Sancta Familia Medical Clinic
10506 Burt Circle
Omaha, NE 68114-2094
Phone: 402-991-3393 Fax: 402-991-3390

Notice of Privacy Practices Receipt & Permission to Disclose Protected Health Information

This notice describes how medical/protected health information about you may be used and disclosed. Please read this carefully. This form is to accompany the Notice of Privacy Practices.

Summary: As a patient you:
1. Can inspect and copy your health information. 2. Can request corrections to your health information.
3. Can request that your information be restricted. 4. Can request confidential communication.
5. Can obtain a report of disclosures of your information. 6. Can obtain a paper copy of this notice.

We want to help assure you that your medical/protected health information (PHI) is secure. This notice contains information about how we will help ensure that your information remains private.

Disclosing health information:
Your personal health information may be disclosed to necessary parties to provide for treatment, payment and health care operations. You may also authorize release to family members or other persons.

Patient's Name (please print)_____ DOB:_____

Persons to whom information may be disclosed:
Name: _____ Relationship: _____ Phone#:_____

☐ Add as an Emergency Contact

Name: _____ Relationship: _____ Phone#:_____

☐ Add as an Emergency Contact

Receiving health information:
Please indicate the phone number that you wish to be used for receiving calls about your appointments, lab and testing results, and other health information. Be aware that a cell phone number is not considered a secure and private line. You may list both a cell and home if you wish.
Phone number(s): _____

___ Yes, you may leave confidential detailed messages on my telephone voicemail listed above.

___ Yes, you may leave a message for a returned call.

___ No, you may NOT leave confidential detailed messages on my telephone voicemail listed above.

I acknowledge that I was provided with the Notice of Privacy Practices of Sancta Familia Medical Clinic.

_____ _____ _____
Signature of patient/ legal guardian if under 19 years **Relationship** **Date**

*This authorization is effective until a written request from the patient is submitted, revoking authority.

Sancta Familia Medical Apostolate

10506 Burt Circle Omaha, NE 68114-2094

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ACKNOWLEDGEMENT AND AUTHORIZATION:

- I hereby assign my insurance benefits to be paid directly to the healthcare provider.
- I authorize Sancta Familia Medical Apostolate to release medical information required to process my claim.
- I have read and understand the Financial Policy for Sancta Familia Medical Apostolate.
- I authorize Sancta Familia Medical Apostolate to obtain/have access to my medication history.
- I authorize my provider's office to contact me by mobile phone.

Print Patient's Name:_____ **DOB**:_____

Signed:_____ **Date**:_____

(Patient, Parent, legal guardian or authorized representative-Please denote relationship to patient)

Sancta Familia
Medical Apostolate
Corpus Fidele
All for the Glory of God

New Adult Patient Medical Intake Form

Your medical information is important. Please take time to fill out this sheet.
You may write "None" or "N/A" if needed. All information is confidential.

Name:	DOB:	Date:

PREFERRED PHARMACY: _____

MEDICATION ALLERGIES? _____
Reaction: (rash/hives/shortness of breath) _____

PRESENT MEDICATIONS/Supplements or Herbals and their dose:

_____
_____
_____
_____
_____

SOCIAL HISTORY:

Home and Environment
Are there any smokers in your house? Yes No
Have you been exposed to chemicals or toxins? Yes No

Education and Occupation
What is the highest grade or level of school you have completed or the highest degree you have received?

_____

Occupation: _____

Marital Status:
Single Married Divorced Widowed Separated N/A

How many children: _____

Substance Use:
Do you or have you ever smoked tobacco? Never Year Started _____ Year Quit _____
Packs per day _____

Do you or have you ever used any other forms of tobacco or nicotine? Yes No

What is your level of alcohol consumption? None Occasional Moderate Heavy

Do you use any illicit or recreational drugs? Yes No

What is your level of caffeine consumption? None Occasional Moderate Heavy

Advanced Directive:
Do you have an advanced directive? Yes No

Diet and Exercise:
What is your exercise level? None Occasional Moderate Heavy

Travel:
Have you recently traveled abroad?

SURGICAL PROCEDURES (DATE)

_____

_____

_____

WOMEN ONLY:

Pregnancies: _____ Living Children: (term) ___ /(premature)___ Miscarriages: _____

Abortions: _____ Last Pap smear: _____ History of Abnormal PAP? _____

Last Mammogram: _____ Last Menstrual Period: _____

OTHER:
Last Colonoscopy: Date_____ Never

DIABETICS ONLY:
Last diabetic eye exam: _____ Last A1c check: _____

Last urine protein screening: _____

PERSONAL AND FAMILY HISTORY: NAME:_____

☐ Mark here if you were adopted or if your family history is unknown

****For Grandparents use "P" for paternal and "M" for maternal i.e. PGM = paternal grandmother****

Check those that apply	Yourself	Mother	Father	Grandparents**	Brother	Sister	Children
Alcoholism/Addictions							
Allergies							
Alzheimer's							
Anemia							
Anxiety							
Arthritis							
Asthma							
Autoimmune disorder							
Bleeding disorder							
Cancer ***(Include Type)*** (include age of diagnosis)							
COPD/emphysema							
Coronary artery disease							
Depression							
Diabetes ***(Include Type)***							
Eczema							
Epilepsy							
Genetic Disorder ***(Include Type)***							
Gout							
Headaches							
Heart attack (include age of diagnosis)							
Heart disease (include age of diagnosis)							
Hepatitis ***(Include Type)***							
High Blood Pressure							
High Cholesterol							
HIV/AIDS							
Hyperthyroidism							
Hypothyroidism							
Inflammatory Bowel Disease (Crohn's, etc)							
Kidney disease							
Liver disease							
Mental illness ***(Include Type)***							
Migraines							
Stroke							
Tuberculosis							
Ulcers							
Other:							

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Request for Access to Medical Records

Notice to Patient: You may use this form to request to inspect or copy information maintained about you. This type of request is described in our Practice's Notice of Privacy Practices. To revoke this request provide a written notice to our office.

Patient Name _____ **Date of Birth** _____

Please FAX a copy of my records to Sancta Familia Medical Apostolate.

Doctor Name _____

Name and Location _____

_____

Phone _____ **Fax** _____

Please send the following health information:

( ) Complete Medical Record

( ) Medical Records from _____ **to** _____
Date Date

( ) Specific Records Listed: _____

If applicable, include, health information related to testing, diagnosis, and/or treatment of (initial applicable line): _____ HIV (AIDS) _____ Sexually Transmitted Diseases

_____ Mental Health _____ Drug and/or Alcohol Abuse

Patient Name Print _____

Patient Signature _____ **Date:** _____

For Personal Representative of Patient or To Access Patient Information
I hereby certify that I have the legal authority under applicable law to make this request on behalf of the patient identified above or the Patient has requested that I can receive medical information.

Print Representative Name _____

Relationship _____

Signature of Representative _____ **Date:** _____