William Newton
HILLSIDE
FAMILY MEDICINE

Alvin D. Bird, DO	Hope Guerrero, APRN	Rodrick Heger, DO	Jennifer Satterlee, APRN

Welcome to our Clinic

Patient First Name	Last Name
Date of Birth	Social Security Number

Gender: Male Female	Race	Marital Status: S M W D Separated
Preferred Contact Method: Email Phone Postal Patient Portal	Appt. Notification Contact Method: Email Text Call Primary Call Cell Call Work	Email

Street Address	City	State	Zip

Primary Phone #	Work Phone #	Mobile/Other Phone #

Emergency Contact Last Name, First Name	Relationship	Phone #

Guarantor Name		Patient's Relationship to Guarantor
Date Of Birth	Social Security #	Address
Primary Phone #	Work Phone #	Employer

Employer	Occupation	City, State, ZIP

Insurance Information	Secondary Insurance Name
Insurance Company:	Insurance Company:
Policy #:	Policy #
Subscriber Name:	Subscriber Name:
Subscriber DOB:	Subscriber DOB:
Please Check here if NO Insurance: ☐	Please Check here if NO Insurance: ☐

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Patient Name:	DOB:

PERSONAL MEDICAL HISTORY: PLEASE MARK ALL THAT APPLY

ADHD	COPD/Emphysema	High Cholesterol	Rheumatoid Arthritis
Alcoholism	Dementia	HIV	Seizure Disorder
Allergies, Seasonal	Depression	Hepatitis	Sleep Apnea
Anemia	Diabetes: 1 or 2	Irritable Bowel Syndrome	Stroke
Anxiety	Diverticulitis	Lupus	Thyroid Disorder
Arrhythmia	DVT	Liver Disease	Ulcerative Colitis
Arthritis	GERD	Macular Degeneration	Neuropathy
Asthma	Glaucoma	Osteoporosis	**Other not listed:**
Bipolar	Heart Disease	Osteopenia	
Bladder Problems	Heart Attack	Parkinson's Disease	
Bleeding Problems	Hiatal Hernia	Peripheral Vascular Disease	
Cancer:			
Headaches	High Blood Pressure	Peptic Ulcer	
Kidney Stones	Psoriasis	Crohn's Disease	
Kidney Disease	Pulmonary Embolism		

Allergies:

Drugs:
Food
Other: (bees, pets, etc.)

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Patient Name	DOB

SURGICAL HISTORY: PLEASE LIST ALL PRIOR SURGERIES AND APPROXIMATE DATES PERFORMED:

Surgery	Date

HOSPITAL ADMISSIONS OR RECENT EMERGENCY ROOM/URGENT CARE VISITS THIS YEAR:
Month/Year

Admission/ER/UR	Month	Year

ADULT IMMUNIZATIONS:

Immunization	No	Yes	Date: Month/Year
Pneumococcal 13 (Prevnar 13)			
Pneumococcal 23 (Pneumovax)			
Tetanus and Diptheria (TD)			
Tetanus and diphtheria toxoids and acellular pertussis vaccine (PPSV23)			
Zoster vaccine, recombinant (RZV)			
Zoster vaccine live			
Human papillomavirus vaccine (HPV)			

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Patient Name:	DOB:

Last Menstrual Period	Date	Normal Abnormal
Colonoscopy	Yes / No Date:	Normal Abnormal
Mammogram	Yes / No Date:	Normal Abnormal
Dexa (Bone Density)	Yes / No Date:	Normal Abnormal
PSA	Yes / No Date:	Normal Abnormal

	Frequency
Tobacco Use	
Alcohol Use	
Drug Use	
Caffeine	
Exercise	

Medication	Dosage	Frequency

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Patient Name:	**DOB:**

Preferred Pharmacy: List all Pharmacies used local and home delivered

Pharmacy Name:	**Address**	**Phone Number**

SOCIAL / CULTURAL HISTORY:

Education Level	Elementary	High School	Vocational	College	Graduate/Professional

Do you have any vision problems that affect your communication? ☐ **Yes or** ☐ **No**

Do you have hearing problems that affect your communication? ☐ **Yes or** ☐ **No**

Do you have any limitations to understanding and / or following instructions? ☐ **Yes or** ☐ **No**

Who lives in the home:

Number of Children:

List any family medical history:

Condition/Disease	Mother	Father	Sibling	Grandparent (maternal/paternal)

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Patient Name:	**DOB:**

Authorization to release information:
I authorize for information regarding my medical care to be released to the following person(s) if he or she so requests:

Name	Relationship to patient	Phone number

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I authorize the release of any information required for claim(s) submission to my insurance company(s). I also authorize that payments be made directly to WN Hillside Family Medicine

Signature: _____ Date: _____

Parent, if minor: _____ Date: _____

**Please return completed form to WN Hillside Family Medicine

**Allow 7-10 days for processing.

Office Use Only:

Approved	Denied	Appointment scheduled: Date / Time
Initials	Initials	Patient Notified By:

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AUTHORIZATION FORM FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Phone Number: _____ Other Names Used: _____

Name of Guardian or Legal Representative: _____

Person/Facility/Organization Authorized to Release Information:

_____

Person/Facility/Organization Authorized to Received Information:
William Newton Hillside Family Medicine Address: 1700 E Ninth, Winfield, KS 67156
Phone Number: 620-221-0110 Fax Number: 620-221-0623

The following health information that relates to services beginning on:

_____ to _____ may be released

□ Complete Chart □ Visit Notes □ Patient Summary □ Lab Results

□ X-Ray Results □ Itemized Bill □ Other

Reason for Disclosure:
□ Continuum of Patient Care □ Transfer of Patient Care □ Personal

This authorization is valid for one year following the date of my signature below.

I understand that I have a right to revoke this authorization at any time by presenting a written revocation to the Medical Record Department. I understand the revocation will not apply to information already released in response to this authorization or my insurance company when the law provides my insurer with the right to contest a claim under my policy.

- Unless otherwise revoked, this authorization shall remain in effect for one year from today's date or on the expiration date indicated above for records generated as a result of services occurring on or prior to this date.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to assure treatment.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentially laws.

_____ _____
Signature of Patient or Legal Representative Date

Relationship to patient: _____