I:
Dr.:
Vrfd.:

Jenks Family Physicians

New Patient Health Questionnaire - Adult

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

What is the main reason for your visit today? _____

What other problems would you like to address today?

_____ _____

_____ _____

Past Medical History: Have you ever had (or currently have) any of the following? (Please circle)

Anemia
Allergies
Anxiety/Depression
Arthritis
Asthma
Bladder Infections
Bleeding Disorders
Blood Tranfusion
Diabetes: Type I Type II
Eye Disease
GERD
Glaucoma
Heart Disease/Disorders
Heart Murmur
Hepatitis: A B C
High Blood Pressure
High Cholesterol
Kidney Disease
Pneumonia: Hospitalized? ___
Rheumatic Fever
Sleep Apnea: Diagnosed? ___
Sexually Transmitted Disease
Stroke: When? _____
Thyroid Disorders: Hypo? Hyper?
Ulcer
Tuberculosis
Whooping Cough
Cancer: Type _____

Pharmacy: _____

Vitals: BP: _____ / _____

Pulse:_____

SpO2: _____%

Ht: _____ Wt: _____

Other (please list): _____

Past Surgical History: Please list all previous surgeries

Surgery	Date	Surgeon	Surgery	Date	Surgeon

Allergies: Please list all adverse reactions you may have had to medications, foods, or other substances

☐ **I have no allergies that I know of**

Medication/Substance	Type of reactions	Medication/Substance	Type of reaction

Latex Allergy? Yes No

Iodine/Shellfish/Seafood Allergy? Yes No

Jenks Family Physicians

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

Family Medical History:

	Living	Deceased	Sex	Current Age (or age at death)	Conditions or Diseases
Father:	☐	☐		_____	_____
Mother:	☐	☐		_____	_____
Siblings:	☐	☐	___	_____	_____
Siblings:	☐	☐	___	_____	_____
Siblings:	☐	☐	___	_____	_____
Children:	☐	☐	___	_____	_____
Children:	☐	☐	___	_____	_____
Children:	☐	☐	___	_____	_____
Other:	☐	☐	___	_____	_____

Has any member of your family developed heart problems before the age of 60? Y N Relationship: _____

Has any member of your family developed cancer? Y N Relationship: _____ Type: _____

Social History:

Marital Status: Married Engaged Divorced Separated Widowed Single

Current/Previous Employment Field: _____

Tobacco Use: Never Previously, but quit _____ years ago

Currently Use _____ Packs per day

Alcohol Use: Never 1-2 drinks/week 3-10 drink/week > 10 drinks/week

Illegal Drug Use: Never Prior Use Drug(s) used _____

Please describe household members (For example: "I live with my wife, son, and daughter)

_____

Medications: Please list all current medications

	Medication	Dose	How often	Medication	Dose	How often
Example:	Aspirin	81 mg	1 daily			

Jenks Family Physicians

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

Preventative Health Maintenance:

Date of last Influenza (Flu) Shot: _____

Are Your Immunizations Up to Date?: Y N Unsure

Approximate Year of Last Tetanus Vaccination: _____

Date of last Pneumovax (Pneumonia) Shot: _____ Never

Prior Bone Density (Osteoporosis) Screening: Y N When: _____

Prior Colon Cancer Screening: Y N When: _____

Prior Cholesterol Screening: Y N When: _____

Prior Cardiac Stress Testing: Y N When: _____

Prior HIV/AIDS Testing: Y N When: _____

MALES

Prior Prostate Exam: Y N When: _____

Prior PSA Test: Y N When: _____

FEMALES

Prior Pelvic Exam: Y N When: _____

Prior Pap Smear: Y N When: _____

Any previous Pap Smear Abnormal?: Y N

Prior Breast Exam: Y N When: _____

Prior Mammogram: Y N When: _____

Current or Previous Smokers

Prior Chest X-ray: Y N When: _____

Prior Pulmonary Function Testing (Breathing Studies): Y N When: _____

Prior Attempts to Quit Smoking: Y N When: _____

Are you interested in discussing smoking cessation today?: Y N

Other Doctors: Please list your other physicians or specialist you are currently seeing and their specialty

_____ _____

_____ _____

Do you have a Living Will? Y N

How did you find out about Jenks Family Physicians?

_____

JENKS FAMILY PHYSICIANS – PATIENT INFORMATION SHEET

Name (Last, First, MI) _____ Nickname_____ Zip Code _____

Address _____ City _____ ST _____

Phone (H)_____ Fax (H) _____ **DOB _____ / _____ / _____** Gender ❑ F ❑ M

Cell Phone/Pager _____ Phone (W) _____ Message Phone _____

Email Address _____ May we email you info. reminders pertaining to the clinic? Yes _____

Marital Status ❑ S ❑ M **Soc. Sec. # _____/_____/_____** Driver's Lic. # _____

❑ W ❑ D Employer _____

❑ Legally Sep Address _____ City/ST/ZIP _____

Were you referred to Jenks Family Physicians? If so, please tell us by whom. ❑ Friend (their name) _____

❑ Physician: (Physician's Name) _____ Other: _____

Is this visit related to an MVA (Motor Vehicle Accident) or Workers' Compensation Claim? ❑ Yes ❑ No
If Yes, please see receptionist for additional form.

Emergency Contact

Name _____ Relationship to Patient _____

Address _____ City _____ ST _____

Phone (H)_____ (W) _____ Comments _____

Guarantor/Responsible Party/Legal Guardian
❑ Self (Proceed to next section) ❑ If other than Self, please complete below.

Name _____ Relationship to Patient _____

Address _____ City _____ ST _____

Soc. Sec.# _____ DOB _____ / _____ / _____ Phone (H)_____ (W) _____

Employer _____ Address _____ City/ST/ZIP _____

If Married, Please Complete:
Spouse Full Name _____ DOB _____ / _____ / _____

Soc. Sec.# _____/_____/_____ Daytime Phone # _____

Primary Insurance
Insured Name _____ Effective Date _____

Company _____ Plan _____

Policy or ID # _____ Group # _____ Phone # _____

Address _____ City/ST/ZIP _____

Secondary Insurance
Insured Name _____ Effective Date _____

Company _____ Plan _____

Policy or ID # _____ Group # _____ Phone # _____

Address _____ City/ST/ZIP _____
Please read Financial Policy of Jenks Family Physicians on the next page, date, and sign.

Deductible Amount: $_____ Copay Amount: _____

Jenks Family Physicians
615 East Main Street | Jenks, OK 74037
(918) 299-8080 Fax: (918) 298-2838

Patient Identification

Printed Name: _____ Date of Birth: _____

Address: _____

Social Security # _____Telephone: _____

Information to be Released From

Name: _____

Address: _____

Covering the Periods of Health Care

From (date) _____ To (date) _____

From (date) _____ To (date) _____

Please check type of information to be released:

Last three office visits	Pathology report	Discharge summary
History and Physical exam	Consultation reports	Progress notes
Laboratory test results/reports	X-ray reports	X-ray films/images
Operative reports	Emergency room record	

Other, (Specify):_____

Purpose of Request:

Treatment or consultation	At the request of the patient	Billing or Claims payment

Other, (Specify) _____

Person Authorized to Receive Information

***Name*: Jenks Family Physicians**
615 E Main St.
Jenks, OK 74037
Phone: (918) 299-8080 Fax: (918) 298-2838

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release.
***Circle One*: Yes No _____ Initials**

I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquird immunodeficiency Syndrome) testing and/or treatment, I agree to its release.
***Circle One:* Yes No _____Initials**

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on the authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at 615 E. Main St, Jenks, OK 74037. Unless revoked, the automatic expiration date will be one year from the date of signature.

Re-Disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The Facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that Jenks Family Physicians may not condition my treatment on whether I sign this authorization form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. I authorize Jenks Family Physicians to use and disclose the protected health information specified above.

Jenks Family Physicians

Signature of Patient: _____ Date: _____

Authority to Sign if not Patient:_____

Identity of requestor Verified via: Photo ID Matching Signature Other, specify

Jenks Family Physicians
Financial Policy – Patient Authorization for Treatment – Release of Information

Jenks Family Physicians is committed to providing high quality healthcare services to all of our patients in an ethical, professional and cost effective manner. We want to ensure that you receive the maximum allowable benefits from your medical insurance. In order to achieve this goal, we need your assistance in understanding and following our financial policy.

The financial payment policy of this practice is to collect for services at the time of the patient's visit. Payment in full is due when services are rendered. As a service to our patients, we will file claims directly to your insurance carrier if acceptable insurance identification is provided. However, co-payment, deductibles and co-insurance are due in full at the time of service. Acceptable insurance identification is defined as a valid insurance card or policy with valid driver's license. Additionally, all services that require pre-authorization must be authorized prior to service being rendered.

Please be sure to provide correct insurance billing information or any other change of information on each visit.
If you choose to bill your own insurance or are required to file your own insurance, the facility will provide the patient with a claim form, but will treat the account as self-pay.

We accept cash, check, money orders, Visa and MasterCard.

Patients and Guarantors are responsible for all charges resulting from treatment provided by Jenks Family Physicians.

Returned checks will be charged back to the patient's account with a service fee of $25. Returned checks not redeemed within 15 working days of written notice to the maker may be referred to the prosecutor for collection.

Delinquent accounts will be assigned to a collection agency or attorney for collection and will be reported to the credit bureau.

Patient / Payor Categories

Self-Pay / No Insurance – Payment is due at the time services are rendered unless payment arrangements have been approved in advance by our credit manager.
HMO Plans – Co–payments, if required by the plan, are due prior to services being rendered. Patients are financially responsible for visits to the clinic not covered by their plan.
PPO Plans – The facility will file claims directly to your PPO Insurance. Deductibles and co-insurance or co-payments are due at the time of service. Patients are financially responsible for visits to physicians not on their plans.
Private Medical Insurance – As a courtesy to you we will file your primary insurance. You are responsible for filing your secondary insurance. Deductibles and co-insurance are due at the time of service.
Medicare – Patients are responsible for their deductible and co-insurance.
Workers' Compensation – In order for the facility to file a Workers' Compensation claim, you will need to provide us with the name of your insurance carrier, the date of your injury and your claim number (if available).
MVA or Other Liability Claims – In order for the facility to file third party liability, you will need to provide us with the name of your insurance carrier, date of accident and claim number.

It is important, to notify us, at the time you make your appointment, if the visit is related to an injury covered by a third party.

Authorization for Treatment – By virtue of my signature, I authorize Jenks Family Physicians and any of its employees or other authorized personnel or agents to provide general healthcare services to me.

Signature – By patient's signature below, patient represents that patient is 18-years of age or over and legally capacitated to give consent to treatment and authorize release of information.

I have thoroughly read and understand the Financial Policy of Jenks Family Physicians I understand and agree that regardless of my insurance status, I am responsible for the balance on my account for any professional services rendered.

_____
Signature - Patient / Guarantor **Date**

Please Read and Sign

Assignment of Benefits
I authorize payment of medical benefits be paid directly to Jenks Family Physicians on my behalf for any services furnished.

Authorization to Release Medical Information
I authorize the release of medical information needed to determine the benefits payable for related services.

_____
Signature – Patient / Guarantor **Date**

HIPAA - Acknowledgement of Receipt of Notice of Privacy Practices

Your signature below indicates that you have received a copy of Jenks Family Physicians Notice of Privacy Practices.

Printed Name of Patient _____ Signature _____

Authority to Sign if Not Patient _____ Date _____

JENKS Family PHYSICIANS
615 E. MAIN | JENKS, OK 74037

August 1, 2019

Re: Updated Clinic Policies

Dear Patients:

As of April 1st, 2010, new guidelines and policies have been instituted under federal law regarding prescription refills and other clinic practices. Most of these guidelines pertain to Medicare patients only, however in order to be federally compliant we have instituted the following clinic-wide policies.

Please review the attached policies and sign where noted. Please leave the signed copies on the exam room table as you leave, and we will gather these up and scan to your chart. We have included a copy of these policies for you to take home to keep as well.

If you have any questions regarding these guidelines, please feel free to discuss with us at any time, or email at: info@jenksfp.com.

Sincerely,

Brian Lewis, DO
Ashley Shope, PA-C
Thuc-Vi Nguyen, PA-C
Brent Wakefield, MD
Stacey Morrison, PA-C
Jon Esponge, FNP-C
Andrew Donnelly, MD
Kelsey Postoak, PA-C

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Ashley Shope, PA-C
918-299-8080
Fax: 918-298-2838
Email: info@jenksfp.com
www.jenksfamilyphysicians.com

Medical Home Agreement

This Medical Home Agreement Concept is an AGREEMENT between YOU and YOUR PROVIDER, to focus on meeting ALL of your Healthcare Needs.

As your Medical Home Primary Care Provider (PCP), we agree to:

1. Honor your rights as a patient and treat you with dignity and respect.
2. We will focus on listening to your concerns, educating you on your health care needs and preventive services.
3. Focus on treating you as a whole person: physically, mentally and emotionally.
4. Focus on providing you with ***ongoing, quality*** and ***safe*** medical care, including prevention of future health complications.
5. Work to schedule timely office appointments for your chronic and urgent healthcare needs.
6. Be available to you 24 hours a day, by office appointment, phone calls and/or other electronic communication.
7. Provide you with other healthcare resources when we are absent or unavailable.
8. Provide you with referrals to specialist as deemed ***medically*** necessary by your PCP.
9. Provide you with treatment, medications, equipment and any other resources deemed ***medically*** necessary by your PCP.

As a Medical Home Patient, your responsibility is the following:

1. Work with us as your ***PCP,*** to meet ***all*** of your health care needs.
2. Communicate with us about all your healthcare concerns and goals.
3. Report ***any*** changes related to your health, treatments, medications, etc.
   This includes use of ***all medications***-prescription, over-the-counter, herbal and street drugs. This also includes any medical equipment being used or that has been ordered or recommended for use.
4. Call us ***before*** going to the Emergency Room, unless it is life threatening.
5. Notify us ***after*** any Emergency Room, Urgent Care Clinic or Hospital visit.
6. Schedule medical appointments in a timely manner, including ***follow-up*** appointments.
7. Keep appointments as scheduled with us and any appointments scheduled with a specialist.
8. If you cannot keep an appointment call ***before*** your appointment time to cancel or reschedule the appointment.
9. You may be dismissed from your PCP if you repeatedly miss appointments without notice or do not follow the responsibilities listed in the medical home agreement.

Your Healthcare is a TEAM Approach involving BOTH YOU and YOUR PROVIDER.

_____
Print Patient or Guardian Name

_____ _____
Patient or Guardian Signature Date

_____ _____
Provider Signature Date

JENKS FAMILY PHYSICIANS MEDICATION REFILL POLICY

Our staff members at Jenks Family Physicians are dedicated to providing you with convenient and conscientious medication refill services. Running out of refills of your Rx before your next appointment often creates a hassle for everyone. Many medical offices frequently require patients to request additional Rx refills from their doctor by communicating this need through their pharmacist, then relying on the pharmacist to contact the physician for approval. We, however, have observed that these policies often create medical errors, miscommunication, and delays for many patients. As a result, we would ask that you make such requests for additional medication refills through our office directly instead of through your pharmacist.

01. In order to request a prescription refill, please contact our office during normal 8-5 pm business hours at 918-299-8080. Please select option 2 on our phone line in order to request a refill and select your appropriate physician. Please follow our instructions as outlined in the recorded voice-mail. Our prescription voice-mail lines are checked several times throughout the day. Approximately 99% of all refill requests made from 8 am to 5 pm are handled during the same business day by our staff. All refill requests are reviewed by a physician prior to being authorized. As a result, please allow at least 24-hours in order for us to safely address all refill requests. You will be notified by our staff when your request has been fully addressed.

02. In the event that 24-hours has passed and you have not been notified that your refill request has been addressed, please contact our front office receptionists and ask to speak with our nurse manager regarding your delayed request. Occasionally, patient requests may be inaudible, incomplete, and very rarely left incomplete by our nursing staff. We will make every effort to complete your refill request in a timely and courteous manner. Your feedback is always appreciated.

03. Ideally, all refills will be handled during your office visits. We request that you notify us during your visit as to what refills you will require. For instance, if your next check-up is in 6 months, and you know that you'll be out of refills on a Rx in 3 months, please let us know during your visit. We will typically authorize additional refills during your visit in this circumstance. Often times patients stop taking a medication, change a medication, or have a new or different medication added by another physician which makes it difficult on our part determining what medication refills you may need if you do not specifically request them from us. Communication and planning during each visit with us regarding what medications you need is essential.

04. Our shared goal should be to arrange all of your medication refills to occur on the same schedule when possible. This eliminates the need for multiple phone

calls to our office, unnecessary visits for medication refills, and multiple trips to your pharmacy. Please make every effort with us to synchronize your medication refills.

05. Many, but not all, prescription plans allow for 90-day prescriptions for non-controlled substances. We highly encourage this whenever possible. Please be sure to notify us if you would prefer a 90-day prescription.

06. Occasionally, patients prefer brand name medications when a generic version of the same medication is available. For example, some patients have found that brand name Prozac seems to work better for them than generic Fluoxetine. Please be sure to notify your physician or nurse **each and every time** you request a refill if you desire a brand name instead of a generic medication; otherwise we will always default to generic medications whenever possible.

07. Starting in 2009, Medicare and a few private insurance companies are requesting that all medications be delivered electronically or by fax to your pharmacy rather than the traditional means of a hand-written prescription. It is highly likely this will become industry standard within the next decade. Starting in 2012, all physicians' offices will be financially penalized by Medicare for failure to adhere to this policy. As a result, we are making every effort to fax or electronically send most prescription refills directly to your pharmacy of choice. On occasion, we do experience a problem with electronic and fax failures. We appreciate your patience and understanding with this government mandate. In order to avoid any inconvenience, we recommend that you place a phone call to your pharmacy verifying that your prescription is ready to be picked up, prior to making any trips to your pharmacy. Should you find that your prescription has not been received, please notify us immediately by speaking with one of our receptionists or nurse manager.

08. All routine requests for controlled substances must be handled through your regularly scheduled doctor's appointment. We typically schedule such follow-up visits in 1, 3, or 6 month intervals, and refill per DEA guidelines. We typically do not take refill requests for controlled substances such as pain killers, attention deficit disorder medications, or controlled anxiety medications outside of a doctor's appointment. We will, of course, be willing to address your specific situation if any extenuating circumstances arise. As always, we do not under any circumstances refill lost or stolen prescriptions for controlled substances.

09. As a general rule, we do not start new Rx's or alter dosages of existing Rx's outside of a face-to-face doctor's appointment, unless previously agreed upon

during your most recent visit. Exceptions to this would be titration of blood pressure or diabetes medications or other specifically discussed situations and arrangements you may have with your physician.

10. Requests for antibiotics without a recent accompanying doctor's visit will usually be declined unless there are extenuating circumstances. Unfortunately, antibiotic over-use has contributed to the spread of many drug-resistant bacteria which endangers us all. For example, the dominant form of staphylococcus in the Jenks community is now penicillin-resistant. Because of this, antibiotic use at Jenks Family Physicians will be controlled and prescribed judiciously.

I, _____, have reviewed the above policies thoroughly and agree to abide by these patient responsibilities as described above.

_____ _____

Signature Date

JENKS FAMILY PHYSICIANS REFERRAL POLICY

Our staff members are dedicated to providing you with assistance regarding specialty and diagnostic referrals. We take this responsibility very seriously in order to deliver optimum coordination of your healthcare. Please review our policies thoroughly as outlined below:

Our staff arranges all referrals to specialists, hospitals, imaging centers, and laboratories at no cost to our patients. We receive no reimbursement from any insurance company for the provision of referral services. We receive no renumeration from any specialist, hospital, imaging center, or laboratory in exchange for a referral.

Jenks Family Physicians provides no warranty regarding the quality, convenience, or outcome of the services of any referral source outside of our own clinic.

Our staff will make every attempt to expedite your referral request within ten days or less. Due to insurance restrictions and specialist availability, however, we make no guarantees regarding the timeliness of your referral. In the event that you have not heard back from our office within ten days, please contact us to check on the status of your referral.

Our staff will make a good faith effort to insure that any referral to a specialist, hospital, imaging center, or laboratory will be in-network and a covered service with your insurance provider. Due to insurance limitations and restrictions however, we make no guarantees that your referral will be paid for by your insurance provider. We expect all of our patients to act as the primary custodian of their insurance services, and to be familiar with insurance network limitations, covered services, deductible liabilities, and any additional payment requirements.

We request that you contact your insurance company and verify that your referral will be a covered service prior to any referral appointment or procedure. Occasions sometimes arise where an insurance representative communicates to our staff that a service is covered, only to be discovered later that the service was not. While we have always been able to resolve these situations for our patients, we wish to emphasize that having you contact your insurance **prior** to any service is the best way to protect your financial interests. We specifically decline any financial or other responsibility for assuring that your insurance company provides coverage for the healthcare recommendations that we have made for you.

Regarding lab tests drawn in our clinic, we will make a good faith effort to route your laboratory specimens to the outside lab company recommended by your insurance company. Laboratory specimens are currently handled at our office by DLO, RML (CommunityCare network laboratory), and LabCorp (United network laboratory). These laboratory companies pick up specimens from our office on a daily basis. We make no

warranties regarding the quality or timeliness of your laboratory results once your laboratory specimen has left our office. If your insurance requires the use of a specific lab company, we request that you notify us at the time of your specimen collection. We encourage each of our patients to become familiar with their insurance company's individual laboratory benefit plan and deductible/co-pay responsibilities.

I, _____, have thoroughly reviewed the above policy and agree to adhere to my responsibilities as a patient as described above.

_____ _____

Signature Date

JENKS FAMILY PHYSICIANS PREVENTIVE HEALTHCARE POLICY

At Jenks Family Physicians, we consider an annual physical an important part of your complete healthcare strategy. Under ideal circumstances, we believe an annual physical should be performed as a separate visit outside of a problem-oriented visit (e.g. sore throat visit, injury, or diabetes check-up). An annual physical provides us with the opportunity to discuss preventive healthcare strategies as outlined below. In addition, it provides us an opportunity to update your complete medical record and address any long range planning regarding your healthcare needs at all stages of life from childhood to end-of-life planning.

Scheduling of annual physicals typically requires a 30-minute visit. We believe this type of healthcare should be a personal decision and leave it to you, the patient, to decide whether you would like to schedule such a visit with us. We recommend the following preventive healthcare items listed below. We will leave it to you to decide which of these services you would like for us to arrange for you, or which of these services you would simply like to discuss further with us.

Immunizations: We recommend all childhood immunizations required for public school entry by the state of Oklahoma. We follow and utilize the immunization schedule as outlined by the Oklahoma State Healthcare Authority. We recommend annual influenza immunization for all patients for whom it is not contraindicated. We recommend at least a one-time immunization of Pneumovax (pneumonia vaccine) & herpes zoster (shingles) immunization for all patients age 65 or older. We recommend human papillomavirus (HPV) vaccination for all eligible patients between the ages of 9 to 26. We recommend meningococcal (meningitis) immunization for all teenagers and young adults. We recommend Tetanus-Diptheria-Pertussis immunization for all adults every 10 years, and sooner when indicated.

For adults we recommend the following:

- annual pap smears for all women over the age of eighteen.

- annual mammograms for all women over the age of forty.

- annual prostate screening and PSA evaluation for all men over the age of forty.

- colonoscopy (colon cancer screening) for all patients over the age of 50 at an interval of at least every ten years, or sooner for higher risk patients.

- bone density screening for all patients over age 64, or sooner for patients at high risk of osteoporosis.

- aortic aneurysm screening for all patients over age 64 who have had a smoking history.

We recommend cardiac stress testing and carotid ultrasound screening for any patients with significant cardiovascular risk factors or symptoms.

We recommend specific full-body skin cancer screening for any patient with a personal or family history of skin cancer, excessive sun exposure, or skin changes.

We recommend the following laboratory screenings for all adult patients at least every three years: complete blood count (CBC), comprehensive metabolic profile (CMP) including liver and kidney function evaluation, thyroid stimulating hormone (TSH) testing, cholesterol profile, urinalysis (UA), and electrocardiogram (EKG).

For all smokers we recommend complete tobacco cessation. Currently there are no consistent and reliable guidelines regarding early detection of lung cancer due to tobacco use. As a result of this, we do recommend a thorough physical examination at least annually for all tobacco users, as well as a spirometry (lung function) evaluation and chest x-ray in any symptomatic patient.

I, _____, have thoroughly reviewed the above recommendations and agree to notify my physician and arrange a specific appointment for any and all of these services for which I wish to obtain or discuss.

_____ _____

Signature Date

As part of our participation with the Centers for Medicare & Medicaid Services it has been requested that we obtain the following demographic information from our patients. If you would prefer not to provide the requested information, please select "Declined" in the appropriate category.

Patient Name: _____ Patient DOB: _____

Person Completing Form if Not Patient: _____

Race:

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White/Caucasian
- Other Race
- Declined

Ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino
- Declined

Preferred Language:

- English
- Arabic
- Chinese
- French
- German
- Japanese
- Russian
- Spanish
- Vietnamese
- Other
- Declined