS COMPENSATION | |
|--|----------------|
| Company Name & Address | |
| Date of Injury | |
| Contact Person & Phone Number | |
| Policy Number | Effective Date |
| Workers Compensation Employer Name | |
| Workers Compensation Employer Address | |
| Workers Compensation Employer City/State/Zip | |
| Workers Compensation Employer Phone | |

| SECONDARY INSURANCE (Medicare supplement or secondary insurance) | |
|---|-------------------------------|
| Ins. Company Name & Address | |
| Policy Holder's Name | Relationship to Patient |
| Policy Number | Group Number |
| Policy Holder's SS Number | Policy Holder's Date of Birth |
| Policy Holder's Employer Name | |
| Phone Number | |

| THIRD INSURANCE (tertiary) | |
|-------------------------------|-------------------------------|
| Ins. Company Name & Address | |
| Policy Holder's Name | Relationship to Patient |
| Policy Number | Group Number |
| Policy Holder's SS Number | Policy Holder's Date of Birth |
| Policy Holder's Employer Name | |
| Phone Number | |

If Medicare: Are you employed? ___ Yes ___ No Are you covered by an employer health insurance? ___ Yes ___ No

HOW DID YOU HEAR ABOUT OUR CLINIC? _____

NAME OF REFERRING DOCTOR: _____ ADDRESS: _____

NAME OF FAMILY DOCTOR: _____ ADDRESS: _____

Please complete reverse side



PATIENT _____

MR. # _____ DOB _____

Medicare Secondary Payer Questionnaire: To be completed by patients who present with Medicare insurance products.

1. Do you have any group health insurance coverage based upon your current or former employment? Yes _____ No _____
2. Do you have any group health insurance coverage based upon your spouse or other family member's current employment? Yes _____ No _____
3. Are you receiving any of the following benefits?

| | | |
|-------------------------|-----------|----------|
| Black Lung | Yes _____ | No _____ |
| Veterans Administration | Yes _____ | No _____ |
| End Stage Renal Disease | Yes _____ | No _____ |
4. Is this service related to an automobile injury or illness? Yes _____ No _____
 Is this service related to a work-related injury or illness? Yes _____ No _____
 Is this service related to any other third party liability injury or illness? Yes _____ No _____

If you have answered yes to any of the above questions, we will request further benefit information.

FOR FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

I understand that I am financially responsible to pay Des Moines University it's usual charges for all services received through Des Moines University, including any balances not covered by my insurance carrier(s). I hereby assign all of my rights to receive any and all insurance proceeds, otherwise payable to me, for coverage(s) provided by my health insurance carrier(s) to Des Moines University, and direct that payment of proceeds be made directly to Des Moines University.

RECORDS RELEASE FOR CLAIMS PAYMENT

I authorize the release of medical record information or excerpts thereof to any insurance company or third party payor for utilization management audit purposes and/or the purposes of verifying the services rendered and obtaining payment of the account. I understand that execution of this authorization waives my right of confidentiality as to the material released pursuant to this authorization, per HIPAA regulations.

Consent to treat I authorize the healthcare providers of DMU Clinic to administer treatment as deemed necessary for my care. As a teaching institution, students may be involved in my care. I certify that no guarantee has been made as to the results that may be obtained from the treatment.

This authorization form will remain in effect for 1 year from signature date unless revoked by me in writing, and may not be revoked as to services rendered prior to my notice of revocation. A photocopy of this authorization form is to be considered as valid as an original.

Patient's signature

Date

Parent/Guardian's Signature

Date

Please fill out all the following information:

Date _____

Name _____

Date of Birth _____ Age _____

Signature _____

Sex Male Female

Occupation _____

Married Single Divorced Widowed

Do you have an advance directive or a living will?
 Yes No

Please indicate any religious, cultural, or spiritual values you wish to be considered in your health care treatment decision making:

Medications and Allergies

Please list all current medications. Please include all prescription and over the counter drugs as well as birth control pills, herbal medications, and vitamins.

| Medication | Dosage/How Often |
|------------|------------------|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |
| 5. _____ | _____ |
| 6. _____ | _____ |
| 7. _____ | _____ |
| 8. _____ | _____ |
| 9. _____ | _____ |
| 10. _____ | _____ |

| Allergies | Reaction |
|-----------|----------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Social History (circle yes or no)

| DRUG/ALCOHOL USE | | |
|--|-----|----|
| Do you or have you ever smoked? | YES | NO |
| If yes, how many cigarettes a day? | | |
| If former smoker, when did you quit? | | |
| If former smoker, how long did you smoke? | | |
| Do you drink alcohol? | YES | NO |
| Do you use illegal drugs? | YES | NO |
| Do you drink caffeine? | YES | NO |
| If yes, how much per day? | | |
| Do you exercise? | YES | NO |
| If yes, what activity? CIRCLE Jogging, Running, Cycling, Spinning, Aerobics, Step, Tennis, Racquetball, Weights, Martial Arts, Other | | |
| How many days per week? | | |
| Time/duration (minutes)? | | |
| Shoes and Inserts | | |
| What is your shoe size? | | |
| What brand of shoes do you wear for exercise? | | |
| Do you wear inserts or orthotics? | YES | NO |
| If yes, are they custom-made for your foot? | YES | NO |

Past Surgical History

Please check the box if you have had the surgery and then indicate the year if you know it.

| SURGERY | Y | YEAR | SURGERY | Y | YEAR |
|------------------------|---|------|-----------------------|---|------|
| Back Surgery | | | Joint | | |
| Eyes | | | Hip | | |
| Foot Trauma | | | Knee | | |
| Heart Bypass | | | Other: | | |
| Kidney Transplant | | | Foot & Ankle Surgery: | | |
| Lower Extremity Bypass | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |


DES MOINES UNIVERSITY
Welcome to our practice!!

Past Medical History

Please check if YOU have had any of the following:

| | | | |
|--------------------------|--|------------------------------|--|
| AIDS | | Heart Disease | |
| Alcoholism | | High Blood Pressure | |
| Alzheimer's | | High Cholesterol | |
| Anemia | | Joint Pain | |
| Anesthesia Complications | | Kidney Disease | |
| Anxiety | | Kidney Stones | |
| Asthma | | Liver Disease | |
| Back Pain | | Migraines | |
| Blood Disorder | | Osteoporosis | |
| Blood Clots | | Pneumonia | |
| Blood Transfusions | | Reflux (gastric) | |
| Cancer / Type: | | Seasonal Allergies | |
| Dementia | | Seizures | |
| Depression | | Sexually Transmitted Disease | |
| Diabetes | | Stroke | |
| Emphysema | | Thyroid Disease | |
| Eye Disease | | Other | |
| Glaucoma | | | |

Hospitalizations:

| Date (mo/year) | Reason |
|----------------|--------|
| | |
| | |
| | |
| | |

Comments on Past Medical History: _____

Family History

| Family Member | Age if Living | Age Deceased | Cause of Death |
|----------------------|---------------|--------------|----------------|
| Mother | | | |
| Father | | | |
| Maternal Grandmother | | | |
| Paternal Grandmother | | | |
| Maternal Grandfather | | | |
| Paternal Grandfather | | | |
| Sibling | | | |
| Children | | | |

Family History Continued

Use the key to indicate if any of your family members currently have or have had any of the conditions/diseases listed.

M=Mother F=Father B=Brother
S=Sister G=Grandparent

| DISEASE/COND. | M | F | B | S | G |
|---------------------|---|---|---|---|---|
| Alcoholism | | | | | |
| AIDS | | | | | |
| Alzheimer's | | | | | |
| Anemia | | | | | |
| Anesthesia Problems | | | | | |
| Anxiety | | | | | |
| Asthma | | | | | |
| Bleeding Disorders | | | | | |
| Blood Clots | | | | | |
| Cancer | | | | | |
| Type: | | | | | |
| Depression | | | | | |
| Diabetes | | | | | |
| Emphysema | | | | | |
| Glaucoma | | | | | |
| Heart Disease | | | | | |
| High Cholesterol | | | | | |
| High Blood Pressure | | | | | |
| Kidney Disease | | | | | |
| Migraines | | | | | |
| Osteoporosis | | | | | |
| Seizures | | | | | |
| Stroke | | | | | |
| Thyroid Disease | | | | | |
| Tuberculosis (TB) | | | | | |

Additional Comments on Family History: _____

History of Testing

| Test | DATE | | NORMAL RESULTS | ABNORMAL RESULTS |
|-------------------|------|------|----------------|------------------|
| | MO. | YEAR | | |
| Bone Density Scan | | | | |

Primary Care Physician/Provider: _____

Referring Physician/Provider: _____

Patient Name: _____ Date of Birth: _____

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

I give permission to be contacted at the following phone number(s) regarding messages, appointments, and/or personal health information for myself, or my minor children, unless restricted by state and/or federal regulations.

Primary phone number for appointment reminder calls: _____

Other phone numbers I may be contacted at:

Home: _____ OK to leave a message? Yes No

Cell: _____ OK to leave a message? Yes No

Work: _____ OK to leave a message? Yes No

Fax: _____

Other: _____ OK to leave a message? Yes No

The following person(s) have my permission to act as my designated health care representative. They may communicate verbally, and in writing, with Des Moines University Clinic staff about my personal health information. *This information may include medical information, financial and insurance information, HIV, drug and alcohol, and/or mental health information.*

Name: _____ Phone number: _____

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

Relationship to patient: _____

Name: _____ Phone number: _____

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

Relationship to patient: _____

I hereby authorize Des Moines University Clinic to communicate my personal health information as stated above. *This information may include medical information, financial and insurance information, HIV, drug and alcohol, and/or mental health information.*

Disclaimer: I understand that DMU Clinic cannot guarantee confidentiality of information shared with the person(s) listed above, or when leaving a message at a phone number listed above.

I understand that this permission will be valid until I revoke this in writing.

Signature of patient or legal representative Date Relationship to patient if not signed by patient

For DMU Staff Only Medical Record Number: _____

Des Moines University Clinic
3200 Grand Avenue., Des Moines, IA 50312

Patient Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices of the Des Moines University Clinics, effective date April 14, 2003.

Patient

Date

Patient Consent Form

Our Notice of Privacy provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by submitting a written request to the Health Information Manager, Des Moines University Clinic, 3200 Grand Avenue, Des Moines, Iowa 50312.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient

Date

MRN#: _____

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