UPMC Hamot Physician Network

Medical History Form

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Current Job: _____ How long have your been in your current job: _____

Who lives in your house? (Family, Boarders, Friends) - _____

_____

Any special spiritual or religious needs? ☐ No ☐ Yes _____

Any special cultural needs? ☐ No ☐ Yes _____

What language is spoken at home? _____

Do you require an interpreter or special accommodations? ☐ No ☐ Yes (Please explain below)

_____

Please list your medications below, if you prefer you may provide an up-to-date list or bring all of your medication bottles

MEDICATION	DOSAGE	FREQUENCY

Preferred Pharmacy: _____

List any ALLERGIES (including reaction) to medications, x-ray dyes, foods or other substances? ☐**No known Allergies**

_____

_____

Medical History:

Please check the boxes of any problems you have had or are currently experiencing.

☐	Abnormal Bleeding	☐	Change in Appetite	☐	GERD	☐	Hypothyroid	☐	Seizures/Fainting
☐	Alcohol/Drug Problems	☐	Clotting Disorder	☐	Gout	☐	Inflammatory Bowel	☐	Sexual Problems
☐	Anemia	☐	Colitis	☐	Headaches/Migraines	☐	Irritable Bowel	☐	Sleep Apnea
☐	Anesthesia Complications	☐	COPD	☐	Hearing Problems	☐	Kidney disease	☐	Stomach Problems
☐	Anxiety/Nervousness	☐	Dental/Gum Disease	☐	Heart Attack	☐	Kidney Stones	☐	Stroke/TIA
☐	Arthritis	☐	Depression	☐	Hemorrhoids	☐	Liver Disease	☐	Trouble Urinating
☐	Asthma	☐	Diabetes	☐	High Blood Pressure	☐	Obesity	☐	Tuberculosis
☐	Blood Disorder	☐	Difficulty Sleeping	☐	High Cholesterol	☐	Phlebitis	☐	Venereal Disease/STD
☐	Blood in the Stool	☐	DVT/Blood Clots	☐	HIV/AIDS	☐	Pneumonia	☐	Viral Hepatitis
☐	Bowel Habit Changes	☐	Eye Problem	☐	Hives/Rashes	☐	Rheumatic Fever	☐	Weight Loss
☐	CAD/Heart Disease	☐	Gallbladder Disease	☐		☐		☐	
☐	Cancer (type and date):								
☐	Other:								

Hospitalizations/Surgical History:

Year	Surgeries or Illness	Year	Surgeries or Illness

Family History:

Please check all that apply ☐ History Unknown (adopted)

	No History	Mother	Father	Sister(s)	Brother(s)	Children
Adverse Anesthesia Reaction						
Alcohol/ Drug Problem						
Autoimmune Disorder (Lupus, Rheumatoid Arthritis)						
Bleeding Disorders or Blood Clots						
Cancer (Breast, Colon, Prostate, Ovarian, etc)						
Diabetes						
Heart Trouble						
Hypertension- High Blood Pressure						
High Cholesterol						
Mental Illness						
Neurological- (Alzheimer's, MS, Parkinson's, etc)						
Respiratory-(Asthma, COPD, etc)						
Stroke						
Thyroid Disease						
Deceased- indicate age at time of death						

Other Family History: _____

_____

Social History:

Tobacco Use: ☐ Never used tobacco products ☐ Former tobacco user

☐ Cigarettes - packs per day _____ ☐ Pipe ☐ Cigars

Smokeless Tobacco: ☐ Chew ☐ Snuff

Do you drink alcoholic beverages? ☐ No ☐ Yes If yes, how many drinks per week?_____

Do you use recreational drugs? ☐ No ☐ Yes If yes, what substance/ frequency?_____

Do you use smoke detectors in your home? ☐ No ☐ Yes Carbon Monoxide Detectors? ☐ No ☐ Yes

Do you wear seatbelts? ☐ No ☐ Yes Do you keep fire arms in your home? ☐ No ☐ Yes

Do you have a written Advance Directive or a Living Will? ☐ No ☐ Yes - If yes, please provide office with a copy

Do you ever feel afraid of your partner/ caretaker? ☐ No ☐ Yes

Do you have someone available to assist you in a time of need? ☐ No ☐ Yes

Health Maintenance History:

Immunizations and Tests: Check the box next to those you have had and indicate the year in the line provided.

- ☐ _____ Flu Shot
- ☐ _____ Pneumonia Vaccine
- ☐ _____ Tetanus Shot / DTaP / Tdap
- ☐ _____ Polio Series
- ☐ _____ MMR (Measles, Mumps, Rubella)
- ☐ _____ Meningococcal
- ☐ _____ Hepatitis A
- ☐ _____ Hepatitis B (3 shots)
- ☐ _____ Gardasil
- ☐ _____ Zostavax (Shingles Vaccine)
- ☐ _____ Chicken Pox vaccine
- ☐ _____ TB Test
- ☐ _____ Dental Care
- ☐ _____ Cholesterol Testing
- ☐ _____ Prostate exam
- ☐ Other _____
- ☐ _____ Stool Test for Blood
- ☐ _____ Colonoscopy
- ☐ _____ Pap Test
- ☐ _____ Mammogram
- ☐ _____ Breast Exam
- ☐ _____ Bone Density Test

Level of Independence	Self	Need Assistance
Eating/ Meal Preparation		
Toileting		
Walking		
Bathing/ Showering		
Dressing		
Household Tasks		
Driving/transportation needs		

For Women Only- Gynecologic and Obstetric History:

Could you currently be pregnant? ☐ No ☐ Yes

Age at onset of Periods: _____ Frequency: _____ Length of Period: _____

Number of Pregnancies: _____ Births: _____ Miscarriages: _____ Living Children: _____

Method of Birth Control: _____ History of Hormone Replacement Therapy? ☐ No ☐ Yes

Complications during Pregnancy: _____

Prolonged or Abnormal Bleeding? ☐ No ☐ Yes Pelvic Pain ☐ No ☐ Yes Breast Lump(s) ☐ No ☐ Yes

Leakage of Urine/incontinence: ☐ No ☐ Yes Abnormal Discharge ☐ No ☐ Yes

History of Abnormal Pap Smear? ☐ No ☐ Yes If yes, explain _____

History of Abnormal Mammogram? ☐ No ☐ Yes If yes, explain _____

Parent/Guardian/ Patient Signature: _____ **Date:** _____

UPMC

UPMC – CONSENT FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS (TPO) IN PENNSYLVANIA

IMPRINT PATIENT IDENTIFICATION HERE

UPMC, for the purposes of this consent, includes all hospitals, physician offices and other facilities providing healthcare services which are part of the UPMC system that are located in Pennsylvania.

I. CONSENT TO TREATMENT This consent cannot be modified. Any handwritten changes to the form shall not be legally binding or enforceable.

1. I,_____(print or type name) on behalf of_____(patient name and relationship) consent to the provision of treatment that may include diagnostic procedures, mental health, drug and alcohol abuse treatment, medical treatment and/or admission to UPMC, including its hospitals, other health care facilities and physicians (all "affiliates"), which my physician or his/her authorized agent may consider necessary or advisable. I understand special consent forms may need to be signed for specific procedures. For licensed mental health and drug and alcohol abuse treatment facilities, this TPO will act as a consent for treatment only (and not for the release of information that I must separately authorize). If I have a religious objection to specific care to be provided, I may ask UPMC not to provide such care.
2. I understand that my care may include examinations, diagnostic tests, medical treatment, taking photographs/video and making audio recordings that may be used for my care and/or by UPMC for education, as well as, health care operations purposes.
3. I understand and agree that others, under the direction of a physician, may assist or participate in providing hospital and/or medical care to me at UPMC teaching facilities. These people may include but are not limited to residents, fellows, and medical/nursing students.
4. If applicable, I give UPMC permission to appropriately dispose of any specimens/tissue (such as blood samples, PAP smears, skin tags, etc.) taken from my body. Once disposed of, these specimens/tissue cannot be retrieved. I understand and agree that UPMC and its designees may use such specimens/tissue as part of its educational activities. I understand that state and federal law allows UPMC to use specimens/tissue for research purposes without my authorization if my identity is not linked to the specimens/tissue. I will be asked to provide authorization for use of my specimens/tissue in research if my identity is linked to the specimens/tissue.
5. I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment.
6. I understand and agree that UPMC may at its discretion provide certain services to me by means called "telehealth" all of which are covered by this authorization. Telehealth may involve the secure transmission of video, audio, images, pictures and other types of information in real time or via a store and forward application. The provider will determine whether the condition being diagnosed or treated is appropriate for telehealth. I understand that a separate consent may be required to provide mental health and drug and alcohol abuse "telehealth" services.
7. When a physician orders home health, hospice, or ancillary services they will be directed to a UPMC provider unless otherwise requested or required by patient's insurance. UPMC honors patient choice among providers of healthcare.

II. MEDICARE CERTIFICATION (IF APPLICABLE)

I certify that the information given by me in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Service or its intermediaries or carriers, any information needed for this or any related Medicare Claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization providing the services or authorize that physician or entity to submit a claim to Medicare for payment to me. My signature at the end of this consent acknowledges my receipt of an important message from MEDICARE/MEDICARE HMO/TRICARE (formerly known as CHAMPUS / CHAMPVA) and does not waive any of my rights to request a review.

III. MEDICAID CERTIFICATION (IF APPLICABLE)

I certify that the information given on this consent is true, complete, and accurate. I understand that payment and satisfaction of this claim will be from federal and state funds and that any false claims, statement, documents, or concealment of material facts, may be prosecuted under applicable federal and state laws.

IV. RECEIPT OF NOTICE OF PRIVACY PRACTICE/RELEASE OF INFORMATION

1. I have been provided the UPMC Notice of Privacy Practices, either now or previously._____**Patient Initials (required)**
2. I give UPMC and its designees permission to use my information as described in the UPMC Notice of Privacy Practices.

3. UPMC may store information regarding me and my care in a variety of forms, including on computer systems, electronic media, paper, etc. Such information may include sensitive information such as HIV information, mental health information and drug and alcohol abuse treatment information.
4. To the extent permitted under state and federal law, UPMC (including its hospitals, staff, physicians and other entities and programs) may access and share my medical and other information as is necessary for UPMC to provide treatment to me, seek payment for services it provides, or for UPMC's own healthcare-related operations. This includes my specific consent for UPMC to share mental health information (including, but not limited to, all information relating to my diagnosis, prognosis, treatment, care coordination or any other information contained in my patient record).
5. I understand that UPMC may release my information to my primary care/family physician(s) and other providers as is necessary for treatment, consultation referral and/or the provision of other treatment related healthcare services to me. However, in compliance with certain federal and state laws, I may be required to sign a separate consent in order for UPMC to release certain types of sensitive information – including HIV information, mental health information and drug and alcohol abuse treatment information. I also give permission for UPMC to release patient and educational information to my home caregiver.
6. I understand I may be contacted by UPMC by cellular phone, which may include the use of pre-recorded/artificial voice messages, and/or an automated dialing device ("auto dialer") or by text message or e-mail in connection with any communication made to me or related to my accounts **Patient Initials** _____
7. I understand that my information may be released if required by local, state, or federal law.

V. FINANCIAL ARRANGEMENTS

I agree to the following terms related to payment for services provided by UPMC and affiliates:

1. I authorize UPMC to bill my insurance carrier and request such payments to be made directly to UPMC. I certify that the information I have given about my insurance coverage or other payment sources is correct.
2. I assign to UPMC all rights to insurance payments or benefits to which I may be entitled for services provided to me by UPMC. I authorize UPMC to act on my behalf and as my representative to request reconsideration (internal and/or external review process) by my managed care plan or utilization review entity for coverage or grievance review.
3. I authorize UPMC to release any medical or other information required by third parties, my insurer, other payers, and their agents for payment related purposes. I also authorize UPMC to release medical or other information required by third parties, my insurer, other payers and their agents, government agencies or their designees for review of the care provided to me.
4. I assign all rights to benefits, insurance proceeds or other payments or judgments to which I may be entitled for hospital-based physician services (pathology, radiology, neurology, cardiology, anesthesiology, etc.) and/or emergency room services, and/or rehabilitation services to the physician or organization providing the service. I also authorize submission of a claim for payment on my behalf to my insurance carrier.
5. I understand and agree that any hospital and physician charges not paid by my insurance are my responsibility. I understand that final billing will be made upon determination of all charges incurred, less any payments actually received, and/or allowed adjustments from insurers contracted with UPMC. I understand that it is my responsibility to pay UPMC all charges so incurred in accordance with UPMC's standard charges as set forth in UPMC's Charge Description Master (CDM). For more information regarding UPMC's Charge Description Master, please go to https://www.upmc.com/patients-visitors/paying-bill/services.
6. If I choose to pay for certain services out of pocket and exercise my right to limit disclosure of the information to my payer regarding those services, I understand that a separate financial agreement will be put into place regarding the self-pay services and this section will not apply to such services.
7. If I make an application for Medical Assistance/Financial Assistance (or one is made on my behalf), UPMC is permitted to provide information as is necessary to determine whether I am eligible for Medical Assistance/Financial Assistance.

VI. PATIENT VALUABLES

I relieve UPMC of any responsibility for loss of clothing, money, valuables, dentures, glasses, or any other items that I decide to keep with me while I am a patient. I further understand that UPMC will not be responsible and will not replace any property lost, broken, or stolen, which I decide to keep with me, or any property brought to me while I am a patient.

VII. AGREEMENT THAT ANY LEGAL ACTION WILL BE FILED IN A COUNTY IN WHICH CARE IS PROVIDED

I agree that any lawsuit or legal action which is in any way related to the medical care I receive must be filed in a County in which the care at issue is provided. _____ **Patient Initials**

VIII. MINOR ABLE TO CONSENT FOR CARE (IF APPLICABLE)

I am under 18 years of age and for the following reason(s)_____,
I am entitled under Pennsylvania Law to consent to medical, dental or other health services for myself, and if applicable, for my minor children without the consent of any other person._____**Patient Initials (required if completing this section)**

I have read this Authorization/Consent for Treatment, Payment and Health Care Operations form or have had it read to me, and it has been explained to my satisfaction. I understand that this consent for Treatment, Payment and Health Care Operations form may be valid for up to one (1) year from the date that I sign it and applies to all UPMC facilities (such as physician practices, hospitals, clinics, etc.).

Patient Signature (two witnesses required for verbal consent)	Date	Time	Signature of UPMC Representative/Witness
Signature/Identify on behalf of patient/relationship Name	Date	Time	Signature of UPMC Representative/Witness

West Erie Medical Group
1600 Peninsula Drive, Suite 9
Erie, PA 16505

P (814) 877-7035
F (814) 877-6276

UPMC

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize _____ to release information from the record of:
Name of Facility/Person

_____ _____ _____ to
Patient Name | Birth Date | SSN/MR#

West Erie Medical Group
1600 Peninsula Drive, Suite C
Erie PA 16506

(814) 877-7035 Phone | (814) 877-6276 Fax

Facility/Person Address

for the purpose of (PROVIDE A DETAILED DESCRIPTION): _____

Parts 1 and 2 must be completed to properly identify the records to be released.

1. Type of records to be released and approximate date(s) of service (check all that apply):

☐ Inpatient ☐ Emergency Dept Dates: _____
☐ Outpatient ☐ Physician Office/Clinic

I authorize the release of: (check all that apply) ☐ Mental Health Information ☐ Drug and Alcohol Information, contained in the records indicated above.

2. Specific information to be released (check all that apply):

☐ Consults
☐ Discharge Summary/Instructions
☐ Laboratory Reports/Tests
☐ Mammography Report
☐ Emergency Dept. Report
☐ Medical History & Physical Exam
☐ Medication Records
☐ Operative Report
☐ Pathology Report
☐ EKG Report(s)
☐ Physician Orders
☐ Progress Notes
☐ Psychiatric/Psychological Eval
☐ Radiology Report
☐ Other: _____

HIV-related information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. ☐ Do not release

I understand that this Authorization is effective for a period of 90 days from the date of the signature, unless otherwise specified below. No time frame may exceed one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release the information. See side two of this form for additional patient rights and responsibilities.
If applicable, specify other expiration date/event here: _____

Date of Signature | Signature of Patient (14 years of age or older may authorize release of mental health information. A minor can authorize release of drug & Alcohol treatment information without parental consent.) | Date of Signature | Signature of Parent, Legal Guardian or Authorized Representative* (complete below)

Date of Signature | Witness/Staff Member Signature

*Authorized Representative's relationship and authority to act on behalf of patient: _____

ORAL AUTHORIZATION (for persons physically unable to sign)
NOT Applicable To HIV Related Information or Drug & Alcohol Treatment Information

I witness that the patient understood the nature of this release and freely gave their oral authorization. (Two witnesses are required)

Date | Witness #1 | Date | Witness #2

UPMC Hamot Physician Network

Demographic Form

Dear Patient,

In order for us to serve you better and ensure completeness of your information, please take a moment to provide us with the below information.

Last Name: _____ First Name: _____ MI_____

Date of Birth: _____ Marital Status: _____ Sex: _____

Race: _____ Ethnicity: ☐Hispanic/Latino ☐ Non-Hispanic/Latino ☐Not specified ☐Decline

Address: _____ Social Security Number: _____ -_____-_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer Name: _____ Work Phone: _____

Email Address: _____

If Patient is a minor, please list parent or guardian name: _____

Emergency Contact:

Name: _____ Relationship to patient: _____

Home Phone: _____ Cell Phone: _____

Insurance Information

Primary Insurance Company Name: _____ PCP copay $_____ Spec copay $_____

Identification or Policy number: _____ Group Number: _____

Policy Holder Name: _____ Date of Birth: _____

Relationship to Patient: _____ Social Security Number of policy holder: _____

Policy Holder Address: _____

City: _____ State: _____ Zip: _____

Secondary Insurance Company Name: _____ PCP copay $_____ Spec copay $_____

Identification or Policy number: _____ Group Number: _____

Policy Holder Name: _____ Date of Birth: _____

Relationship to Patient: _____ Social Security Number of policy holder: _____

Policy Holder Address: _____

City: _____ State: _____ Zip: _____

Signature: _____ Date: _____

Revised 9/11/17

UPMC CHANGING

Personal Representative Designation Form

Dear Patient:

We understand that you wish to appoint a personal representative to act on your behalf as described below. In regard to this matter, the privacy of your health care information is important to us. In the spaces below, provide the requested information about yourself (the patient) and the person you are designating to act as a personal representative concerning your health care information. Once you return this completed, signed, and dated form to us, we can verify your request, adjust our records accordingly, and speak to your personal representative.

Read this form carefully and then fill it out completely by printing or typing. If printing, use a pen.

Note that, subject to the disclaimers in the following paragraph, this form can be used to document the following types of personal representative activities on behalf of the patient:

- Make appointments for health care services;
- Have discussions with health care providers about routine tests and treatments (that do not require informed consent);
- Access to medical information, as necessary, to have discussions with health care providers about routine tests and treatments. However, unless the personal representative is a licensed physician who is credentialed to provide healthcare services at UPMC, use of UPMC's internal electronic medical record systems to access such medical information is not permitted.

Note that this form is not applicable and cannot be used for UPMC behavioral health patients or for any patient when major health care decisions are involved, including, but not be limited to:

- Procedures/services that require informed consent (and withdrawal of consent if applicable);
- Admissions to and discharges from nursing homes or other long-term care facilities;
- Donation of organs, body parts, or body for medical purposes, including the authorization of an autopsy;
- Continuation or withdrawal of life support; and
- For major health care decisions, a formal power of attorney or living will is required.

In the event you do NOT want a personal representative to discuss your healthcare on your behalf, please fill out form and write "none" in the personal representative name box.

UPMC CHANGING

Personal Representative Designation Form

This personal representative designation applies to the following UPMC entity/locations:

List all applicable entities: WEST ERIE MEDICAL GROUP
1600 PENINSULA DRIVE, SUITE C
ERIE, PA 16505

REQUIRED INFORMATION:

Patient's Name:	Patient's Date of Birth:	Patient's Phone:
Patient's Address:		
Name of Patient's Personal Representative:		Personal Representative Phone:
Personal Representative Address:		Personal Representative Fax:
Any limitations on issues your personal representative may discuss? Yes _____ No _____ If yes, please specify:		
Expiration date for this designation (unless/until you specify in writing the expiration, this form will remain in effect until the patient no longer receives services at UPMC).		

REQUIRED SIGNATURES:

Personal Representative Signature: _____ Date: _____

Patient Signature: _____ Date: _____

Please return this completed form by mail to: _____

WEST ERIE MEDICAL GROUP
1600 PENINSULA DRIVE, SUITE C
ERIE, PA 16505

or by fax to: _____