TRI-COUNTY FAMILY MEDICINE ASSOCIATES

Phone: (716) 241-7067
Fax: (716) 241-7197

Dr. James E. Wild
Dr. Dana Anderson

• 1 School Street • Suite 107 • Gowanda, NY 14070 •

Amy Jo Burroughs, RPA-C
Mallory Ward, RPA-C

NEW PATIENT INFORMATION

(Newborn to 12 Years Old)

Name _____
(Last , First, Middle)

Address_____

SS #_____ Date of Birth _____ Race_____

Ethnicity_____ Primary Phone#_____

Primary Language_____ Pharmacy_____
(Name & Location)

Mother's Name_____ Mother's Maiden Name_____ Mother's Phone#_____

Mother's Address: _____

Mother's Employer_____ Employer's Phone#_____

Father's Name_____ Father's cell phone#_____

Father's Address_____

Father's Employer_____ Employer's Phone#_____

Insurance Company_____ Policy#_____

Group#_____

Policy Holder's Name_____ Policy holder's DOB _____ Relationship_____

Personal Medical History (check any that <u>patient</u> has)

- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ Kidney Disease
- ☐ Hepatitis
- ☐ Seizures
- ☐ Mental Health Disorder
- ☐ Thyroid Dysfunction
- ☐ Asthma
- ☐ COPD(emphysema, chronic bronchitis)
- ☐ Chicken Pox (In Past) Date:_____
- ☐ Visual Impairment
- ☐ Hearing Impairment
- ☐ Sleeping Problems
- ☐ Difficulty with Friendships
- ☐ Difficulty with School
- ☐ Difficulty Toileting
- ☐ Bed Wetting
- ☐ Other (please list below):

Does the patient use any Assistive Devices? (Please List Below):
(Examples: wheelchair, oxygen, glasses)

Patient Name: _____

Medications – Please Include Vitamins & Herbs:

Name of Medication	Dose of Medication	Frequency (how many times a day you take medication)

Please List Your History of Surgical Procedures:

Type	Date

Please List Any Serious Injuries You Have Had:

Type	Date

Please List All of Your Allergies:

Allergy to:	Reaction:
Allergy to:	Reaction:
Allergy to:	Reaction:
Allergy to:	Reaction:
Allergy to:	Reaction:

☐ **No Known Medication Allergies**

Does the patient see any other Doctors or Medical Specialists?
(If so, please list the doctor or facility you go to)

Does your child see a Dentist: **Yes / No / NA**
When was child's last dental exam**:**

Is patient up to date on their immunizations? **Yes / No / Unknown**

****Please provide us with an updated immunization record so we can provide the appropriate care your child needs****

Patient Name: _____

Family History

Does anyone in your immediate family have any of the following, please check and note your relationship

	Relationship		Relationship
☐ Diabetes	_____	☐ Thyroid Disorder	_____
☐ Heart Disease	_____	☐ Asthma	_____
☐ High Blood Pressure	_____	☐ Cancer, Type:	_____
☐ Heart Murmur	_____		
☐ Mental Health Disorder	_____	☐ Other:	

Do any diseases frequently repeat in your family, if so explain: _____

Social History Newborn to 5 Years Old
(If your child is older than 5 go to next page)

- Does this child live with: (Please circle or write) Parent(s) / Friend / Other Family Member_____
- Is this child exposed to second-hand cigarette smoke? **Yes / No**
- Does child use safety belt or car seat when in vehicle? **Yes / No**
- Does child use a helmet when riding bike, skateboard or ATV? **Yes / No**
- Does child live in a home with working smoke detectors? **Yes / No**
- Does child live in a home with working carbon monoxide detectors? **Yes / No**
- Is child physically active? **Yes / No**
- Do you have concerns about your child's hearing? **Yes / No**
- Do you have concerns about your child's vision? **Yes / No**
- Does anyone who lives with your child smoke? **Yes / No**

Eating Habits

- Does child eat fruit: **Yes / No / NA** Number of servings per day:_____
- Does child eat vegetables: **Yes / No / NA** Number of servings per day:_____
- Does child eat meat and or fish: **Yes / No / NA** Number of servings per day:_____
- Does child eat / drink dairy products: **Yes / No / NA** Number of servings per day:_____
- Does your baby drink breast milk or formula? Breast Milk / Formula / Both / NA
    - If you are giving formula how many ounces does your child take in 24 hours? _____ oz. Type of formula? _____
- Does your child drink more than 12 oz. of soda/ sports drinks daily? **Yes** **No**
- Does your child skip meals routinely? **Yes** **No**

Social History Ages 6 to 12 Years Old

Child's Name: _____ Date of Birth:_____

Please answer the following questions. It will help your medical provider spend more time discussing those specific issues that concern you.

Please list your child's medication or food allergies, if any:

_____

Are Parent(s): (Circle) **Married** **Unmarried** **Single** **Separated** **Divorced**

Other: _____

Who lives with your child? Please list below: (Example: mother, father, grandfather, sister, aunt, etc.)

_____

Do you have concerns about your child's hearing?	**Yes**	**No**
Do you have concerns about your child's vision?	**Yes**	**No**
Does anyone who lives with your child smoke?	**Yes**	**No**

School

Current grade: _____ Name of School:_____

Do you have concerns about your child's school performance (Example: grades, getting along with teachers)?	**Yes**	**No**
Do you have concerns about your child's interactions with peers at school (bullying or fighting)?	**Yes**	**No**

Nutrition

Does your child drink more than 12 oz. of soda/ sports drinks daily?	**Yes**	**No**
Is your child a vegetarian?	**Yes**	**No**
Does your child skip meals routinely?	**Yes**	**No**
Does your child struggle with Anorexia, Bulimia, Obesity, or being Underweight?	**Yes**	**No**
Does your child get at least 3 servings of milk or other calcium-containing foods daily?	**No**	**Yes**

How many servings of fruits and vegetables does your child eat each day?_____

Physical Activity

Does your child typically watch MORE than 2 hours of TV/Computer/Video games, etc. daily?	**Yes**	**No**
Has your child fainted while exercising?	**Yes**	**No**
Does your child cough or have shortness of breath with exercise?	**Yes**	**No**
Has your child had a significant head injury in past 2 years?	**Yes**	**No**
Does your child get at least 30 minutes of moderately strenuous activity most days?	**No**	**Yes**

Oral Health

Does your child see a dentist at least once a year? (every 6 months is best)	**No**	**Yes**
Does your child brush teeth at least two times daily?	**No**	**Yes**

Patients Name:_____

Social History Ages 6 to 12 Years Old Continued

Sleep

Does your child snore on a regular basis?	**Yes**	**No**
Does your child get at least 8 hours of sleep on a typical school night?	**No**	**Yes**
Do you have any other concerns about your child's sleep, such as bedwetting	**Yes**	**No**

If so, please describe:

Safety

Does your child wear a helmet when skiing/skating/biking/on ATV, dirt bike, motorcycle?	**No**	**Yes**	**Sometimes**
Does your child wear always wear a seatbelt when in the car?	**No**	**Yes**	**Sometimes**
Does your child usually use sunscreen/hats/other sun protection when outdoors	**No**	**Yes**	**Sometimes**
Does your child know how to stay safe around water (pool, rivers, etc)?	**No**	**Yes**	
Have you discussed stranger awareness with your child?	**No**	**Yes**	
Does your child know how to use 911 in an emergency?	**No**	**Yes**	
Are there guns in the home or any home your child regularly visits?	**Yes**	**No**	

Do you have concerns that your child is being abused?	**Yes**	**No**
Do you have concerns that your child is drinking alcohol?	**Yes**	**No**
Do you have concerns that your child is using drugs?	**Yes**	**No**

Mental Health

Do you have concerns about your child's mood (anxiety, depression)?	**Yes**	**No**
Do you have concerns about your child's relationship with parents or siblings?	**Yes**	**No**
Has your child ever threatened to hurt themselves?	**Yes**	**No**

For Girls Only

Has your daughter had her first period?	**Yes**	**No**	**Unsure**
If yes, do you or she have any questions about her periods?	**Yes**	**No**	**Unsure**

Patient Name: _____

ACCOUNTABILITY FORM
TRI-COUNTY FAMILY MEDICINE ASSOCIATES, PC
1 SCHOOL STREET, SUITE 107
GOWANDA, NY 14070

I hereby authorize the doctor, nurse or medical staff to talk freely to the following people regarding my medical condition.

Your first two (2) listed will be your emergency contacts.

Name	**Relationship**	**Phone Number**
*_____	_____	(____)_____
*_____	_____	(____)_____
_____	_____	(____)_____
_____	_____	(____)_____
_____	_____	(____)_____
_____	_____	(____)_____
_____	_____	(____)_____

_____
Patient Signature **Date**

_____
Witness **Date**

HIPAA Privacy Information

How May We Contact You Regarding Appointment Information?	**How May We Contact You Regarding Medical Information**
☐ Home Phone (Including Auto Call) ☐ Mobile Phone (Including Auto Call) ☐ Work Phone ☐ With Another Person ☐ Sent Via Mail ☐ Sent Via E-Mail/Patient Portal	☐ Home Phone (Including Auto Call) ☐ Mobile Phone (Including Auto Call) ☐ Work Phone ☐ With Another Person ☐ Sent Via Mail ☐ Sent Via E-Mail/Patient Portal

TRI-COUNTY FAMILY MEDICINE ASSOCIATES
1 SCHOOL STREET, SUITE 107
GOWANDA, NY 14070
PHONE: (716) 241-7067 FAX: (716) 241-7197

JAMES E. WILD, M.D. **DANA P. ANDERSON, M.D.**
AMY-JO BURROUGHS, RPA-C **MALLORY WARD, RPA-C**

Name of doctor or facility to release records: _____

Address: _____

Phone: _____ Fax: _____

Release records to: **Tri County Family Medicine**
1 School Street, Suite 107
Gowanda, NY 14070
Fax: 716-241-7197

Patient Name:_____ **D.O.B.:**_____

Address:_____

( ) I hereby authorize and request that you release all medical records in your possession, concerning my illness and/or treatment during the time period from _____ to _____. (**If patient is changing primary care physicians please include all records including, but not limited to: Health Care Proxy, immunization records, most recent colonoscopy, mammogram and dexa scan if done**). Do release HIV/AIDS and/or sexually transmitted disease related and/or drug/alcohol abuse/ treatment information. I understand that this is a duel release inclusive of sensitive medical information including HIV.

( ) Send only the following selected items: _____

I understand that my consent to obtain information will expire in one year, and that I may withdraw this consent in writing at any time.

Signed: _____ Date: _____

Relationship (if other than self): _____

Witness: _____

This information has been disclosed to you from confidential records that are restricted by law. Federal law prohibits you from making further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by law. Any unauthorized further disclosure in violation of federal law may result in a fine and/or jail time. A general authorization for the release of the medical or other information is not sufficient authorization for further disclosure.

Notice of Privacy

THIS NOTICE DESCRIBES INFORMATION ABOUT YOU AND HOW IT MAY BE USED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

We are committed to treating and using protected health information (PHI) about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your PHI. This Notice is effective April 14, 2003 and applies to all PHI as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit TCFM, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication amongst the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating heath professionals,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding your record and how your health information is used helps you to: ensure its accuracy, better understand your health record and who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of TCFM, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

TCFM is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer, Sara Jones, 337-3010.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W. Room 509F, HHH Building Washington, D.C. 20201.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Any information obtained by TCFM employees will be recorded and used to determine the course of treatment of your care. Your provider will document in your record his or her plan of treatment and how it will be carried out by TCFM employees. TCFM will then record the actions they took and their observations. In that way, the provider will know how you are responding to treatment.

We will also provide your subsequent health care provider with copies of various reports that should assist him or her in treating you.

We will use your health information for payment. For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations. For example: TCFM employees will use information in your health record to assess the care and outcomes in your case. This information will then be used in an effort to improve the quality and effectiveness of the healthcare we provide.

Communication with your designated representative: TCFM using their best judgment, may disclose to your designee, health information relevant to your care or payment related to your care. Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Notice of Privacy

Patient Consent to the Use and Disclosure of Health information for treatment, payment or healthcare operation.

I,_____ understand that as part of my healthcare, TCFM originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

> A basis for planning my care and treatment
> A means of communication amongst the many health professionals who contribute to my care
> A source of information for applying my diagnosis and surgical information to my bill
> A means by which a third-party payer can verify that services billed were actually provided
> A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

> The right to review the notice prior to signing this consent
> The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

I understand that TCFM is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by section 164.506 of the Code of Federal Regulations.

I further understand that TCFM reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should TCFM change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail, or if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.

_____
Patient Signature

_____
Date

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FOR OFFICE USE ONLY
{ } Consent received by _____ on_____.
Date
{ } Consent refused by patient and treatment refused as permitted.

Statement by Witness (must be 18 or older): I declare that the person who signed this document appeared to execute the proxy willingly and free from duress. He or she signed (or asked another to sign for him/her) this document in my presence. I am not the person appointed as proxy by this document.