CULLMAN INTERNAL MEDICINE

CIM Dr: _____

Patient Personal History

Appt date: _____

BLACK INK ONLY

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Gender: MALE / FEMALE

Last Name: _____ Phone #: _____

First Name: _____ Work or Cell #: _____

Middle Name: _____ Social Security #: _____

Address: _____ Birthday: _____

City: _____ State: _____

Zip Code: _____ Employer: _____

Marital Status: _____ Spouse Name: _____

Spouse DOB: _____ Social Security #: _____

Spouse work #: _____ E-Mail: _____

Preference: Phone / E-Mail / Mail / Text Language: _____

Race: _____ Primary Insurance: _____

Primary Ins #: _____ Secondary Insurance: _____

Secondary Ins #: _____ Policy Holder: _____

DOB: _____ Local Pharmacy: _____

30 or 90 Days? _____ Phone #: _____

Fax #: _____ Mail Order Pharmacy: _____

Address: _____

Previous Physician or Referring Physician: _____

Signature of Responsible Party: _____ Date: _____

Person to notify in an Emergency (Not living in your household):

_____

Relationship: _____ Phone #: _____

Cullman Internal Medicine
1890 Al Hwy 157 Suite 300
Cullman, Al 35058
256-737-8000 Fax: 256-737-8058

Authorization for Medical Records Release

Patient Name (Print):

_____

Date of Birth: _____

Date Request Received: _____ Date of Expiration: _____

Persons/Place providing the information: _____

Phone #: _____ Fax #: _____

Persons / Place receiving the information: _____

Specific description of information (including date(s): _____

_____

Purpose of use or disclosure: _____

The patient or the patient's representative must read and initial the following statements: I understand that I may revoke this authorization at any time by notifying the Cullman Internal Medicine Privacy Officer in writing, but if I do, it will not have any effect on any actions Cullman Internal Medicine took before they received the revocation.

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I understand that Cullman Internal Medicine may not condition the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits on signing this authorization, except under the following circumstances:

- Initial enrollment in health plans can be conditioned on signing an authorization for the health plan in review PHI to make eligibility determinations.
- Furnishing healthcare services to me at the request of a third party can be conditioned on me signing an authorization for disclosure of the PHI to the third party requesting the treatment.

Signature of patient or patient's representative: _____

Printed name of patient or patient's representative: _____

Relationship to Patient: _____

CULLMAN INTERNAL MEDICINE, P.C.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____ SSN: _____

Phone: _____

Cullman Internal Medicine is dedicated to protecting the privacy of every patient. It is your right to receive quality care without concern that your personal health information will be shared or disclosed to others. Your medical information is protected by law and will only be used in treatment, payment, and healthcare operation scenarios. Employees of Cullman Internal Medicine and affiliated business associates have signed confidentiality statements and contractual agreements agreeing to follow the policies and procedures of our practice in protecting your privacy. While disclosures of personal health information to doctors, nurses, and specialists are often necessary for treatment, your medical information will not be sold to any outside agency or pharmaceutical company nor will it be released for any reason other than treatment, payment, healthcare operations or when required by state and federal laws without your written authorization. You have the right to access and request changes to your medical record, find out what disclosures have been made, and request restrictions on uses and disclosures of your health information. If at any time you have any questions or concerns you may contact our Compliance Officer at 256-737-8046. This privacy notice is subject to change.

Please list the family members or other persons, if any, we may inform about your general medical condition and your diagnosis, which might include appointments, medical history, treatment, test results, and/or reference to any mental or nervous disorders, drug, and/or alcohol abuse, or sexually transmitted disease.

_____ *Relationship:* _____ *Phone:* _____

_____ *Relationship:* _____ *Phone:* _____

_____ *Relationship:* _____ *Phone:* _____

Please list the family members or other persons, if any, we may inform about your general medical condition and your diagnosis ONLY in an emergency:

_____ *Relationship:* _____ *Phone:* _____

_____ *Relationship:* _____ *Phone:* _____

This information about you is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised, however, that any revocation will be effective only to the extent we have not already acted in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuse to sign the authorization.

_____ _____

Patient Signature or Personal Representative Date

_____

Printed Name

CULLMAN
Internal Medicine

CIM is privileged to be part of your healthcare team.

Name: _____ DOB: _____ Age: _____ Male ( ) Female ( )

ANY DIAGNOSIS OR TREATMENT FOR:

	ME (x)	IMMEDIATE FAMILY (x)
High Blood Pressure?	____	____
Heart Issues? (Specify)	____	____
Blockage?	____	
Extra Fluid?	____	
Irregular Rhythm?	____	
Passing out / dizziness?	____	____
High Cholesterol?	____	____
Diabetes / Sugar?	____	____
Depression / Anxiety?	____	____
COPD / Asthma?	____	____
Sleep Apnea / Snoring?	____	____
Thyroid Problem?	____	____
Chronic Pain / Meds	____	____
Stomach Problems?	____	____
Kidney Problems?	____	____
Stroke / TIA?	____	____
Thinning Bones?	____	____
Cancer? (Site / Treatment)	____	____

Me: _____

Family: _____

DATE OF MOST RECENT SCREENING:

Lung Cancer: _____ Colon: _____

Prostate: _____ PAP: _____

Bone Density: _____ Mammo: _____

*SURGERIES _____

_____

_____

*Smoker? Current ____ Past ____

*Alcohol No___Yes___ (1-2 ___ 3+___daily)

*Caffeine No___Yes___ (1-4 ___5+___daily)

*Smokeless Tobacco No__Yes__(#___daily)

*Any recent falls? No ___ Yes ___

*Do you have a Living Will? No ___ Yes ___

*Advanced Directive? No ___ Yes ___

Hobbies: _____

_____

_____

CULLMAN
Internal Medicine

Medications & History

Medications

(Name - Strength - Daily Dose)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

List any Allergies

(Please List Medication Allergies & Reaction)

_____

_____

_____

_____

****If Needed, Please use the back of this sheet for additional Medications and/or Allergies****

Immunization History (Please list dates - Check with pharmacy if needed)	Please list the name & location of any specialists that are a part of your healthcare team.
Pneumovax 23: _____ **Prevnar 13:** _____ **Prevnar 20:** _____ **RSV:** _____ **Influenza:** _____ **COVID-19:** _____ **Tdap:** _____ **Tetanus:** _____ **Hep B:** _____ **Zostavax:** _____ **Shingrix:** _____	**Heart:** _____ **Kidney:** _____ **Orthopedic:** _____ **Neuro:** _____ **Skin:** _____ **Lung:** _____ **Sleep:** _____ **Pain:** _____

What have we *not* asked that you feel is important?

_____

_____

_____

_____

_____

_____

_____

CULLMAN INTERNAL MEDICINE, P.C. CONSENT

Patient Name: _____ **DOB:** _____

CONSENT TO TREAT/WAIVER OF RESPONSIBILITY DUE TO NONCOMPLIANCE

I acknowledge that I have read, understand, and accept the following prior to undergoing my initial evaluation at the office of Cullman Internal Medicine P.C. Certain disorders can potentially lead to physical illness, injury, or even death if left untreated. Your physician encourages all patients to remain compliant with their office visits and treatments. It is the responsibility of patients to reschedule missed or canceled appointments. Prior to interrupting evaluation or discontinuing treatment, it is highly recommended that patients discuss this decision with their physician and his/her staff. Cullman Internal Medicine P.C. will not be held responsible for problems related to poor compliance including failure to complete the evaluation process or refusal of treatment. If you have any questions or concerns regarding this policy, please feel free to discuss them with your physician. **I hereby consent to medical treatment that may be deemed advisable by his or her physician practicing at Cullman Internal Medicine**.

EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE

You agree, in order for us to service your account or to collect monies you may owe, Cullman Internal Medicine, P.C. and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or the use of an automatic dialing device, as applicable. **I/We have read this disclosure and agree that Cullman Internal Medicine, P.C., its employees, and/or agents may contact me/us as described above.**

MEDICAL AUTHORIZATION TO BILL INSURANCE/STATEMENT OF FINANCIAL RESPONSIBILITY

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to _____ all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer, and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named provider to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and laboratory in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and lab's expenses. This lifetime assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement. **I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers. I understand it is my responsibility to notify Cullman Internal Medicine, P.C. of any changes to my insurance, phone number, address, or other contact information.**

Patient Signature or Personal Representative _____ Date _____

Print Name _____ DOB_____