

Patient Information Form

Name: FIRST _____ MIDDLE INITIAL _____ LAST _____

Preferred Name_____Date of Birth_____Marital Status_____

Sex: _____ Social Security # _____

Address: _____

City: _____ State:_____Zip:_____

Home Phone Number: _____-_____-_____ Cell Phone Number: ___-___-____

Work Phone Number: _____-_____-_____ Preferred Number: _____

Email Address: _____

Employer: _____

Race_____Ethnicity_____

Preferred Language_____

Preferred Pharmacy_____

Guarantor/Responsible Party Name (if different): _____

Guarantor Address: _____

Insurance Type: _____

Policy ID: _____ Group Number: _____

Policy Holder: _____Policy Holder Birthdate_____

Emergency Contact:_____

Relation to patient: _____ Phone Number: ___-___-____

Lincoln Family Wellness, P.C.

Authorization for Release of Information to Family Members

Patient Name:_____ DOB:_____

SSN:_____ Address:_____

Contact Phone Number:_____

I,_____ (Patient Name), direct Lincoln Family Wellness, PC to disclose and release my protected health information described below to:

Name:_____ Relationship:_____

Address:_____ Contact Phone Number:_____

Health Information to be disclosed upon the request of the person named above:

☐ Disclose my complete health record (including but not limited to diagnosis, test results, medications, plan of treatment and billing for all conditions).

☐ Disclose my health record, as above, But DO NOT disclose the following (check all that apply):

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please Specify): _____

The authorization shall be effective until revoked. This includes all past, present and future periods unless otherwise specified.

You may revoke this authorization in writing at any time by notifying our office, preferably in writing.

Patient/Guardian Signature:_____ Date:_____

Lincoln Family Wellness, P.C.

Michelle K. Manning, M.D. • Janet K. Sellon, M.D. • Timothy J. Dalton, M.D. • C. Kyle Haefele, M.D.
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1101 South 70th Street Suite 101
Lincoln, NE 68510

Full Name: _____ **DOB:**_____ **Date:**_____

HEALTH HISTORY FORM

ALLERGIES ☐ No Allergies

Allergy	Allergic Reaction

MEDICATIONS/SUPPLEMENTS *ATTACH LIST IF NEEDED*

Medication (including strength)	Dose	Times Per Day

SURGERIES/HOSPITALIZATIONS *ATTACH LIST IF NEEDED*

Reason	Year	Surgeon	Facility

PERSONAL MEDICAL HISTORY

Disease/Condition	Current	Past
ADHD/ADD		
Alcoholism		
Asthma		
Cancer		
Depression/Anxiety		
Diabetes		
COPD/Emphysema		
Heart Disease		

Disease/Condition	Current	Past
High Cholesterol		
Thyroid Disease		
Renal (Kidney) Disease		
Migraine Headaches		
Sleep Apnea		
Stroke		
OTHER:		

SPECIALISTS *ATTACH LIST IF NEEDED*

Specialist Type	Specialist Name	Last Visit

PLEASE COMPLETE BOTH SIDES.
ARRIVE 15 MINUTES PRIOR TO SCHEDULED APPOINTMENT TIME WITH YOUR PHOTO ID AND INSURANCE CARD

Full Name: _____ **DOB:**_____ **Date:**_____

FAMILY HISTORY ☐ **UNKNOWN** ☐ **ADOPTED** ***ATTACH LIST IF NEEDED***

Family Member	Year Of Birth	Age of Death	Healthy	Cancer	Heart	Stroke	Diabetes	Other
Father								
Mother								
Sibling M or F								
Sibling M or F								
Child M or F								
Child M or F								

SOCIAL HISTORY

Marital Status:_____ **Occupation:**_____

Tobacco/Nicotine Use

☐ Current Type:_____ How much per day:_____

☐ Past Type:_____ How much per day:_____ Quit Date:_____

☐ Not Applicable

Second Hand Smoke Exposure

☐ Current ☐ Past ☐ Not Applicable

Drug Use

☐ Current Type:_____

☐ Past Type:_____ Quit Date:_____

☐ Not Applicable

Alcohol Use

☐ None in the past 12 months

☐ Current How often: _____ How many at a time:_____

Ever more than 6 on one occasion and if so how often: _____

Caffeine Intake

☐ Yes Type: _____ How many cups per day: _____

☐ No

Exercise

☐Yes How often:_____ Type:_____

☐No

HEALTH MAINTENANCE HISTORY ****ATTACH IMMUNIZATION LIST IF AVAILABLE****

Test	Date	Facility	Results
Pap Smear			
Mammogram			
Colonoscopy			
PSA			
Bone Density			

Lincoln Family Wellness, P.C.

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient:

Full Name: _____

Other Name(s) Used: _____ Date of Birth: _____

Address: _____ City: _____ State: ____ Zip: _____
Phone: (____) _____

Name of practice where records reside:

Name: _____

Address: _____ City: _____ State: ___ Zip _____

Phone: (____) _____ Fax: (____) _____

Information to be released to:

Lincoln Family Wellness
1101 S 70th St Suite 101
Lincoln, NE 68510
Phone: 402-488-1400 FAX: 402-488-3879

Specific information to be disclosed:

□ Medical Record from date _____ to date _____

□ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.

□ Other: _____

Include: ***(Indicate by Initialing)***

_____ Drug, Alcohol or Substance Abuse Records

_____ Mental Health Records (Except Psychotherapy Notes)

_____ HIV/AIDS-Related Information (Including HIV/AIDS Test Results)

_____ Genetic Information (Including Genetic Test Results)

Reason for release of information:

(Choose all that Apply)

□ Treatment/Continuing Medical Care

□ Personal Use

□ Insurance

□ Legal Purposes

□ Disability Determination

□ School

□ Employment

□ Other *(Specify)*: _____

The individual signing this form agrees and acknowledges as follows:

(i) **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(ii) **Effective Time Period:** This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date: Month: _____ Day: _____ Year: _____.

(iii) **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

(iv) **Special Information:** This authorization may include disclosure of information relating to **DRUG, ALCOHOL** and **SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

(v) **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:

Patient/Legal Representative: _____ Date: _____

If Legal Representative, relationship to _____

Witness (optional): _____ Date: _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Signature of Minor (if applicable): _____ Date: