

Harmony Health Services Patient Medical History Form--Male

Name: _____ Date of Birth: _____

Reason for Visit Today: _____ Occupation: _____

Referred by: _____ PCP: _____ Marital Status: S M D

Medical History

Have you ever been treated for the following medical problems (please circle):

High Blood Pressure	Rheumatic Fever	Psychiatric Problems
Urinary Infections	Deep Vein Thrombosis	Ulcers
Migraines/Headaches	Heart Disease	Asthma
Breast Problems	Sidney Stones	Seizures
Hepatitis (Jaundice)	Heart Murmur	Stroke
Diabetes	Thyroid Disease	Ulcer

Other: _____

Have you ever been hospitalized: Yes No If yes, please list dates/locations and reasons:

Have you ever had any surgeries: Yes No If yes, list dates/procedures/locations and any complications:

Have you ever had a blood transfusion: Yes No If yes, what was the reason:

Allergies: _____

Current Medications: _____

Family History

Has anyone in your family had (please circle the following, if yes, list relationship/age)

Cancer: Colon _____ Prostate _____
Testicular _____ Other _____

Blood Clotting Problems	Heart Attack/Disease	Osteoporosis
High Blood Pressure	Thyroid Disease	Diabetes
Stroke		

Do you smoke: Yes No Do you drink: Yes No If yes, how many in an average week? _____

Do you use any recreational drugs: Yes No If yes, which ones: _____

Do you exercise regularly: Yes No

Signature

Date

Harmony Health Services
1620 25th Street, Bedford, IN 47421

I hereby authorize Harmony Health Services to obtain information from the following:

Physician/Hospital: _____

Address: _____
City State Zip

Phone: _____

Fax: _____

(If you are requesting records from ore than one facility of physician, please ask for additional forms)

I am requesting the release of the following:

____ Statement of charges and/or payments

____ Records of all visits

____ Record of visit for specific date(s): _____

____ Discharge Summary

____ History & Physical

____ Operative Report

____ Other, Please specify: _____

Information to be released to:

Harmony Health Services

Erica Scheffer, MD

Ariel J. Gonzalez, MD

1620 25th Street

Bedford, IN 47421

812.279.6790

812.279.6791

This authorization is given freely with the understanding that:

1. Any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. That a photocopy or fax of this authorization is as valid as an original.
3. That I may revoke this authorization at any time, except where information has already been released. This authorization is valid for sixty (60) days from the date it is signed, or sooner if noted below.
4. I agree to pay Harmony Health Services for any costs incurred in preparing the copy of the requested record(s). Fees available upon request.

Patient's Name Printed

Date

Patient's Signature (Guardian)

Social Security Number

Witness

PHARMACY VERIFICATION

NAME: _____

PHARMACY: _____

DATE: _____

The pharmacy that you have chosen above will be the pharmacy that all of your medications will be sent to.

If you decide to use another pharmacy, you will need to come in and sign a new form. No medications will be sent to a pharmacy other than the one you have on file with us.

Our policy is that all prescription refills require a 24 hour notice.

Please check with your pharmacy 24 hours after you have contacted our office for the refill. If the pharmacy does not have the prescription, please have the pharmacy call the office.

We only need one call for your prescription refill. We ask that you do not call our office multiple times.

Thank you.

Harmony Health Services

Consent for Communication Health Information to Personal Representatives

Name: _____

Address: _____

City, State, Zip Code

Telephone Number: _____

Date: _____

I, give my written consent for Harmony Health Services to share information regarding my protected Health Information (HIPAA) and care to the following listed person(s). I understand that these person(s) may be treated as personal representative(s) of myself.

Personal Representative(s) that you may share my health information with:

Name	Relationship	Telephone Number
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Name	Relationship	Telephone Number
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Name	Relationship	Telephone Number
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You may leave a message (please check all that apply)

_____ at home

_____ at work

_____ answering machine/voice mail

Verification Data: _____

Mother's Maiden Name

_____ City of Place of Birth

Patient's Signature

Date

Witness