

Today's Date _____

James C. Wasson, M.D., P.C.

Patient Medical History Form

Patient _____ Date of Birth _____
First Name Middle Initial Last Name

Drug Allergies _____ Allergies _____

List Current Medications	Dosage	Frequency

List Surgeries/Hospitalizations	Year

List Current Medical Issues: (Reason for Visit)

List Other Chronic Medical Problems:

Sreening Tests	Year
Last Mammogram?	
Last Colonoscopy?	
Last PSA Level?	

Family History	YES	NO
Heart Disease		
High Blood Pressure		
Stroke		
Cancer		
Glaucoma		
Diabetes		
Epilepsy / Convulsions		
Thyroid Disease		
Kidney Disease		
Osteoporosis		
Other not listed?		

Personal History	YES	NO
Smoking Frequency?		
Are you Interested in stopping?		
Alcohol		
How much?		
Drug Abuse		
How much?		
Do you have a living will ?		
Women only:		
Are you currently Pregnant?		
Are you planning pregnancy?		

Patient _____ Date of Birth _____

Notice of Privacy Practices – Patient Acknowledgement

I have received notice of this practice's policy which provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information and abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of uses and disclosures that are prohibited or materially limited by law and a description of the ones that will be made only with my written authorization and that I may revoke such authorization.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
 - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
 - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
 - The right to receive confidential communications of protected health information.
 - The right to inspect, copy and amend protected health information.
 - The right to receive an accounting of disclosures of protected health information.
 - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new revisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request. (Signature below)

Communication Policy

It is the office policy of James C. Wasson M.D., P.C. and staff not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone, and /or pager. Also, faxing patient information to your work place is prohibited. Whenever returning telephone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Also, information will not be left with an unauthorized person who may answer the telephone.

I authorize James C. Wasson, M.D., P.C. and /or their staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

	Yes	No
Home Telephone		
Answering Machine / Voice Mail		
Work Telephone		
Cell Phone and/or Voice Mail		
Fax medical records for referrals to another physician		
Spouse:		
Parent:		
Other: (State Relationship)		

Signature _____ Date _____

Relationship to patient (if signed by a personal representative of patient): _____