HAPPI Health
813 Franklin Street Huntsville, AL 35801
2597 Sparkman Drive Huntsville, AL 35801
Franklin Phone: (256) 519-3650 Sparkman Phone: (256) 585-6212
Fax: (256) 585-6713

New Patient Form-ADULT Date: _____

Patient's Name_____
First Middle Last Nickname

_____
Date of Birth Social Security Number Gender Cell Phone (Does it receive text mgs? YES / NO)

_____
Street Address (include apt #, if any) City State Zip

_____
Alternate Phone Work Phone Employer Occupation

Spouse's Name_____
First Middle Last Nickname

_____
Address (if different) City State Zip Primary Phone (Include Area Code)

_____
Date of Birth Social Security Employer Emp. Phone

Preferred Pharmacy and street location: _____

Emergency Contact

_____
Contact's Name (1) Relationship Phone (Include Area Code)

_____
Contact's Name (2) Relationship Phone (Include Area Code)

Insurance Information

Insurance (1) _____
Contract # Group # Co-pay

_____
Guarantor Relationship to Patient D.O.B. SSN GENDER

Insurance (2) _____
Contract # Group # Co-pay

_____
Guarantor Relationship to Patient D.O.B SSN GENDER

Which method would be best for appointment reminders: Text Cell/Voice Mail Home Phone/Voice Mail
Email_____ Other_____

*We are required to collect Race, Ethnicity, and Preferred Language. If you prefer not to report that information, you may write the option "Refused/Unreported."

_____
Race Ethnicity Language

How Did You Hear About Us? WRSA-Lite 96.9 WZYP-104.3 WAFF-TV 48 WAAY-TV 31 Internet Yellow Pages
Other: _____

Patient Name: _____

MEDICARE PATIENTS: I authorize H.A.P.P.I. to release medical information about me to the Social Security Administration or its intermediaries for Medicare Claims. I assign the benefits payable for services to H.A.P.P.I. and understand that if I have questions or complaints that I should contact the Privacy Official.

Patient Initials: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I have been informed that a copy of HAPPI, Inc. Notice of Privacy Practices is posted in the waiting room area. A copy of this Notice will be furnished to me upon my request.

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996, (a Federal Law). Of significant concern to healthcare organizations is the Administrative Simplification section of the Act, which requires health care organizations to comply with specific rules regarding: unique identifiers for health plans, providers, individuals, employers, healthcare transaction & code sets for transmitting data electronically, privacy regulations over disclosure and use of health information. Security regulations over protections of electronic health information: It is our policy to NOT release confidential and/or unauthorized information except appointment confirmation by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager and the patient portal. Whenever returning phone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone.

I hereby authorize HAPPI, Inc. to leave medical information pertaining to my care by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager and the patient portal and will assume responsibility to notify them whenever this information changes.

May we fax medical records for your referrals? YES NO

Please list names of people with whom we may discuss your medical care or who may bring your child to an appointment:

Spouse Name: _____ Parent Name: _____

Other: _____

If we cannot release your medical information to anyone but you, please initial here: _____

REQUEST FOR MEDICAL CARE: I voluntarily consent to examination, lab evaluation, treatment and the rendering of care, including treatments and performance of diagnostic procedures. I grant my consent for treatment for myself, my spouse, or my minor children/dependent as listed on this form.

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I have received a copy of the practice's Privacy Notice and agree to follow these policies.

Patient or Guardian Signature: _____ Date _____

***All signatures will be kept on file for one calendar year; anytime your information changes, please notify the front desk. Medical paperwork will be updated on an annual basis.

Date:_____

Patient Name:_____ DOB:_____

Please check all conditions which you have had:

GENERAL
___ Serious Infections
___ (e.g. pneumonia)
___ Diabetes Mellitus
___ Rheumatic Fever
___ HIV Infection
___ Cancer (what type?)
___ Hearing Loss
___ Vision Loss

HEENT
___ Glaucoma
___ Allergies "hay fever"
___ Frequent Ear Infections
___ Frequent Sinus Infections

RESPIRATORY
___ Asthma
___ Emphysema

LYMPHATIC/ HEMATOLOGIC
___ Thyroid Goiter
___ Over Active Thyroid
___ Under Active Thyroid
___ Transfusions
___ Anemia

GI/GU
___ Kidney Stones
___ Kidney Failure
___ Prostate Disease
___ Endometriosis
___ Sexually Transmitted Infection

SKIN/BREAST
___ Acne
___ Eczema

CVS
___ High Blood Pressure
___ Congestive Heart Failure
___ Heart Murmur
___ Heart Valve Disease
___ Angina
___ Heart Attack
___ High Cholesterol
___ Abnormal Heart Rhythm
___ Blood Clots in Veins
___ Blocked Arteries in Neck
___ Blocked Arteries in Legs
___ Blood Clots in Lungs
___ Sleep Apnea

MUSCULOSKELETAL/ EXTREMITIES
___ Osteoporosis
___ Rheumatoid Arthritis
___ Degenerative Joint Disease
___ Fibromyalgia
___ Neck Pain (herniated disc)
___ Back Pain (herniated disc)

___ Stomach Ulcers
___ Ulcerative Colitis
___ Cohn's Disease
___ Bleeding from Intestines
___ Diverticulitis
___ Colon Polyps
___ Irritable Bowel Disease
___ Hepatitis
___ Cirrhosis of the Liver
___ Liver Failure
___ Pancreatitis
___ Gallstones
___ Psoriasis
___ Fibrocystic Breast Disease

NEUROLOGIC/PSYCHIATRIC
___ Chronic Vertigo (Meniere's)
___ Peripheral Nerve Disease
___ Migraine Headaches
___ Stroke
___ Multiple Sclerosis
___ Depression
___ Anxiety

Please indicate any surgeries you have had and the year you had them.

Year	Year	Year	Year
___ Angioplasty	___ Trauma Related Surgery	___ Stomach Surgery	___ Tubal Ligation
___ Carotid Artery Surgery	___ Back or Neck Surgery	___ Inguinal Hernia	___ C-Section
___ Other Vascular Surgery	___ Hip Surgery	___ Colonoscopy	___ Hysterectomy
___ Coronary Bypass Surgery	___ Knee Surgery	___ Gallbladder	___ Ovary Removed
___ Chest/Lung Surgery	___ Carpal Tunnel Surgery	___ Appendectomy	___ Breast Surgery
___ Tonsillectomy	___ Sinus Surgery	___ Prostate Surgery	___ Thyroid Surgery
___ Neurosurgery	___ Ear Surgery	___ Bladder Surgery	___ other

Please indicate when you last had any of the following preventive tests or services.

Year	Year	Year	Year
___ Cardiac Angiogram	___ Flu Vaccine	___ Prostate Cancer Blood Test	___ Mammogram/Breast Exam
___ Stress Test	___ Pneumonia Vaccine	___ Rectal Exam	___ Pap Smear
___ Echocardiogram	___ Tetanus Vaccine	___ Colon Cancer Stool Test	___ Date of Last Physical Exam
___ Chest X-Ray	___ Hepatitis Vaccine	___ Flexible Sigmoidoscopy	Other_____
___ EKG	___ Bone Density Test	___ Barium Enema	
X-ray_____	CT_____	MRI_____	

Please list any allergies or intolerance to drugs or other substances._____

_____

Please list the medications currently taken, including dosage and frequency:

_____

_____

_____

FAMILY MEDICAL HISTORY

Please check or list any major illness in your family members. (Mother, Father, Brothers, Sisters, or Children)

___ Tuberculosis	___ Diabetes Mellitus	___ Kidney Disease	____ Breast Cancer
___ Emphysema	___ Thyroid Disease	___ Epilepsy	____ Ovarian Cancer
___ Heart Disease	___ Anemia	___ Neurological Disorder	____ Colon Cancer
___ High Blood Pressure	___ Hemophilia	___ Liver Disease	____ Prostate Cancer
___ Osteoporosis	Other:_____	Other:_____	Other:_____

PERSONAL INFORMATION

Please write in or circle the information that applies to you:

Are you employed? _____ How many hours/wk.?_____ Occupation:

Education	Sexuality	Marital Status	Living Status	Diet	Exercise	Alt. Medicine
primary	heterosexual	single	alone	none	none	holistic
secondary	homosexual	married	w/ spouse	low fat	walking	chiropractic
college	bisexual	divorced	w/ parents	low chol	aerobics	homeopathy
post grad	transsexual	widowed	assisted living	low carbs	Weigh tlifting	acupuncture
doctorate		separated	nursing home	vegetarian	days/wk.	herbal

Tobacco
never/ past/ active

cigarette/ cigar/ pipe
never/ past/ active
snuff/ dip/ chew
Started_____
Quit_____
Amount per day_____

Alcohol
never/ past/ active

liquor/ wine/ beer
number of drinks_____
per day/ week/ month
AA/ Alcohol Rehab

Illicit Drugs
never/ past/ active

cocaine/ marijuana
heroin/ amphetamine
barbiturate/ LSD/ PCP
IV Drug abuse
NA/ Drug Rehab

Caffeine
never/ past/ active
coffee/ tea/ soda
number of drinks per day_____

How would you rate your overall health? Good Fair Poor

Do you see any specialists? If so, please list below.

Allergist:_____
Cardiologist:_____
Dermatologist:_____
ENT:_____
Endocrinologist:_____
Gastroenterologist:_____
Other:_____

Hematologist/Oncologist:_____
Neurologist:_____
Psychologist:_____
Pulmonologist:_____
Rheumatologist:_____
Urologist:_____

Have you travelled outside the United States in the last year? _____ If so, where? _____

I certify that the information collected in this paperwork is correct.

Signature: _____Date: _____