Medicines & Allergies

PATIENT NAME:_____

Signature:_____

Date:_____

PHARMACY:

MAIL ORDER:_____

PH:_____FX:_____

LOCAL PHARM:_____

PH: _____FX:_____

Please print carefully and include all of the information requested. Use two sheets if necessary.

Be sure to record **ALL** medicines you are currently taking, as well as any Vitamins, Supplements, and any over-the-counter (OTC) medications.

Please list any allergies at bottom of page.

PRESCRIPTIONS, OVER-THE-COUNTER (OTC), SUPPLEMENTS, AND VITAMINS

MEDICINE NAME	BRAND/GENERIC	DOSAGE	HOW/WHEN TAKEN	PRESCRIBED/OTC PRESCRIBING DR	UPDATED DATE/INITIAL

ALLERGIES:_____

_____

This information must be updated at each appointment. Thank you!

HEALTH QUESTIONAIRE A Helen Stosel MD, INC.

Name_____ Age_____ Date_____

Referred by_____ Primary Care Physician_____

REASON FOR VISIT_____

MEDICAL HISTORY

Have you received regular medical care for any condition? If yes, please list: _____

_____

Have you had any surgeries? If yes, please list:_____

_____

Females:

What age did you start having menstrual cycles? _____ At what age did your menstrual cycles stop? ____

Do you have irregular menstrual cycles? No Yes _____

Any children? If yes, any heavier than 9lbs at birth? No Yes _____

Did you have diabetes during any of your pregnancies? No Yes _____

Do you have allergies? If yes, what sort of reaction? No Yes _____

CURRENT MEDICATIONS

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

ALLERGIES:_____

Have you recently taken prednisone or other hormones? No Yes _____

FAMILY HISTORY	Age	Health Status (if deceased, cause of death)
Father	_____	_____
Mother	_____	_____
Siblings	_____	_____
_____	_____	_____

Has any blood relative ever had any of the following?

Diabetes? Type 1 or Type 2 No Yes _____

Thyroid condition? No Yes _____

Heart Trouble? No Yes _____

High blood pressure? No Yes _____

High cholesterol? No Yes _____

Any Cancer? No Yes _____

Osteoporosis? No Yes _____

Autoimmune disorders? No Yes _____

Other health issues? No Yes _____

HEALTH QUESTIONAIRE B

Helen Stosel MD, Inc.

Name_____Age:_____Date:_____

Social History:

Marital Status (circle one): Single Married Divorced Widowed

Total # of Children_____

Do you have any biological (not adopted or step-children) children? If yes, how many? No Yes _____

Occupation:_____

Highest Level of education completed: _____

Do you use alcohol? If yes, state how much and how frequently?	No	Yes _____
Do you smoke tobacco? If yes, how much and for how long?	No	Yes_____
Do you use illegal/recreational drugs?	No	Yes_____

Review of Systems:

GENERAL	Any recent weight changes?	No	Yes_____
	Have you recently felt more tired/loss of energy?	No	Yes_____
	Have you been in poor health most of your life?	No	Yes_____
SKIN	Any recent skin infections or excessive dryness?	No	Yes_____
	Any new hair growth / change in hair growth?	No	Yes_____
	Any excessive sweating?	No	Yes_____
HEENT	Headaches?	No	Yes_____
	Difficulty Swallowing?	No	Yes_____
	Dry Mouth? Excessively Thirsty?	No	Yes_____
NECK	Any lumps, swelling, or enlarging of neck?	No	Yes_____
	Any enlarged glands?	No	Yes_____
ENDOCRINE	Any known thyroid problem?	No	Yes_____
	Any recent hormone therapy?	No	Yes_____
	Are you bothered by cold or warm temperature?	No	Yes_____
RESPIRATORY	Any difficulty breathing?	No	Yes_____
CARDIOVASCULAR	Any palpitations?	No	Yes_____
	Any recent onset of chest pain?	No	Yes_____
	Swelling of hands, feet, or ankles?	No	Yes_____
GASTROINTESTINAL	Frequent diarrhea or constipation?	No	Yes_____
	Cramping or abdominal pain?	No	Yes_____
	Recent change in bowel habits?	No	Yes_____
GENITOURINARY	Frequent urination?	No	Yes_____
	Kidney Stones?	No	Yes_____
	Recent change in menstrual cycles?	No	Yes_____
MUSCULOSKELETAL	Any weakness of muscles or joints?	No	Yes_____
	Difficulty walking?	No	Yes_____
	Any change in glove/ring size?	No	Yes_____
NEURO-PSYCHIATRIC	Feeling anxious or depressed?	No	Yes_____
	Have you had a seizure recently?	No	Yes_____
HEMATOLOGIC	Are you slow to heal after cuts?	No	Yes_____
	Any history of anemia?	No	Yes_____

Anything else that we did not mention but you would like us to know about?_____

_____

Patient Signature X_____Date_____

Helen Stosel M.D.

PATIENT INFORMATION

Name:	Date of Birth
Address One:	Social Security #
Address Two:	Sex:
City	Language:
State:	Employer:
Home Phone #:	Emergency Contact:
Work Phone#:	Emergency Phone#:
Cell Phone#:	Emergency Relationship:

GUARANTOR INFORMATION

Name:	Date of Birth
Address One:	Social Security #
Address Two:	
City	Employer:
State:	Employer Address:
Home Phone #:	Address Two:
Work Phone#:	Employer City:
Cell Phone#:	Employer State:

GUARANTOR INFORMATION

Primary Insurance:	Secondary Insurance:
Certificate#:	Certificate#:
Group Number:	Group Number:
Group Name:	Group Name:
Copay:	Copay:
Subscriber Name:	Subscriber Name:

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, Helen Stosel M.D. when she accepts assignment.

Authorizations To Release Medical Information. I hereby authorize my Provider, Helen Stosel M.D. to release any information necessary for my course of treatment

_____ _____

Signed (patient or parent if minor). Date

PERMISSION to RELAY INFORMATION

As required by the Health Insurance Portability and Accountability Act of 1996, you have a right to request that communications concerning your Protected Health Information (PHI) be made through confidential or encrypted channels. If you request to receive confidential communications for PHI by alternative means, you must give us an alternative phone number or another method of contacting you. ***Some method of contact must be provided***.

We will not ask why you are making your request and will make every effort to accommodate all reasonable requests.

This form supersedes any prior request for communication of information I may have made.

Extended Authorization

Please list any persons you would like to have access to your billing, appointment, or health information (with the exclusion of information that is protected under State and Federal law) such as your spouse, caretaker, or other family member:

Name	Relationship
_____	_____
_____	_____
_____	_____

Restrictions on Communication Methods

Our methods of communicating with you may be through United States Postal Service, secure email, fax, and telephone (including leaving messages on your voicemail). Types of communication may include appointment reminders, medical records as requested, marketing, and company announcements. Please indicate below any ways in which you do NOT want to receive communications:

____No Restrictions

____No calls to phone number (s), except: _____
____No voicemails left on phone number (s), except: _____
____No mail, except for the following address: _____
____ Other (please specify): _____

_____ _____
Signature of Patient / Responsible Party Date

_____ _____
Name of Patient / Responsible Party Relationship to Patient

Helen Stosel, MD

REQUEST FOR RELEASE OF MEDICAL RECORDS

Date_____

To: _____
Physician's Name

_____
Address

_____

_____ _____
Phone Fax

NOTES [ ] LABS [ ] RADIOLOGY [ ] DATES:

_____
Records Requested

I hereby request that my medical records be released to:

Dr. Helen Stosel, MD

25910 Acero #250
Mission Viejo, CA 92691
949-951-7100 Fax 949-951-7110

_____
Patient's Name (print) Date of Birth

_____
Address City ST Zip

_____
Social Security #

_____
Patient's Signature Date

Helen Stosel MD, INC.

FINANCIAL INFORMATION SHEET

Patient Name _____

CREDIT CARD INFORMATION

Name as shown on credit card: _____

Type of Card (circle one) AMEX MasterCard Visa Discover

Credit Card Number: _____

Expiration Date: _____/_____/_____ CVV: _____

Billing Zip Code for Card: ZIP Code _____

Card Holder Signature: _____

Patient Signature: _____

Dr. Stosel accepts the following credit cards: American Express, Discover, MasterCard, and Visa. She also accepts personal checks and cash. Payment is due at time of appointment.

ACKNOWLEDGEMENT AND RECEIPT OF PRIVACY PRACTICES

I have been provided with a copy of the Notice of Privacy Practices for Helen Stosel MD, INC. as it is currently in effect. I have read and understand the information presented in the Notice. I understand that I am entitled to receive a paper copy of the notice at any time I request one, and I can make my request for a paper copy to the Privacy Office at Dr.Stosel MD address. I also understand Helen Stosel MD, INC. reserves the right to change notice. If any future changes are made to the Notice, on my next visit or admission following implementation of such changes, I will be provided with a copy of the new notice in effect.

Patient Name_____Date of Birth_____

Patient Signature_____

Parent or Guardian Signature _____Date_____

(if patient is under 18)

Restrictions on Patient Information

_____

_____

Special Contact Requirements

_____

_____

_____

For Office Use Only

*(You may use this section to document a patient's inability, refusal, or choice not to read the Notice, or sign the acknowledgement).*_____

_____