



Patient Medical History Form

Patient Name: _____ Date of Birth: _____

MEDICATIONS TAKEN	DOSE	FREQUENCY	REASON TAKING
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If necessary. Please continue listing medications on another piece of paper or on the backside of this form. Your medications are important to Dr. Ginsburg. →

ANY MEDICATION ALLERGIES? Yes No If yes, be specific _____

IMMUNIZATIONS: Influenza (Flu): Yes No Date: _____ Pneumococcal: Yes No Date: _____

MEDICAL HISTORY

PREVIOUS SURGERIES, SERIOUS INJURIES, HOSPITALIZATIONS

COLONOSCOPY w/in the last 10 years: Yes No Date: _____ Physician: _____

PATIENT SOCIAL HISTORY:

Are you a: Current Smoker Former Smoker Never a Smoker Are you interested in quitting? Yes No
 Tobacco Use? No Yes Packs per Day ____ Do you smoke: everyday some days, but not everyday
 Recreational Drug Use? No Yes
 Caffeine Consumption: No Yes If Yes, please explain: _____
 Alcohol Use? Never Rarely Moderately Daily

FAMILY MEDICAL HISTORY

Age	Please list diseases and health history	If deceased, cause of death
Father: _____	_____	_____
Mother: _____	_____	_____
Siblings: _____	_____	_____
Children: _____	_____	_____

Authorization to Access Rx History Information: I hereby authorize Platinum Surgical Care to access my historical prescription drug information. Without this authorization we will not be able to prescribe any controlled substances to you.

Patient Name: _____ Signature: _____ Date: _____

Preferred Pharmacy: _____ Phone Number: _____

Location or Address of Pharmacy: _____

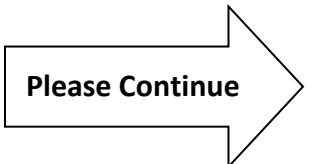
Preferred Laboratory/Radiology Facility to be used for tests/labs: _____ Location: _____

The following information is now being required for Healthcare/Government reporting purposes. **Please complete ALL 3 questions listed below.**

Race: White Black or African American Hispanic American Indian or Alaskan Native Asian Other _____

Language: English Spanish Indian Other _____

Ethnicity/Nationality: Non-Hispanic Hispanic Other _____



Patient Name: _____ **Date of Birth:** _____

CONSTITUTIONAL SYMPTOMS

Good general health lately No Yes
Recent weight change No Yes
Fever No Yes
Fatigue No Yes
Headaches No Yes

EYES

Eye disease or injury No Yes
Wear glasses/contact lens No Yes
Blurred or double vision No Yes
Glaucoma No Yes

EARS, NOSE & THROAT

Hearing loss or ringing No Yes
Earaches or drainage No Yes
Sore throat or voice change No Yes
Swollen glands in neck No Yes

CARDIOVASCULAR

Heart disease No Yes
Shortness of breath with
 walking or lying flat No Yes
Hypertension No Yes
Chest pain or angina pectoris No Yes
Palpitations No Yes

RESPIRATORY

Chronic or frequent coughs No Yes
Spitting up blood No Yes
Shortness of breath No Yes
Asthma or wheezing No Yes

GASTROINTESTINAL

Loss of appetite No Yes
Change in bowel movement No Yes
Nausea or vomiting No Yes
Rectal Bleeding or
 blood in stool No Yes
Abdominal Pain No Yes

BREAST

Breast discharge No Yes
Breast pain No Yes
Breast lump No Yes

NEUROLOGICAL

Frequent headaches No Yes
Lightheaded or dizzy No Yes
Convulsions/seizures No Yes
Numbness/tingling sensation No Yes
Stroke No Yes
Head injury No Yes

ENDOCRINE

Glandular/Hormone problems No Yes
Thyroid disease No Yes
Diabetes No Yes

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts No Yes
Bleeding/bruising tendency No Yes
Anemia No Yes
Phlebitis No Yes
Past transfusion No Yes
Enlarged Glands No Yes

GENITOURINARY

Frequent urination No Yes
Burning/painful urination No Yes
Blood in urine No Yes
Kidney Stones No Yes

CURRENT HEIGHT: _____ **WEIGHT:** _____

Are you interested in speaking with Dr. Ginsburg regarding diet and exercise? Yes or No (circle one)

Platinum Surgical Care
Gregg A. Ginsburg, M.D., F.A.C.S.
1455 Highway 61, Suite B, Festus, MO 63028
5034 Griffin Road, St. Louis, MO 63128
555 West Pine St., Farmington, MO 63640
Phone number (636) 931-4744 or Toll free 877-931-4744
Fax number (636) 931-4739

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

Printed Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

To address any special needs you may have and to assure your patient information is kept confidential please answer the following questions:

Other than yourself, do you authorize our office to discuss your health information with another family member or spouse? Circle one YES NO

If so, please list names below for our record.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Do you authorize our office to call your home and leave a message about test results or other information on your answering machine? YES NO I don't have a machine

Do you authorize our office to call you at work? YES NO N/A

Comments: _____

OFFICE USE ONLY

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

Reason: _____

Staff Initials: _____ Date: _____

Platinum Surgical Care
Gregg A. Ginsburg, M.D., F.A.C.S.
1455 Highway 61, Suite B
Festus, MO 63028
Phone number (636)931-4744 or Toll free 877-931-4744
Fax number (636)931-4739

THIS FORM WILL BE USED TO OBTAIN/RELEASE MEDICAL RECORDS
WHEN REQUIRED FOR TREATMENT
PLEASE SIGN AND DATE ONLY OUR OFFICE WILL COMPLETE
DOCUMENT IF NEEDED

AUTHORIZATION FORM FOR USE AND/OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION

Name: _____ Date of Birth: _____

I hereby authorize _____ to obtain or release protected health information for the purposes described below.

Description of the specific information to be obtained or released: _____
_____.

The persons in our workforce authorized to make the disclosure is: Medical Records Dept.

The person or entity to whom we will disclose the information, and who may use it, are: _____
_____.

The purpose for which the use/disclosed information will be used: _____
_____.

- You may refuse to sign this authorization. Your refusal will NOT affect your ability to obtain treatment, payment or eligibility for benefits.
- If the persons who are authorized to receive the information above are NOT health care providers or health plans covered by federal health privacy laws, they may re-disclose that information and those laws would no longer protect it.
- You may inspect or copy the protected health information to be used or disclosed under this authorization. Please send your request to the above address.
- Once you give us this authorization, we can rely on it until you revoke it or, if you have not revoked it, until it expires. You can revoke this authorization by delivering a dated and signed letter to our office at the above location. However, your revocation will not prohibit us from
 - a. any acts we have already taken in reliance of the authorization, or
 - b. any right associated with an insurer's contest of a claim under its policy, if the authorization was obtained in order to obtain insurance coverage. If not revoked, this authorization will expire one year from the date of the signature below.

X _____ Date: _____

Signature (Patient or Legal Representative)

Capacity of Legal Rep. _____

NOTICE OF PRIVACY PRACTICES
For
Platinum Surgical Care
Gregg A. Ginsburg, M.D., F.A.C.S

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health and Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. “HTPAA” provides penalties for covered entities that misuse personal health information.

As required by “HIPAA”, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example would include a physical exam.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree to a requested restriction.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a copy of the notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of January 1, 2009, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice or Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:

U.S. Dept. of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257, Toll free 1-877-696-6775