OLYMPUS FAMILY MEDICINE

PATIENT INFORMATION UPDATE

PATIENT INFORMATION

FULL NAME: ____
LAST FIRST MI

DATE OF BIRTH: ______/______/______ SOC SEC #: ______-______-______
MM DD YYYY

ADDRESS: ______________________________ HOME PHONE: ______________
STREET

______________________________ CELL PHONE: ______________
CITY STATE ZIP

EMAIL: ______________________________ WORK PHONE: ______________

EMPLOYMENT: ______________________________

MARITAL STATUS: S M D W PARTNER NAME: ______________________________
LAST FIRST MI

EMERGENCY CONTACT: ______________________________ PH #: ______________
LAST FIRST MI

PREFERRED PHARMACY (name & location): ______________________________

PRIMARY INSURANCE PLAN COMPANY: ______________________ INS PLAN PHONE: ______________

GROUP ID #: ______________ SUBSCRIBER ID #: ______________ COPAY: ______________
(POLICY NUMBER)

PRIMARY INSURED'S NAME: ______________________ PRIMARY'S DOB: ______/______/______
LAST FIRST MI MM DD YYYY

PATIENT'S RELATIONSHIP TO PRIMARY: SELF CHILD SPOUSE OTHER: ______________

SECONDARY INSURANCE PLAN COMPANY: ______________________ INS PLAN PHONE: ______________

GROUP ID #: ______________ SUBSCRIBER ID #: ______________ COPAY: ______________
(POLICY NUMBER)

PRIMARY INSURED'S NAME: ______________________ PRIMARY'S DOB: ______/______/______
LAST FIRST MI MM DD YYYY

PATIENT'S RELATIONSHIP TO PRIMARY: SELF CHILD SPOUSE OTHER: ______________

HEALTH INFORMATION

DATE OF LAST PHYSICAL EXAM: ______________ DATE OF LAST PAP SMEAR: ______________

IN THE LAST 6 MONTHS, HAVE YOU HAD ____ LAB WORK ____ X-RAYS/CT/MRI/ULTRA SOUND ____ MAMMOGRAM

IF YES, PLEASE EXPLAIN: ______________________________

CURRENT MEDICATIONS

PLEASE LIST **ALL** MEDICATIONS YOU ARE TAKING (Ex: Zantac, 150 mg, once a day, heartburn)

Medication	Dosage	Frequency	Reason prescribed

PLEASE INDICATE ANY **CHANGES** IN YOUR HEALTH FROM YOUR LAST VISIT SUCH AS SURGERIES, HOSPITALIZATIONS, OR ILLNESSES. ______________________________

____

PATIENT SIGNATURE: ______________________________ DATE: ______________

OLYMPUS FAMILY MEDICINE

ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and how your medical information can be used by the staff of *Olympus Family Medicine* in providing and arranging your medical care.

I hereby give consent for *Olympus Family Medicine* to use and disclose protected health information (PHI) about me to carry out treatment, payment, health care operations, and as otherwise allowed by law. The Notice of Privacy Practices provided by *Olympus Family Medicine* describes such uses and disclosures in detail. *Olympus Family Medicine* has the right to revise its Notice of Privacy Practices at any time and is available for review at www.OlympusMed.org or by my written request to *Olympus Family Medicine,* Notice of Privacy Request 4461 Coit Rd, Suite 307 Frisco, TX 75035.

HIPAA PRIVACY ACT INFORMATION RELEASE FORM

May *Olympus Family Medicine* release medical information to anyone other than you?

____ **YES**, PLEASE RELEASE INFORMATION TO: ____ **NO**, ONLY RELEASE INFORMATION TO ME.

Name: ______________________________

RELATIONSHIP: ______________________________

CONTACT #: ______________________________

EMAIL: ______________________________

NAME: ______________________________

RELATIONSHIP: ______________________________

CONTACT #: ______________________________

EMAIL: ______________________________

***OLYMPUS FAMILY MEDICINE* MAY LEAVE DETAILED INFORMATION VIA:**

____ CELL PHONE # ______________________________

____ VOICE MAIL/ HOME #______________ ______________

____ EMAIL (NON-ENCRYPTED) ______________________________

With this consent, *Olympus Family Medicine* may call and/or mail my home or alternate location, or call or text my cell phone, and leave a message on voice mail or answering machine in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminders, insurance items, and calls pertaining to my clinical care including laboratory test results, among others.

By signing this form, I acknowledge that I have reviewed *Olympus Family Medicine's* Notice of Privacy Practices; I consent to allow *Olympus Family Medicine* to use and disclose my PHI to carry out treatment, payment, and healthcare operations; and I have provided instructions regarding release of my individual healthcare information. I may revoke my consent in writing except to the extent that the practice has already made disclosures based upon my prior consent. If I do not sign this consent, or later revoke it, *Olympus Family Medicine* may decline to provide treatment to me.

______________________________ ______________

SIGNATURE OF PATIENT, PARENT, OR LEGAL GUARDIAN DATE

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PRINT NAME OF PATIENT