

Personalized Prevention

Your Family & Heart Care
Rhonda Hettinger DNP, NP-C, CLS

Patient Information

Name (First M. Last): _____

Address: _____

City/ State/ Zip: _____

Date of Birth: _____

Social: _____

Sex (Circle One): Male Female

Marital Status (Circle One): Single Married Widowed Divorced

Spouse's Name: _____

Home Telephone: _____

Cell Telephone: _____

Work Telephone: _____

Employer: _____

Email: _____

(Email if you would like us to send you email reminders of appointment)

Emergency Contact Information (Name, Phone Number, Relation and Address):

Primary Insurance

Insurance Company: _____

Policy/ ID Number: _____ Group: _____

Carrier of Insurance: _____

If carrier of insurance is different than patient, please fill out below:

Name: _____

Date of Birth: _____ Social Security Number : _____

Relationship to Patient: _____

Secondary Insurance

Insurance Company: _____

Policy/ ID Number: _____ Group: _____

Carrier of Insurance: _____

If carrier of insurance is different than patient, please fill out below.

Name: _____

Date of Birth: _____ Social Security Number: _____

Relationship to Patient: _____

I hereby assign, transfer, and set over to Your Family and Heart Care Center with Personalized Prevention, all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I hereby consent to routine diagnostic procedures and medical treatment provided through Your Family and Heart Care Center with Personalized Prevention and I understand procedures and medical treatment provided through Your Family and Heart Care Center with Personalized Prevention and I understand that no guarantee of results has been made. Patients who fail to present for a scheduled appointment, without contacting the office 24 hours prior to their appointment, will be considered a "no show". A fee of \$25.00 will be charged directly to the patient, not the insurance. Patients who are assessed a "no show" fee MUST pay this fee before their next appointment is scheduled.

Patient Signature: _____

Date: _____

In accordance with the HIPPA Guidelines, I hereby authorize Your Family and Heart Care Center with Personalized Prevention to discuss my medical information with the following:

Name	Relationship	Phone
1. _____		
2. _____		
3. _____		

I hereby authorize Your Family and Heart Care Center with Personalized Prevention to leave a detailed message on my answering machine.

Yes _____ Phone Number _____ No _____

Your Family and Heart Care Center with Personalized Prevention is concerned about the privacy of our patient's health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

I acknowledge that I have received the Notice of Privacy Practices for:

Your Family and Heart Care Center with Personalized Prevention

Name of Patient (Please Print): _____

Patient Signature or Authorized Representative: _____

Date: _____

Patient History Form

Name: _____

Date of Birth: _____

Please fill out this form answering all the questions, even if you have filled this form out previously. This information is important to update your history prior to your appointment.

Past Medical History: (Please circle yes or no- Do not leave blank.)

Heart Disease	Yes or No	Lung Condition	Yes or No
Stroke	Yes or No	Thyroid Condition	Yes or No
Heart Attack	Yes or No	Diabetes	Yes or No
Angioplasty/ Stent	Yes or No	Kidney/ Bladder Illness	Yes or No
Open Heart Surgery	Yes or No	Stomach/ Colon Illness	Yes or No
Heart Palpitations	Yes or No	Cancer	Yes or No
Heart Valve Disease	Yes or No		
High Blood Pressure	Yes or No		
High Cholesterol	Yes or No		
If female, have you completed menopause?	Yes or No		

Date of Last Mammogram: _____ Date of Last Eye Exam: _____

Date of Last Colonoscopy: _____ Date of Last Gynecological Exam: _____

Please list any surgeries you have had:

Family Medical History:

Heart Disease	Yes or No	Father	Mother	Brother	Sister
Diabetes	Yes or No	Father	Mother	Brother	Sister
Stroke	Yes or No	Father	Mother	Brother	Sister
High Blood Pressure	Yes or No	Father	Mother	Brother	Sister

Is your father still living? Yes or No age/ cause of death _____

Is your mother still living? Yes or No age/ cause of death _____

Number of brothers or sisters still living _____

Number of brothers or sisters deceased _____

Social History:

Smoking Yes or No

Past Smoker Yes or No Packs per day _____ Date quit smoking _____

Alcohol Use Yes or No How often _____

Review of Symptoms

Name _____

General

- Fever
- Weight loss
- Weight gain
- Weakness / fatigue

HEENT

- Headaches
- Nose bleeds
- Eye pain
- Blurred vision
- Ear pain
- Hoarse voice
- Sore throat
- Congestion

Neck

- Stiffness / pain
- Swollen glands

Lung

- Shortness of air
- Wheezing
- Cough
- Coughing up blood

Heart

- Chest pain
- Palpitations
- Fast heart rate
- Passing out
- Short of air lying flat
- Swelling

Stomach

- Nausea
- Vomiting
- Change in appetite
- Pain or cramping
- Heartburn
- Diarrhea
- Constipation
- Change in bowels
- Blood in stool

GU

- Painful urination
- Frequent urination
- Blood in urine
- Strong odor to urine
- Frequent UTI's

Musculoskeletal

- Muscle / Joint pain
- Muscle weakness
- Joint swelling
- Leg swelling
- Numbness
- Tingling
- Pain injections

Skin

- Rash
- Skin discolored
- Hair loss

Neurologic

- Headache
- Dizziness
- Tremors
- Involuntary tremors
- Unsteady walking

Endocrine

- Always thirsty
- Always cold
- Always warm
- Blurred vision

Blood / Lymphatic

- Easy bruising
- Swollen glands

Allergy

- Frequent infections
- Seasonal allergies

Psychiatric

- Depression
- Anxiety
- Change in sleep
- Change in thoughts

Women

- Menopausal
- Decreased libido
- Vaginal dryness
- Sleep difficulties
- Hot-flashes
- Anxiety
- Fatigue
- Orgasm difficulties

Men

- Fatigue
- Decreased libido
- Erectile dysfunction
- Weak urinary stream
- Weak ejaculation
- Orgasm difficulties



Rhonda Hettinger DNP, NP-C
1615 Blackston View Drive, Suite E
Clarksuille, Indiana 47129

Phone: 812-725-1550
Fax: 812-725-1553
www.yourpersonalprevention.com

Authorization to Release Information and Payment

I authorize Your Family and Heart Care Center Care with Personalized Prevention LLC to bill my insurance carrier on my behalf for services rendered. I understand that I am financially responsible for any amount not covered by my insurance carrier. I authorize Your Family and Heart Care Center Care with Personalized Prevention LLC to release to my insurance carrier any information concerning my health care, advice, treatment, or supplies provided which may be necessary to secure payment of these claims.

Patient Printed Name: _____

Patient Signature: _____

Date: _____