

PATIENT INFORMATION

Patient Name _____ Today's Date _____

Social Security# _____ Age _____ Date of Birth _____

Mailing Address: _____

Male Female Marital Status: S M W D Home Phone# _____

Work Phone # _____ Mobile Phone# _____

Hobbies: _____

Employer: _____ Occupation: _____

Email Address: _____

In case of Emergency Notify: _____

Relationship: _____ Phone: _____

PAST MEDICAL HISTORY

In this time of rapidly expanding medical knowledge and the increasing specialization associated therewith, there exists a very real risk of the specialist not being aware of the general health and medical background of the patient. On occasion, such information may critically affect what procedures we may safely undertake on you and under what circumstances. We therefore ask that you give us the following medical information.

General Health Good Fair Poor

If not good please explain: _____

Do you exercise regularly? Y N If yes, please explain: _____

Height: _____ Weight: _____ Recent Weight Change? Y N

Date of last: Check Up: _____ Chest X-ray: _____ EKG: _____

Name of Primary Care Doctor: _____

Serious Illnesses: _____

Previous Surgery: _____ Name of Surgeon: _____ Date of Surgery: _____

Complications of Surgery? _____

Past Injuries: _____

FAMILY HISTORY

Tuberculosis Y N

Cancer Y N

Diabetes Y N

Heart Disease Y N

Lung Disease Y N

Kidney Disease Y N

Mental Conditions Y N

Epilepsy Y N

Blood/Bleedings Disorders Y N

High Blood Pressure Y N

Asthma Y N

MEDICAL INFORMATION

Patient Name: _____ Today's Date: _____

Please list procedures being considered: _____

Please list all medications which you are currently taking or have used in the past 6 MONTHS. Be sure to include any of the following:

Birth Control Pills, aspirin, ibuprofen containing drugs, diet pills, diabetic medications, steroids, glaucoma drops, asthma medications, Digoxin, Lanoxin, nitroglycerin, Isordil, Inderal, other heart medications, Lasix, other diuretics, high blood pressure medications, Coumadin, Persantine, tranquilizers, sleeping pills, anti-depressants, pain pills or shots, epilepsy medications

List all medications currently taking or have taken in the last 6 months:

Name of Drug	Amount	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all Drug Allergies: _____

Have you ever used (circle) LSD / Speed / Cocaine / Marijuana? _____ Never _____

Are you a smoker? YES/NO _____ Ex-Smoker YES / NO _____ Non-smoker YES / NO _____

How much were you smoking? _____ Quit how long ago? _____

What is your consumption of Coffee/Tea _____ Tobacco _____ Alcohol _____

Please circle all of the following medical conditions you now have or have had in the past:

Bleeding tendency / hepatitis / diabetes / blood transfusions / glaucoma / dry eyes / TB
Lung disease / asthma or wheezing / emphysema / bronchitis / irregular heart beat / stroke
Chest pain / heart disease / heart attack / heart burn / intestinal ulcers or bleeding / depression
Mental illness / drug or alcohol addiction / HIV / AIDS / Sleep Apnea / C-PAP /
Other: _____ None of the Above _____

Is there any possibility that you might be pregnant at this time? YES / NO

Have you or anyone in your family ever had unusual reactions to anesthesia (muscle weakness, jaundice, breathing problems, or unexpected fevers)? YES / NO

Patient Signature: _____ **Date:** _____

Summary of Privacy Practices

This is a summary of our Notice of Privacy Practice, which describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted by law. It describes your rights to access and control of your Protected Health Information. We are required by law to maintain the privacy of your protected health information and to provide you with a notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time, and reserve the right to do so. The new notice will be effective for all protected health information that we maintain at that time.

We will use your protected health information as part of the rendering patient care, including treatment, payment, and healthcare operations. You authorize the release of pertinent information as part of medical care, as well as pertinent information as part of a health-care expense to include medical insurance companies, banking, finance companies and credit card companies.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or as required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use of the disclosure indicated in the authorization.

You have the right to request a restriction of your protected health information. You have the right to request confidential communications of your protected health information. You have the right to inspect any copy your protected health information. You're the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. You have the right to obtain a paper copy of this notice from us. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by calling 205-871-3361 or by email: info@paulhowardmd.com. Please include "HIPAA Patient Complaint" on the subject line. We will not retaliate against you for filing a complaint. This summary was published along with the Notice of Privacy Practices.

I, _____, acknowledge I have received or had available to me a complete copy of the Notice of Privacy Practices for the office of Dr. Paul S. Howard. I hereby authorize Dr. Paul S. Howard to use and/or disclose my protected health information in any manner deemed necessary to provide optimal patient care.

Signature of Patient

Date

Paul S. Howard, MD, FACS

There are many ways to communicate with you. It is important to keep appointments and let us know if problems or issues arise. Methods of communicating include telephone, texting, social media, pagers, answering service is available, email, and regular email.

If an emergency arises, keep us alerted to your progress so we may aid in any necessary treatments. Please do not leave a message after hours or on weekends if any urgent or emergent situation exists, as there is a delay in retrieving such messages. All attempts will be made to preserve your privacy in accordance with HIPAA rules.

Please confirm below all acceptable ways of communicating with you:

_____ Telephone
_____ Home #: (_____) - _____
_____ Work #:(_____) - _____
_____ Cell #: (_____) - _____

_____ Texting
_____ Social Media (i.e., Facebook, etc.)
_____ Pager/Answering Service if available
_____ Email: (_____ @ _____)
_____ Regular Mail & Delivery

Do you wish to receive Dr. Howard's Plastic Fantastic E-Newsletter?

___ YES ___ NO