h2u
HEALTH TO YOU

General Consent for Care and Treatment

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	Date
Printed Name of Patient or Personal Representative	Relationship to Patient
Printed Name of Witness	Employee Job Title
Signature of Witness	Date

General Consent for Laboratory and Diagnostic Care and Treatment

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended laboratory or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the laboratory and diagnostic evaluation(s) necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary laboratory and diagnostic testing. By signing below, you are indicating that you consent to laboratory and diagnostic evaluations at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test(s) recommend by your health care provider, we encourage you to ask questions.

I understand that if additional testing, invasive or interventional, is recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	**Date**
Printed Name of Patient or Personal Representative	**Relationship to Patient**
Printed Name of Witness	Employee Job Title
Signature of Witness	**Date**

H2U Health Center at _____

Patient Information:

Patient Name: (Last) _____ (First) _____ (MI) _____
Date of Birth (DOB): _____ Sex: ☐ Female ☐Male ☐Transgender
Social Security Number (SS#): _____-_____-_____
Address: _____
City, State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Unknown
Employer Name: _____ Employer Department: _____
Employee ¾ (If applicable)_____ Medicare Enrolled (check): ____Part A ____Part B ____Part D
How did you hear about us:
_____ Website _____ Co-worker _____ New Hire Orientation _____ Newsletter
Other, please describe:_____

Responsible Party/Policy Holder (If Other Than Patient):

Policy Holder's Name: (Last) _____ (First) _____
Policy Holder's Date of Birth (DOB): _____ Insurance Company_____
Policy # _____ Group #_____
Policy Holder's Social Security Number (SS#):_____-_____-_____

Additional Information:

Email Address: _____* **email address is required in order to access the Patient Portal**
Pharmacy Name/Location: _____
Race: ☐American Indian or Alaska Native ☐Asian ☐Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Declined
Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐Declined
Language: ☐English ☐Spanish ☐Indian ☐Japanese ☐Chinese ☐Korean ☐French ☐German ☐Russian ☐ Other
_____

Emergency Contact Information:

Emergency Contact: (Last) _____ (First) _____
Phone Number: (1) _____ (2) _____
Emergency Contact Relationship to Patient: _____

Current Physician's Names:

Primary Care Provider (PCP): _____
Any Other Physician: _____

I acknowledge that the information provided on this form is accurate and up-to-date to the best of my knowledge. The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that a request for medical information from persons not listed above will require a specific authorization prior to disclosure of any medical information.

_____ _____
Patient Signature / Guardian Signature Date

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Patient History Form

Patient's Name (Last) _____ (First) _____ (MI)_____ Date of Birth MM____/DD____/YYYY____

Medical Problems: Have you had (or do you have) any of the following medical problems: (check Yes or No)

YES	NO		YES	NO		YES	NO		YES	NO	
❑	❑	High Blood Pressure	❑	❑	Breast Cancer	❑	❑	Emphysema	❑	❑	Other Kidney Disease
❑	❑	Heart Disease	❑	❑	Colon Cancer	❑	❑	Tuberculosis	❑	❑	Seizure Disorder
❑	❑	Heart Attack	❑	❑	Other Cancer	❑	❑	Sickle Cell	❑	❑	Rec'd Blood Transfusion
❑	❑	Stroke	❑	❑	Abnormal PAP	❑	❑	Anemia	❑	❑	STD
❑	❑	Diabetes	❑	❑	Hepatitis or Jaundice	❑	❑	Arthritis			
❑	❑	Thyroid Disease	❑	❑	Liver/Pancreas Disease	❑	❑	Kidney Stones			
❑	❑	Positive HIV or AIDS	❑	❑	Asthma	❑	❑	Urinary Tract Infection			

Other (please describe)

_____

_____

Past Surgery: Have you had any of the following operations and year of procedure

❑ Appendix - Year: _____
❑ Hernia - Year: _____
❑ Tonsils - Year: _____
❑ Gall Bladder - Year: _____
❑ Heart - Year: _____
❑ Thyroid - Year: _____
❑ Lung - Year: _____
❑ Hysterectomy - Year: _____
❑ Spine/Joint - Year: _____

Other (please describe)

_____

_____

Patient Social History

Marital Status:	❑ Single	❑ Married	❑ Separated	❑ Divorced	❑ Widowed
Use of Alcohol:	❑ Never	❑ Rarely	❑ Moderate	❑ Daily	❑ Previously, Quit
Use of Tobacco:	❑ Never	❑ Previously, Quit	❑ Current	❑ Packs Per Day: _____	

Use of Drugs: **YES** ❑ **NO** ❑ Type: _____ Frequency: _____

Family Medical History

	Age	Disease	Deceased/Cause of Death
Father			
Mother			
Sibling			

In the event a procedure needs to be rescheduled, what hospital do you prefer?

_____

Signature: _____ Date: _____

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Patient Medication List

Name: _____

Date: _____

Medication Allergies:

_____

_____

_____

Prescriptions						
Name	**Dose**	**How many times per day?**	**When do you take it? (Morning, night, After meals?)**	**Who prescribed it? (Physician's last name)**	**Why do you take it?**	**Do have any side effects? Describe them.**

Over-the-counter medications, herbal remedies, vitamins						
Name	**Dose**	**How many times per day?**	**When do you take it? (Morning, night, After meals?)**	**Who recommended it?**	**Why do you take it?**	**Do have any side effects? Describe them.**