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ANNUAL HEALTH HABITS QUESTIONNAIRE

Alcohol: Do you ever drink alcohol? ☐ No ☐ Yes
☐ Daily ☐ 1-2 per week ☐ 3-5 per week ☐ 1-2 per month ☐ 1-2 per year
Have you ever felt like you should cut down on drinking ☐ Yes ☐ No
Have people ever criticized you for drinking? ☐ Yes ☐ No
Do you ever feel bad or guilty about drinking? ☐ Yes ☐ No
Have you ever taken a drink first thing in the morning to ease your nerves or cure a hangover? ☐ Yes ☐No

Tobacco:☐ Never a smoker/Smokeless Tobacco/Electronic Cigarette/Vaping
☐ Current every day smoker/Smokeless Tobacco/Electronic Cigarette/Vaping
☐ Current some days smoker/Smokeless Tobacco/Electronic Cigarette/Vaping
☐ Former Smoker/Smokeless Tobacco/Electronic Cigarette/Vaping Year quit _____ Years smoked _____

Substance Abuse: Do you use recreational/street drugs? ☐ Currently Use ☐ Previously used ☐Never used

Employment: ☐ Employed Full Time ☐ Employed Part Time ☐ Retired ☐ Student ☐Unemployed

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Number of Children _____

Type of Diet: ☐ Regular ☐ Diabetic ☐ Low Fat ☐ Low Carb ☐ Low Salt ☐ Low Calorie ☐ Vegetarian
Other: _____

Caffeine Intake: O None
☐ Coffee_____cups per day ☐ Tea_____cups per day ☐ Cola_____cans per day

Exercise: ☐ Daily ☐ 1-2 times/week _____mins ☐ 3-4 times/week ____mins ☐ 5-6 times/week ___mins

Are you Currently Sexually Active? ☐ Yes ☐ No
If yes: are you trying for pregnancy? ☐ Yes ☐ No Contraceptive method used: _____
Last Menstrual Cycle_____

Mental Health:
In the past TWO WEEKS have you felt down, depressed or hopeless?
☐ Not at all ☐ Several days ☐ Half the days ☐ Nearly Everyday
In the past TWO WEEKS have you felt little interest or pleasure in your daily activities?
☐ Not at all ☐ Several days ☐ Half the days ☐ Nearly Everyday

Do you have an Advanced Directive, Living Will or Power of Attorney? _____
Have you had a pneumonia shot? ☐ Yes ☐ No Date received/where:_____
Do you get a yearly flu shot? ☐ Yes ☐ No Date received/where:_____
Do you live alone? ☐ Yes ☐ No
Have you fallen in the last 3 months ? ☐ Yes ☐ No

Wellness Screenings:
Pap Smear (where/date)_____Mammogram (where/date)_____
Colorectal Screening (Colonoscopy/Fecal Occult Blood Test) where/date_____

Diabetes: Last A1C/Result _____ Last Eye Exam/Where _____ Endocrinologist_____

Covid-19 Vaccine: YES/NO Date? _____ Manufacturer? (circle) PFIZER MODERNA Johnson & Johnson

PATIENT NAME _____DOB_____DATE_____

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New Patient Health History

PATIENT NAME _____**DOB** _____ **Today's Date**_____

Have YOU ever had
(Circle All That Apply)

Arthritis
Asthma/COPD/Emphysema
Anemia or blood transfusion
Blood clots
Cancer (where? _____)
Colon problems
Depression/Anxiety
Diabetes
GERD/esophageal reflux
Glaucoma
Gout
Heart attack
High blood pressure
High cholesterol
Kidney disease/stones
Liver disease
Migraines
Osteoporosis/osteopenia
Phlebitis/vein disease
Stroke
Thyroid problem
Abnormal Pap
Abnormal mammogram
Other medical conditions/diseases not listed _____

Surgeries/Procedures
(Circle All That Apply)

Appendix
Breast reconstruction
Breast lumpectomy
Bladder surgery
Cataract removal
Cesarean section

D & C
EGD (upper endoscopy)
Gallbladder
Gastric surgery
Heart valve replacement
Hysterectomy (ovaries Y/N?)
Joint replacement (please list) _____
Mastectomy R/L
Thyroid
Tonsillectomy
Transplant
Colonoscopy (Date/Where _____)
Other procedures _____

Family History
(Ex: Father, Mother, Maternal/Paternal Family)

Alcoholism _____
Blood disease _____
Breast cancer _____
Colon cancer _____
Diabetes _____
Heart attack _____
High blood pressure _____
High cholesterol _____
Mental illness _____
Migraines _____
Osteoporosis _____
Rheumatoid arthritis _____
Other _____

Gynecologic History:
How old at first period? _____ Last Period? _____
How long between periods? _____ How long do periods last? _____
Flow: Heavy / Normal / Light Cramps? Y / N
Times Pregnant? _____ Miscarriages _____ Abortions _____ Live Births _____

Allergies _____ **Occupation** _____

Medications_____
_____
_____

What are your health concerns? _____

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AUTHORIZATION FORM

Silver Cross Medical Group
Authorization for Credit Card

NOTE: When your credit card information is entered, it is encrypted and cannot be viewed or accessed by our organization. Our system is registered with Visa and MasterCard and independently certified as a PCI-DSS Level One Service Provider.

AUTHORIZATION
Until further notice, I authorize Silver Cross Medical Group to charge the patient responsibility balance on my account to the following credit card:

CIRCLE ONE: Visa MasterCard Discover AMEX
Last Four Digits of Credit Card Number: _____
Exp. Date (mm/yy): _____/_____

I understand that once the health plan has paid their portion for my care I will receive an Explanation of Benefits (EOB). The health plan EOB will state any remaining balance to be paid by me. I agree that Silver Cross Medical Group may charge my credit card the balance due upon receipt of the EOB. I also understand that Silver Cross Medical Group may charge my credit card any open balance due as well, if they determine that a prior balance exists.

Signature: _____ **Date:** _____
Printed Name: _____
E-Mail: _____
Patient Name (if different than above): _____
Patient Date of Birth: ____ / ____ / _____

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In all cases, proper communication should include “Any known payment responsibility is due at your visit. Any remaining balance as determined by your health plan is your responsibility. We require you to save a credit card for remaining balances.

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MYHEALTH ONLINE PATIENT PORTAL

MYHealth is a free, easy and secure way to manage and monitor your electronic medical records anywhere you have online access – 24 hours a day, 7 days a week.

SIGN UP TODAY

With MYHealth you can:

- View and download lab and radiology results
- View current medications, immunizations, allergy information and health issues
- View vital info such as blood pressure, height and weight
- Send general messages and medication refill requests
- Share results/documents from other specialists with our office
- Download patient education, patient letters and visit summaries

HOW CAN YOU GET STARTED?

1. Provide one of our staff members with the following:

   Your name: _____

   Your DOB: _____

   Your email address: _____

   Your zip code: _____

2. Watch for an email with instructions on how to complete your registration and activate your secure account with 24-72 hours.

   NOTE: Email will come from IQHEALTH not your physician or Silver Cross. Please be sure to check your spam folders.

3. Once your personal account has been activated, you can access MYHealth at any time at **www.iqhealth.com**

Questions About Account Activation?

Account support is available at any time by calling **1-877-621-8014**

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NEW PATIENT POLICY

No Show Policy

In order to provide every patient with the best possible health care, we have instituted a No Show Policy. This will be effective May 1, 2015. If any patient has THREE no show visits in ONE year they will be released from the practice. A no show visit is when a patient either fails to show up for their appointment, or fails to cancel their appointment 24 hours in advance. Reminder that a $50 no show fee will be applied to all missed appointments.

Late Arrival Policy

If you are going to be more than 15 minutes late for your appointment, we request you call our office. If the schedule allows, the appointment time will simply be shifted to accommodate the delay. However, if the tardiness can't be handled, we may request you reschedule your appointment. We work diligently to stay on schedule and suggest you arrive 20 to 30 minutes prior to your appointment time to allow for any necessary paperwork.

Medication Refills

- Please allow 2-3 business days for refills.
- Contact your pharmacy 5 days prior to running out of medication. Ask your pharmacy to send us an electronic refill request.
- Refills are not addressed on weekends; covering physicians do not authorize routine medications on weekends.
- No narcotics or controlled substances are refilled after noon on Fridays or by on call physicians.
- If your prescription is due for a refill, you may be due for a follow up appointment.
- To best provide you care, patients receiving routine medications need to be seen at least once a year and sometimes more frequently.

Pick Up Protocol for Controlled Substances Written Prescriptions

- Prescriptions must be picked up in the office.
- Standard 48-72 hour refill policies apply.
- Must present photo ID at time of pick up. If a designated family member will be picking up prescription, office must be given name of individual in advance.
- Name of person picking up prescription will be documented in medical record.

Expected Turn Around/Response Times

- You can expect to hear from our office via the patient portal or a phone call within 5-7 business days of most testing. If you have not heard from our office after 7 days please feel free to call for results.
- Referrals and authorizations for testing can also take 5-7 business days to process with your insurance. Please allow sufficient time to process. You will be contacted once your insurance plan has given us the approval.

I HAVE READ THIS AND UNDERSTAND THE POLICY.

Patient Name: _____

Signature: _____ **Date:** _____

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NOTICE OF PRIVACY POLICIES

1. We are a member of Silver Cross Medical Group and therefore your information is available to all providers within this network. It is our commitment to protect your health information. This notice describes how our medical information may be used and disclosed and your rights to your protected health information.

2. **How we may use and disclose your health information.** Each time you visit our office, a record is made. We use medical records for treatment, referrals, reimbursement, and for administrative and legal purposes. Information may be shared by paper, mail, fax, electronic mail, or other methods. We may use or disclose your health information for several reasons. Before those situations occur, except for billing reasons, we will ask for your written authorization; these can be revoked at any time.

3. **Your rights.** Although your record is a physical property of our office, you have the right to obtain copies of your medical records (we may charge you a cost based fee). You also have the right to request a list of specific disclosures that we have made. If you believe some information is missing or incorrect, you have the right to request that we correct it.

4. **Our responsibilities.** We are required by law to protect the privacy of your health information, to provide this notice about our privacy practice and to document your acknowledgement of receipt of this notice. We may change our privacy policies at any time, if so we will post the new notice in the waiting area. You may also request a copy of our notice at any time.

5. **For more information or to report a problem.** If your rights have been violated or if you disagree with a decision we made about access to your health information, please contact the Practice's Privacy Officer at (815) 300-7020. You also may send a written complaint to the US Department of Health and Human Resources.

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Pediatric Patient Data Information

Child's Name: _____ Birth Date ____ / ____ / ____

Sex: ☐ Male ☐ Female

Child's Race: _____ Child's Ethnicity: _____

Child Resides with: ☐ Both parents ☐ Father ☐ Mother ☐ Other

Mothers Name: _____ Birth Date ____ / ____ / ____

Mothers Address: _____ City _____

State _____ Zip _____ Home Phone_____Other Phone _____

Fathers Name: _____ Birth Date ____ / ____ / ____

Fathers Address: _____ City _____

State _____ Zip _____ Home Phone_____Other Phone _____

Legal Guardian if applicable: _____ **(Legal documentation required.)**

Address_____ City _____

State _____ Zip _____ Home Phone_____Other Phone _____

Emergency Contact: _____ Relationship _____ Phone _____

Pharmacy (name, location, phone #) _____

Mail Order Pharmacy (if applicable) _____

Contact for Results:

I authorize Silver Cross Medical Group to contact for results:

Parents Only ☐

☐ Home ☐ Cell

OK to leave a message on answering machine? ☐ Yes ☐ No

Other ☐ Name _____ Relationship _____

Authorization to Treat: Parents/Legal Guardians please read and sign agreement:

- I hereby give my consent for the providers at Silver Cross Medical Group to evaluate and treat the patient listed above
- I hereby authorize my insurance benefits to pay directly to Silver Cross Medical Group, realizing I am responsible to pay non-covered services. I authorize the release of medical information to insurance carrier

Signature: _____ Date _____

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NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains patient rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of this notice may change. If we change our notice, you may obtain a revised copy at your request.

ACKNOWLEDGEMENT OF RECEIPT NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
(Signature)

_____
(Date)

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices, but was unable to do so as documented below:

Date: _____ Initials: _____

Reason: _____

_____

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Patient Data Information

Name _____ Birth Date ____ / ____ / ____ Sex: ☐ Male ☐ Female

Phone_____ Cellular Phone _____ Email _____

Ok to leave a message? ☐ Yes ☐ No

Address_____ City _____ State _____ Zip _____

SS# _____ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Race: _____ Ethnicity: _____ Referred by _____

Pharmacy (name, location, phone #) _____

Mail Order Pharmacy (if applicable)_____

Emergency Contact: _____ Relationship _____ Phone _____

Preferred Method of Communication (Choose One) : ☐ Phone ☐ Text

PATIENT INSTRUCTIONS FOR COMMUNICATION PREFERENCES:

I authorize Silver Cross Medical Group to contact for results:

Myself Only ☐

☐ Home

☐ Cell

Ok to leave a message on answering machine? ☐ Yes ☐ No

Other ☐ Name _____ Relationship _____

Other ☐ Name _____ Relationship _____

Did you sustain an injury at work? ☐ Yes ☐ No Are your injuries accident related? ☐ Yes ☐ No

Authorization to Treat:

I hereby authorize my insurance benefits to pay directly to Silver Cross Medical Group, realizing I am responsible to pay non-covered services. I authorize the release of medical information to insurance carrier.

Signature: _____ Date _____