Thornville Family Medical Center
P.O. Box 281, 41 Foster Drive
Thornville, Ohio 43076
Phone (740) 246-6361
Fax (740) 246-4722

Larry I Cowan, D.O. Shelby K Raiser,D.O. Melissa J Koppelman, D.O.

Date:_____

Patient Name:_____
(First) (Middle) (Maiden) (Last)

Patients' Date of Birth:__/__/__ SSN:_____ Male/ Female (Please circle)
Email Address:_____

Mailing Address:_____
(P.O. Box and Street #) (City) (State) (Zip Code)

If Minor, Mothers' Name: _____
Address:_____
Phone Number:(Home)_____(Cell)_____(Work)_____

Fathers' Name: _____
Address:_____
Phone Number:(Home)_____(Cell)_____(Work)_____

Spouse/Legal Guardian Name (First/Last):_____
Phone Number:(Home)_____(Cell)_____(Work)_____

Children's Full Names/ Date Of Birth:
_____
_____
_____

Relative or friend we may leave a message with in the event you can not be reached:

Name:_____ Relationship_____Phone Number:_____

Person to notify in Case of Emergency:

Name:_____ Relationship_____Phone Number:_____

****ATTENTION** parents'/legal guardians' of minor children it is YOUR responsibility to notify the office in the event your child is no longer a covered member on your insurance policy due to turning 18,parent, divorce, etc. If the "Child" wishes to remain a patient at this office they will be required to update their information and show proof of insurance or ability to pay.

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New Patient Health Questionnaire

Name:_____ **Date of Birth:**_____**Age:**_____
Email Address:_____**Weight:**_____ **Height:**_____
Drug Allergies:_____

Chief Complaints/Health Concerns(In order of importance)

_____
_____
_____
_____
_____
_____

Hospitalizations/overnight stays, including normal pregnancies and OP Surgeries:

Year:_____ Illness/Operation_____
Year:_____ Illness/Operation_____
Year:_____ Illness/Operation_____
Year:_____ Illness/Operation_____
Year:_____ Illness/Operation_____

Past Medical History: (Please check mark the box for Yes or leave it blank for No)

- ☐ Aids or HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Trouble
- ☐ Bladder Infection
- ☐ Bleeding Tendency
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chickenpox
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Disease

- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hernia
- ☐ High/Low Blood Pressure
- ☐ Hive/Eczema
- ☐ Infectious Mono
- ☐ Kidney Disease
- ☐ Measles
- ☐ Migraines
- ☐ Mitral Valve
- ☐ Mumps
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Smallpox
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Transfusions
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Whooping Cough
- ☐ Any other disease: Please List_____

Family History:

Has any blood relative had any of the following(if Yes check the box or leave blank if uncertain please)

Relationship:

- ☐ Allergies _____
- ☐ Anemia _____
- ☐ Bleeding Tendency _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Epilepsy _____
- ☐ Heart Disease _____
- ☐ High Blood Pressure _____
- ☐ Stoke _____
- ☐ Tuberculosis _____

Social History:

Tobacco Packs per day:____for_____years.
Alcohol drinks per week:_____
Caffeine cups per day:_____
Use of illegal drugs, if yes what type:_____

Women Only-Year of last:

Breast Exam:_____ Results:_____
Mammogram:_____ Results:_____
Pap Exam :_____ Results:_____

Age of onset of menstrual period:_____ Date of last menstrual period:_____
Use of birth control: Yes or No If yes, what type:_____

# of pregnancies:_____#of live births:_____# of miscarriages:_____# of abortions:_____

The last time you had a (year):

- ☐ Flu Vaccine
- ☐ Hepatitis Vaccine
- ☐ Pneumonia Vaccine
- ☐ Stool blood test
- ☐ Sigmoid exam
- ☐ Cholesterol test
- ☐ Tetanus shot
- ☐ TB test
- ☐ Rubella Vaccine
- ☐ Rectal exam
- ☐ Eye exam
- ☐ PSA

Medications/dosage and instructions:(Please bring medications with you for the first new patient appointment)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Thornville Family Medical Center
Request for Release of Medical Records

Records coming from:

Physician:_____
Address:_____
_____
_____
Phone #:_____ Fax #:_____

I hereby authorize that my medical records may be released to:

Thornville Family Medical Center
41 Foster Drive, P.O. Box 281
Thornville, Ohio 43076
Phone:(740)246-6361]
Fax:(740) 246-4722

Patients Name(s):_____
Address:_____
_____
_____
Phone #:_____Date of Birth:_____
Patient Signature:_____Witness Signature:_____
Today's Date:_____

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I_____ agree that that Thornville Family Medical Center may leave a message on my cell or home phone with the number that I have provided below. Message may indicate lab results, testing results and/or any other message from the office.

I fully understand and accept the responsibility that someone other than me may hear the message left on my machine or phone.

I agree to call the physicians office if I do not personally hear the results of any of my tests or procedures within 4 business days, this includes lab results, x-rays and scans which have been ordered by Dr.Cowan, Dr.Raiser and Dr. Koppelman.

Phone Number:_____

Patient/Guardian Signature:_____Date:_____

Staff Member Signature:_____Date:_____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allowed for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send text to confirm appointments? Yes or No
May we leave a message on your answering machine at your home/cell phone? Yes or No
May we discuss your medical condition with any family member? Yes or No
If yes: Please name the members allowed:
_____
_____

This consent was signed by:_____
(Print Name Please)

Signature:_____ Date:_____
Witness:_____Date:_____