PRIORITY HEALTH
NORTHWEST

Medical History

Full Name: _____ Birth Date: _____

Allergies (Please add reaction/severity)

Medications (Please add dosages and directions)

If you need more room to list allergies and medications, please write them on the back of this form. You may also attach a med list.

Personal Medical History

Disease/Condition	Current ☑	Past ☑
Alcoholism		
Asthma		
Cancer		
Depression/Anxiety		
COPD		
Heart Disease		
High Blood Pressure		
High Cholesterol		
Hypothyroidism		
Renal Disease		
Stroke		
Migraines		
Other		
Other		

Surgeries

Type	Date	Location

Tobacco Use	
Do you smoke? ◯Yes ◯No	◯Current ◯Past
Packs/Day:	# of years:
Other: ◯ Chew ◯Vape	
Alcohol/Drug Use	
Do you drink alcohol? ◯Yes ◯No	# of drinks/week:
◯ Beer ◯ Liquor ◯Wine	
Do you use marijuana or recreational drugs? ◯Yes ◯ No	

Social History, Habits, and Relationship status (Please check all that applies to you)

Are you ◯ working full time, ◯ working part time, ◯ a student, ◯ retired, or ◯ unemployed?
If you are employed, what is your occupation?
Do you have any major stresses in your life? ◯ Work ◯ Marriage/Relationship ◯Finances ◯ Other:
Do you feel safe in your home? ◯ Yes ◯ No. Do you feel you have ever been abused? ◯ Physically ◯ Sexually ◯ Emotionally
Do you have a yearly dental exam ◯ Yes ◯No. Approximate date of last dental exam:
Do you have a yearly eye exam ◯Yes ◯No. Approximate date of your last eye exam:
Do you exercise? ◯Yes ◯No. How often do you exercise per week?
Describe your eating habits. ◯ Good ◯ Fair ◯ Poor ◯ Gluten free ◯ Vegan ◯ Other
Relationship status: ◯Married ◯Single ◯ In a relationship ◯ Divorced/Separated ◯ Widowed
Do you have any children? ◯ Yes ◯ No. How many?

Please continue to the back of the form. Thank you!

PRIORITY HEALTH
NORTHWEST

Please list any other providers/specialists that are taking care of you and their facility information. Examples: Primary Care Physicians, Cardiologists, Nephologists, Endocrinologists, Psychologists, etc...

Family History ◯ Please check here if no significant family history is known.

Check all that apply (Please specify M for maternal or P for paternal grandparents)	Alcohol	Asthma	Cancer	Depression/ Anxiety	Diabetes	Heart Disease	High Cholesterol	Hypertension	Kidney Disease	Stroke	Thyroid Disease	Other ___
Mother												
Father												
Siblings												
Children												
Grandpa												
Grandma												

If you marked Cancer for any family member please indicate what type of cancer: _____

Please write additional medications, allergies, and surgeries here. Thank you!

Reviewing Provider: _____
(Signature)

PRIORITY HEALTH
NORTHWEST

Pediatric Medical History

Full Name: _____

Birth Date: _____ Age: _____

◯ Check if your child has NO known allergies.

Allergies (Please add reaction/severity)

◯ No active meds.

Medications (Please add dosages and directions)

If you need more room to list allergies and medications, please write them on the back of this form. You may also attach a med list.

Personal Medical History ◯ Check if none apply.

Disease/Condition	Current ☑	Past ☑
Alcoholism		
Asthma		
Cancer		
Depression/Anxiety		
COPD		
Heart Disease		
High Blood Pressure		
High Cholesterol		
Hypothyroidism		
Renal Disease		
Stroke		
Migraines		
Other		
Other		

Surgeries ◯ No surgeries

Type	Date	Location

◯ Doesn't apply to my child.

Tobacco Use (This form is used for 0-18. Please check "doesn't apply" above if this section doesn't apply to your child.)	
Do you smoke? ◯Yes ◯No	◯Current ◯Past
Packs/Day:	# of years:
Other: ◯ Chew ◯Vape	
Alcohol/Drug Use	
Do you drink alcohol? ◯Yes ◯No	# of drinks/week:
◯ Beer ◯ Liquor ◯Wine	
Do you use marijuana or recreational drugs? ◯Yes ◯ No	

Social History, Habits, and Relationship status (Please check all that applies to you)

Was the patient adopted? ◯Yes ◯No
Delivery: ◯Vaginal ◯Cesarean ◯ Full Term ◯ Premature
Do you have a yearly dental exam ◯ Yes ◯No. Approximate date of last dental exam:
Do you have a yearly eye exam ◯Yes ◯No. Approximate date of your last eye exam:
Describe the patient's eating habits. ◯ Good ◯ Fair ◯ Poor ◯ Gluten free ◯ Vegan ◯ Other
Are the patient's immunizations up to date? ◯ Yes ◯No
Are there any concerns of abuse? ◯Yes ◯ No
Do you have any concerns about your child's behavior? ◯Yes ◯No
Parent's Relationship status: ◯Married ◯Single ◯ In a relationship ◯ Divorced/Separated ◯ Widowed
Is your child enrolled in daycare or school? ◯ Daycare ◯ Preschool ◯ Elementary ◯ Middle ◯ High ◯ Homeschooled

Please continue to the back of the form. Thank you!

PRIORITY HEALTH
NORTHWEST

Please list any other providers/specialists that are taking care of you and their facility information. Examples: Primary Care Physicians, Cardiologists, Nephologists, Endocrinologists, Psychologists, etc...

Family History ◯ Please check here if no significant family history is known.

Check all that apply (Please specify M for maternal or P for paternal grandparents)	Alcohol	Asthma	Cancer	Depression/ Anxiety	Diabetes	Heart Disease	High Cholesterol	Hypertension	Kidney Disease	Stroke	Thyroid Disease	Other ____
Mother												
Father												
Siblings												
Children												
Grandpa												
Grandma												

Please write additional medications, allergies, and surgeries here. Thank you!

Reviewing Provider: _____
(Signature)

Registration

PRIORITY HEALTH
NORTHWEST

Name_____ Date of Birth _____/_____/_____ Pharmacy_____
First Middle Last Month Day Year
Social Security #_____-_____-_____ Email Address_____
Address _____ City_____ State _____ Zip_____
Home Ph. (____) _____ Business Ph. (____) _____ Cell Ph. (____) _____
◯ Married ◯Single ◯Widow ◯ Divorced Gender: ◯Male ◯Female
Employer Name_____ ◯Full-Time ◯Part- Time ◯Retired ◯Self- Employed
◯Student- Fulltime ◯ Student- Part-time

Responsible Party (If different from patient)

Name_____ Relationship_____
First Middle Last
Social Security #_____-_____-_____ Date of Birth _____/_____/_____
Address _____ City _____ State _____ Zip_____
Home Ph. (____) _____ Business Ph. (____) _____ Cell Ph. (____) _____

*********Notify in Case of Emergency**********

Name_____Relationship_____ Phone # _____

Disclosure and Consents

As required by the Health Insurance Portability Act of 1996, Priority Health Northwest, PLLC may not use or disclose your health information except as provided in our Note of Privacy Practices without our authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information as described in the above notice.

Assignment of Insurance Benefits:

I hereby authorize direct payment of my insurance benefits to Priority Health Northwest, PLLC or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are covered benefit. I understand and agree that I will be responsible for any co-pay or balance due Priority Health Northwest, PLLC is unable to collect from insurance carrier for whatever reason.

Medicare/Medicaid/Tricare Insurance Benefits:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Priority Health Northwest, PLLC or the physician on my behalf.

Authorization to Release Non-Public Personal Information:

I certify that I have received and read a copy of the Priority Health Northwest, PLLC Patient Information Privacy Policy. I hereby authorize Priority Health Northwest, PLLC or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary from medical evaluation, treatment, consultation, or the processing of insurance benefits.

Some Lab/Diagnostic Services are sent to outside Laboratories for further testing. These services will be billed directly to you and or your insurance by the outside provider. You will be financially responsible for any co-pay or balance due for these services if they are not reimbursed by your insurance for whatever reason.

I hereby consent to evaluation, testing, and treatment directed by Priority Health Northwest, PLLC or his or her designee.

➡ **Patient Signature**_____ **Date**_____

(If different from patient) Guarantor Signature_____ Date_____
Guarantor Name and relationship to patient. (Please Print) _____

(Optional) Authorization:
I authorize _____to have access to my records/call for any questions.
Signature: _____ Date: _____

Priority Health Northwest
1800 Norris Place
Spencer, IA 51301
712-580-4570
Fax: 712-580-4573

Patient Name _____ DOB _____
Address _____ SSN# _____

I authorize the use or disclosure of the above-named individual's health information as described below. The following individual or organization is authorized to make the disclosure:

Name _____ Phone# _____
Address _____

The type and amount of information to be used or disclosed is as follows:

Date of service from (date) _____ to (date) _____

_____ Standard Chart Copy
(Includes physician dictated reports, All test results)
_____ Entire Record
_____ Other

_____History and Physical
_____Discharge Summary
_____Lab work
_____ X-ray and imaging reports
_____ EKG
_____Operative report
_____Pathology report

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, or treatment for alcohol and drug abuse.

The information may be disclosed to and used by the following individual or organizations"

Name:_____ Fax:_____ Phone: _____
Address: _____

For the purpose of: continued healthcare ___X_____ personal _____
I understand I have a right to revoke this authorization at any time by presenting a written revocation to Priority Health Northwest, PLLC. I understand the revocation will not apply to: 1. Information already released in response to this authorization 2. My insurance company when the law provides my insurer with the right to consent a claim under my policy.

Unless otherwise revoked, this authorization will expire a year from the date of signature.

Signature of patient or legal representative _____
Date signed _____
If signed by legal representative, relationship to patient _____