TRI-COUNTY FAMILY MEDICINE ASSOCIATES

Phone: (716) 241-7067
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Dr. James E. Wild
Dr. Dana Anderson

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

Amy Jo Burroughs, RPA-C
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New Patient Information
Teens 13 - 18

Name ____
(Last , First, Middle)

Address____

SS #______________________ Date of Birth _____________ Race___________________

Ethnicity_________________ Primary Phone#____________________ Cell 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 patient 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
- ☐ Other (please list below):

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

Females Only:

Do you have regular menses(period)? (Please Circle) **Yes / No**

Have you ever had a PAP smear? **Yes / No**

At what age did you start? ________

How many days do you have your menses? ________

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)

Do you see a dentist regularly? **Yes / No**
When was your last dentist appointment? ____________________

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: ___________________________

Parents:

- Please have your teen fill out the rest of this form to the best of their ability by themselves.

- If you wish you may be present in the room for the beginning of the visit, the physical exam will be done with only the medical provider and patient in the room.

Why do we do this?

Teenagers' concerns about confidentiality can be a major barrier to obtaining health care. In a Louis Harris/Commonwealth Fund poll of more than six thousand five hundred teens, nearly one in three high-school girls and nearly one in four high-school boys admitted to at least one occasion when they needed medical care but did not see a doctor. The number-one reason given: They did not want their parents to know.

Teen History

Your Name: ______________________________ **Date of Birth:** ______________

Please answer all of the following questions. It will help your doctor spend more time discussing issues that may concern you

Are Your Parent(s) (circle): **Married** **Unmarried** **Single** **Separated** **Divorced**
Other: ______________________________

Do you live in more than one home? **Yes** **No**
Who lives with you? Please list (parents, sister, uncle, etc.): ______________________________

Do you have any piercings? **Yes** **No** If yes, where:______________
Do you have any tattoos? **Yes** **No** If yes, where:______________

School/Work

Do you currently attend school? **Yes** **No**

- If Yes, what grade are you in ________
  - Name of School:______________________
- If No: What is the highest grade that you have completed______________
- Do you have concerns about how you are doing in school? **Yes** **No**
- Do your parents or teachers have concerns about how you are doing in school? **Yes** **No**

Do you currently have a job: **Yes** **No**

- If Yes: Where do you work & what do you do at work?:
  ____
  ____

Are there any environmental hazards/concerns in your home or at your job? **Yes** **No**
Examples: Dust, Loud Machines, Mold, ect.
If Yes, Please explain:____

Sleep

Do you drink coffee, energy drinks, tea, or caffeinated drinks **Yes** **No**
If yes, what kind and how many? ______________________________
How many hours of sleep do you typically get?: ________ Do you have difficulty sleeping often? **Yes** **No**

Nutrition/Diet

Are you a vegetarian? **Yes** **No**
Are you unhappy with your weight? **Yes** **No**
Have you ever skipped meals, taken pills, or made yourself vomit to lose weight? **Yes** **No**
Do you get at least 3 servings of milk or other calcium-containing foods daily? **No** **Yes**
Do you drink more than 12 oz. of soda or sports drinks daily? **Yes** **No**
How many servings of fruits and vegetables do you eat each day: ______________

Patient Name: ____________________________

Physical Activity

Do you get at least 30 minutes of moderate exercise/activity daily? **No Yes**

If no, how many days a week do you get exercise:______________________________

Do you play on a school or club team? **No Yes**

If yes, what sport(s)? ____

Have you ever fainted while exercising? **Yes No**

Do you cough or have shortness of breath when you exercise? **Yes No**

Have you gotten aching chest pain when you exercise? **Yes No**

Have you had a head injury in the last two years that affected sports or school? **Yes No**

Safety

Do you wear sunscreen, hats, or other sun protection measures when outdoors? **No Yes Sometimes**

Do you wear a seatbelt when riding in a car, truck or van? **No Yes Sometimes**

Do you wear a helmet when skating, rollerblading, riding a bicycle, scooter, ATV, dirt bike? **No Yes Sometimes**

Does your home have smoke detectors? **No Yes**

Does your home have carbon monoxide detectors? **No Yes**

Are you worried about bullying, violence, or your safety at school? **Yes No**

Do you have concerns about how your family gets along? **Yes No**

Are you worried about violence or safety at your home? **Yes No**

Drug/Substance Abuse

Have you ever smoked cigarettes, e-cigarettes, or chewed tobacco? **Yes No**

Does anyone in your home smoke cigarettes? **Yes No**

Have you ever drank alcohol or have you ever been drunk **Yes No**

Have you ever used drugs such as marijuana, ecstasy, meth, heroin, or others? **Yes No**

Have you ever driven or been in a car with a driver that had been drinking or using drugs? **Yes No**

Emotional Health

In the past two weeks, how often have you been bothered by the following symptoms:

Feeling down, depressed, irritable, or hopeless? **(Please circle below)**

Not at all Several Days More than half of the time Nearly every day

Little interest or pleasure in doing things? **(Please circle below)**

Not at all Several Days More than half of the time Nearly every day

Do you need help managing your stress? **Yes No**

Have you ever made a plan to hurt yourself or others? **Yes No**

Sexual Health

Have you ever had sexual intercourse? **Yes No**

Has anyone ever forced you to have any type of sexual relations? **Yes No Unsure**

Do you need information about preventing pregnancy or sexually transmitted infections? **Yes No Unsure**

Would you like a pregnancy test or sexually transmitted infection testing? **Yes No Unsure**

Do you need information about bisexuality, transgender or gay/homosexual? **Yes No Unsure**

Do you have any concerns that you would like to discuss today? If so, please list:

____

____

Would you like to have HIV testing? **Yes No Unsure**

Patient Name____________________________

The CRAFFT Screening Interview

PART A **During the PAST 12 MONTHS, did you:**	**No**	**Yes**
1. Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.)	☐	☐
2. Smoke any marijuana or hashish?	☐	☐
3. Use anything else to get high? ("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")	☐	☐

PART B	**No**	**Yes**
1. Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
2. Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?	☐	☐
3. Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?	☐	☐
4. Do you ever **FORGET** things you did while using alcohol or drugs?	☐	☐
5. Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on you drinking or drug use?	☐	☐
6. Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?	☐	☐

CONFIDENTIALITY NOTICE:

The information recorded on this page may be protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent. A general authorization for release of medical information is NOT sufficient for this purpose.

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.
AMY-JO BURROUGHS, RPA-C

DANA P. ANDERSON, M.D.
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

==

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.