



PRIORITY HEALTH
NORTHWEST

Medical History

Full Name: _____

Birth Date: _____

Allergies (Please add reaction/severity)

Medications (Please add dosages and directions)

If you need more room to list allergies and medications, please write them on the back of this form. You may also attach a med list.

Personal Medical History

Disease/Condition	Current	Past
Alcoholism	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Depression/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>
Renal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

Surgeries

Type	Date	Location

Tobacco Use

Do you smoke? <input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Current <input type="radio"/> Past
Packs/Day: _____	# of years: _____
Other: <input type="radio"/> Chew <input type="radio"/> Vape	

Alcohol/Drug Use

Do you drink alcohol? <input type="radio"/> Yes <input type="radio"/> No	# of drinks/week: _____
<input type="radio"/> Beer <input type="radio"/> Liquor <input type="radio"/> Wine	
Do you use marijuana or recreational drugs? <input type="radio"/> Yes <input type="radio"/> No	

Social History, Habits, and Relationship status (Please check all that applies to you)

Are you <input type="radio"/> working full time, <input type="radio"/> working part time, <input type="radio"/> a student, <input type="radio"/> retired, or <input type="radio"/> unemployed?
If you are employed, what is your occupation?
Do you have any major stresses in your life? <input type="radio"/> Work <input type="radio"/> Marriage/Relationship <input type="radio"/> Finances <input type="radio"/> Other:
Do you feel safe in your home? <input type="radio"/> Yes <input type="radio"/> No. Do you feel you have ever been abused? <input type="radio"/> Physically <input type="radio"/> Sexually <input type="radio"/> Emotionally
Do you have a yearly dental exam <input type="radio"/> Yes <input type="radio"/> No. Approximate date of last dental exam:
Do you have a yearly eye exam <input type="radio"/> Yes <input type="radio"/> No. Approximate date of your last eye exam:
Do you exercise? <input type="radio"/> Yes <input type="radio"/> No. How often do you exercise per week?
Describe your eating habits. <input type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor <input type="radio"/> Gluten free <input type="radio"/> Vegan <input type="radio"/> Other
Relationship status: <input type="radio"/> Married <input type="radio"/> Single <input type="radio"/> In a relationship <input type="radio"/> Divorced/Separated <input type="radio"/> Widowed
Do you have any children? <input type="radio"/> Yes <input type="radio"/> No. How many?

Please continue to the back of the form. Thank you!



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Please list any other providers/specialists that are taking care of you and their facility information.
Examples: Primary Care Physicians, Cardiologists, Nephrologists, Endocrinologists, Psychologists, etc...

Family History Please check here if no significant family history is known.

Check all that apply (Please specify M for maternal or P for paternal grandparents)	Alcohol	Asthma	Cancer	Depression/ Anxiety	Diabetes	Heart Disease	High Cholesterol	Hypertension	Kidney Disease	Stroke	Thyroid Disease	Other _____
Mother												
Father												
Siblings												
Children												
Grandpa												
Grandma												

If you marked Cancer for any family member please indicate what type of cancer: _____

Please write additional medications, allergies, and surgeries here. Thank you!

Reviewing Provider: _____
(Signature)



Pediatric Medical History

Full Name: _____
Birth Date: _____ Age: _____

Check if your child has NO known allergies.

Allergies (Please add reaction/severity)

No active meds.

Medications (Please add dosages and directions)

If you need more room to list allergies and medications, please write them on the back of this form. You may also attach a med list.

Personal Medical History Check if none apply.

Disease/Condition	Current	Past
Alcoholism	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Depression/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>
Renal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

Surgeries No surgeries

Type	Date	Location

Doesn't apply to my child.

Tobacco Use (This form is used for 0-18. Please check "doesn't apply" above if this section doesn't apply to your child.)

Do you smoke? Yes No Current Past

Packs/Day: _____ # of years: _____

Other: Chew Vape

Alcohol/Drug Use

Do you drink alcohol? Yes No # of drinks/week: _____

Beer Liquor Wine

Do you use marijuana or recreational drugs? Yes No

Social History, Habits, and Relationship status (Please check all that applies to you)

Was the patient adopted? Yes No

Delivery: Vaginal Cesarean Full Term Premature

Do you have a yearly dental exam Yes No. Approximate date of last dental exam: _____

Do you have a yearly eye exam Yes No. Approximate date of your last eye exam: _____

Describe the patient's eating habits. Good Fair Poor Gluten free Vegan Other

Are the patient's immunizations up to date? Yes No

Are there any concerns of abuse? Yes No

Do you have any concerns about your child's behavior? Yes No

Parent's Relationship status: Married Single In a relationship Divorced/Separated Widowed

Is your child enrolled in daycare or school? Daycare Preschool Elementary Middle High Homeschooled

Please continue to the back of the form. Thank you!



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Please list any other providers/specialists that are taking care of you and their facility information.
Examples: Primary Care Physicians, Cardiologists, Nephrologists, Endocrinologists, Psychologists, etc...

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Family History Please check here if no significant family history is known.

Check all that apply (Please specify M for maternal or P for paternal grandparents)	Alcohol	Asthma	Cancer	Depression/ Anxiety	Diabetes	Heart Disease	High Cholesterol	Hypertension	Kidney Disease	Stroke	Thyroid Disease	Other
Mother												
Father												
Siblings												
Children												
Grandpa												
Grandma												

Please write additional medications, allergies, and surgeries here. Thank you!

Reviewing Provider: _____
(Signature)



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Registration

Patient Name _____ Date of Birth ____/____/____ **Pharmacy** _____
First Middle Last Month Day Year

Social Security # _____ - _____ - _____ **Email Address** _____

Address _____ City _____ State _____ Zip _____

Home Ph. (____) _____ Business Ph. (____) _____ Cell Ph. (____) _____

Married Single Widow Divorced Gender: Male Female

Employer Name _____ Full-Time Part-Time Retired Self-Employed

Student-Fulltime Student-Part-time **How would you like to receive your bills?** Email Text Mail

Responsible Party (If different from patient)

Name _____ Relationship _____
First Middle Last

Social Security # _____ - _____ - _____ Date of Birth ____/____/____

Address _____ City _____ State _____ Zip _____

Home Ph. (____) _____ Business Ph. (____) _____ Cell Ph. (____) _____

*******Notify in Case of Emergency*******

Name _____ Relationship _____ Phone # _____

Disclosure and Consents

As required by the Health Insurance Portability Act of 1996, Priority Health Northwest, PLLC may not use or disclose your health information except as provided in our Note of Privacy Practices without our authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information as described in the above notice.

Assignment of Insurance Benefits:

I hereby authorize direct payment of my insurance benefits to Priority Health Northwest, PLLC or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are covered *benefit. I understand and agree that I will be responsible for any co-pay or balance due Priority Health Northwest, PLLC is unable to collect from insurance carrier for whatever reason. If accounts are 45-60 days in default, they maybe subject to a collection agency.*

Medicare/Medicaid/Tricare Insurance Benefits:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Priority Health Northwest, PLLC or the physician on my behalf.

Authorization to Release Non-Public Personal Information:

I certify that I have received and read a copy of the Priority Health Northwest, PLLC Patient Information Privacy Policy. I hereby authorize Priority Health Northwest, PLLC or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary from medical evaluation, treatment, consultation, or the processing of insurance benefits.

I consent for telehealth services to be performed.

Some Lab/Diagnostic Services are sent to outside Laboratories for further testing. These services will be billed directly to you and or your insurance by the outside provider. You will be financially responsible for any co-pay or balance due for these services if they are not reimbursed by your insurance for whatever reason.

I hereby consent to evaluation, testing, and treatment directed by Priority Health Northwest, PLLC or his or her designee.

➔ **Patient Signature** _____ **Date** _____

(If different from patient) Guarantor Signature _____ Date _____

Guarantor Name and relationship to patient. (Please Print) _____

(Optional) Authorization:

I authorize _____ **to have access to my records/call for any questions.**

Signature: _____ Date: _____

Priority Health Northwest
1800 Norris Place
Spencer, IA 51301
712-580-4570
Fax: 712-580-4573

Patient Name _____ DOB _____
Address _____ SSN# _____

I authorize the use or disclosure of the above-named individual's health information as described below. The following individual or organization is authorized to make the disclosure:

Name _____ Phone# _____
Address _____

The type and amount of information to be used or disclosed is as follows:

Date of service from (date) _____ to (date) _____
_____ Standard Chart Copy _____ History and Physical
(Includes physician dictated reports, _____ Discharge Summary
All test results) _____ Lab work
_____ Entire Record _____ X-ray and imaging reports
_____ Other _____ EKG
_____ Operative report
_____ Pathology report

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, or treatment for alcohol and drug abuse.

The information may be disclosed to and used by the following individual or organizations"

Name: _____ Fax: _____ Phone: _____
Address: _____

For the purpose of: continued healthcare personal _____

I understand I have a right to revoke this authorization at any time by presenting a written revocation to Priority Health Northwest, PLLC. I understand the revocation will not apply to: 1. Information already released in response to this authorization 2. My insurance company when the law provides my insurer with the right to consent a claim under my policy.

Unless otherwise revoked, this authorization will expire a year from the date of signature.

Signature of patient or legal representative _____

Date signed _____

If signed by legal representative, relationship to patient _____