PATIENT INFORMATION
STEPHANIE NANI, DO

Please fill this form out in its entirety, making sure it is legible. Thank you!

Date of Exam _____

Patient Name _____ _____ _____
Last *First* *M.I.*

Date of Birth _____ /_____ /_____ ☐ **Male** ☐ **Female** SSN#: _____

Home Address _____

City _____**State** ____ **Zip** _____

Mailing Address (if different) _____

Email Address _____

Phone: ☐ Home _____ ☐ Cell Phone _____ ☐ Work _____
(Check the best number to reach you)

Name of Spouse/Domestic Partner _____

In Case of Emergency Contact _____Telephone _____

Name of Primary Care Physician _____Telephone _____

Person Responsible For Fees (if different than above)

Name _____Telephone _____

Address _____

Insurance Company_____ Policy#_____
Please have card available at time of visit to copy.

Insurance Company _____ Policy#_____

Parent (if patient is a minor) _____

Referred by _____

PATIENT HISTORY

Name: _____

DOB: _____

Height: _____ Weight: _____

Blood Pressure (if checked today) _____

Past Medical History:

Past Surgical History:

Medications (name and dose):

Allergies & Reactions:

Vaccinations: Pneumonia: no ____ yes ____ date: _____
Influenza: no ____ yes ____ date: _____
HPV: no ____ yes ____ date: _____

Social History:
Smoker: no ___ yes ____ ; packs/day _____
previous smoker, when did you quit _____

Single Married Widow(er) Divorced

HIPAA Compliance Patient Consent Form
Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.
The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.

- The practice reserves the right to change the privacy policy as allowed by law. ? The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.

- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO
May we leave a message on your answering machine at home or on your cell phone? YES NO
May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

Signature: _____ Date:_____