BooneHealth
MEDICAL GROUP

1) Please complete the enclosed paperwork and bring with you to your appointment. Please do not mail or fax as this can delay processing.

2) You must arrive 30 minutes early to process your check-in as a first-time patient. Failure to arrive early could result in the need to reschedule your appointment.

3) Bring your insurance card and photo ID, and the enclosed paperwork completed.

4) Any copay or coinsurance is due at the time of service. We accept cash, check, Mastercard, Visa and Discover card.

5) If you do not plan to keep this appointment, please give our office 24 hours notice prior to the appointment.

6) If you are experiencing any COVID-like symptoms, or have had a recent exposure, please call the office and let us know so we can plan accordingly.

We look forward to meeting you.

Sincerely,

Boone Health Primary Care

BooneHealth
BOONE MEDICAL GROUP

New Patient Questionnaire

All Questions Contained in this Questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.) _____ (Circle) Male Female

Date of Birth ___/___/_____ Age:_____

Home Phone	Preferred Pharmacy Name and Location
Cell Phone	Primary Dentist
Email Address	

Race:

- □ Alaskan Native
- □ Asian
- □ Asian Pacific
- □ Black/African American
- □ Hispanic
- □ Native American
- □ Other
- □ Pacific Islander
- □ Unknown
- □ White/Caucasian (Non-Hispanic)

Ethnicity:

- □ Hispanic or Latino
- □ Not Hispanic or Latino
- □ Other

Preferred Spoken Language:

- □ Bulgarian
- □ Central Khmer
- □ Chinese
- □ English
- □ French
- □ German
- □ Haitian/Haitian Creole
- □ Hebrew
- □ Hindi
- □ Italian
- □ Korean
- □ Polish
- □ Portuguese
- □ Russian
- □ Somali
- □ Spanish/Castilian
- □ Swahili
- □ Thai
- □ Urdu
- □ Vietnamese
- □ Other, Please Specify _____

Emergency Contact:

Name_____ Relationship to Pt_____

Best Contact Phone Number _____

Patient Name: Patient DOB:

Today's Date:

BooneHealth
BOONE MEDICAL GROUP

Please list all current medications, including over-the-counter and herbal supplements:

Medication	Dose	Frequency
Medication	Dose	Frequency
Medication	Dose	Frequency
Medication	Dose	Frequency
Medication	Dose	Frequency
Medication	Dose	Frequency
Medication	Dose	Frequency
Medication	Dose	Frequency
Medication	Dose	Frequency
Medication	Dose	Frequency
Medication	Dose	Frequency

Please list all current medication allergies:

Allergy	Reaction
Allergy	Reaction
Allergy	Reaction
Allergy	Reaction
Allergy	Reaction

Non-medication allergies:

Allergy	Reaction
Allergy	Reaction
Allergy	Reaction

Patient Name: Patient DOB:
Today's Date:

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Past Medical History - Please check all that apply:

□ No Past Medical History

□ Allergies
□ Anemia
□ Angina (chest pain)
□ Anxiety
□ Arthritis
□ Asthma
□ Atrial Fibrillation
□ BPH (Prostate Problems)
□ Blood clots
□ Cancer – specify type _____
□ Cerebrovascular Accident (Stroke)
□ COPD
□ Coronary Artery Disease (CAD)
□ Crohn's Disease
□ Depression
□ Diabetes
□ Gallbladder Disease
□ GERD (acid reflux)
□ Hepatitis C
□ Hyperlipidemia (high cholesterol)
□ Hypertension (high blood pressure)
□ Irritable Bowel Disease
□ Liver Disease
□ Migraine Headaches
□ Myocardial Infarction (heart attack)
□ Osteoarthritis
□ Osteoporosis
□ Peptic Ulcer Disease
□ Renal Disease (Kidney Disease)
□ Seizure Disorder
□ Sleep Apnea
□ Thyroid Disease
□ Overactive □ Underactive

□ Other, Please Specify _____

Past Surgical History – Please list all prior surgeries and the approximate year they took place:

□ No Past Surgical History

Surgery:_____ **Year:** _____
Surgery:_____ **Year:** _____
Surgery:_____ **Year:** _____
Surgery:_____ **Year:** _____

Family Medical History

□ No Relevant Family History

Mother's Age:_____ Health Problems: _____
If Deceased, Age of Death: _____ Cause of Death: _____

Father's Age:_____ Health Problems: _____
If Deceased, Age of Death: _____ Cause of Death: _____

Brother/Sister (please circle) Age:_____ Health Problems: _____
If Deceased, Age of Death: _____ Cause of Death: _____

Brother/Sister (please circle) Age:_____ Health Problems: _____
If Deceased, Age of Death: _____ Cause of Death: _____

Patient Name: Patient DOB:
Today's Date:

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Social History

What is your current marital status? Please circle.
Married Single Widowed Divorced Other

Do you drink alcohol?
Yes No Formerly

Do you drink caffeine?
Yes No Formerly

Do you use tobacco?
Yes No Formerly

What is your current smoking status? Please circle.
Current everyday smoker Current some day smoker Former Smoker Never Smoked

Preventative Health

Date of Most Recent Blood Tests (if known):
Cholesterol ___/___/___ Glucose ___/___/___

PSA (males only) ___/___/___

Date and Location of Most Recent Health Screenings (if known):

Colonoscopy ___/____/___ Location:_____

Bone Density ____/___/___ Location:_____

Physical Exam ___/____/___ Location:_____

Prostate Screening (males only) ___/____/___ Location:_____

Mammogram (females only) ___/____/___ Location:_____

Pap Smear (females only) ___/____/___ Location:_____

Patient Name: Patient DOB:
Today's Date:

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Have you ever been diagnosed with diabetes? YES NO

If yes, please answer the following:

Date	Test	Provider
	HbA1c	
	Foot Exam	
	Urinalysis with or without protein	
	Eye Exam	

Immunizations

Date	Immunization	Provider
	Pneumonia	
	Influenza	
	Tetanus	
	Other (please specify)	

This form was filled out by_____ Relationship to patient_____
(print name)

Signature: X_____ Date ___/___/___

Patient Name: Patient DOB:
Today's Date:

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BOONE MEDICAL GROUP

Please list previous primary care physician(s) and any specialist(s) you are currently seeing and/or have seen in the recent past. If we need to obtain records from these providers, we will provide an authorization form during your office visit.

Physician First and Last Name	Practice Name and/or City, State
Physician First and Last Name	Practice Name and/or City, State
Physician First and Last Name	Practice Name and/or City, State
Physician First and Last Name	Practice Name and/or City, State

Patient Name: Patient DOB:
Today's Date:

BooneHealth
1600 E. Broadway, Columbia, MO 65201
573.815.8000 • www.boone.health

Patient Name:_____

Med Rec Number:_____ Acct Number:_____

Age:_____ Gender:_____ DOB:_____ Svc Date:_____

Acknowledgement to Share Information with a Health Information Exchange

CH Allied Services, Inc. dba Boone Hospital Center, Boone Hospital Center's Visiting Nurses, Inc. dba Boone Home Care and Hospice, Boone Physician Services, LLC dba Boone Medical Group and CHAS Physician Services, LLC (collectively referred to herein as "Boone") participates in a Health Information Exchange (HIE). The HIE that Boone Health participates in is a nonprofit, community health information exchange (HIE) that facilitates electronic exchange of patient health information with physicians, hospitals, labs, pharmacies and other providers. This HIE will also connect to other HIEs to allow information to be available to other providers when patients travel outside of our region. Sharing patient information with other providers through an HIE helps Boone save patients' time and make better treatment decisions with a more complete record. It will allow them to avoid duplicate tests and procedures and gain immediate access in emergencies to critical information like allergies, diagnosis, medications and other important data. See Boone's HIE factsheet for more information about how the HIE helps us promote patient health and protects patient information. Patients can also read more about the HIE Boone participates in at **https://boone.health/patients-visitors/**

By initialing below, I understand that Boone shares patient information through the HIE and have received a copy of the HIE's factsheet. The HIE makes every effort to ensure that sensitive patient information, such as HIV/AIDS, mental health, and substance abuse treatment related information (sensitive) information, is blocked from viewing. However, due to system limitations, Boone and the HIE are limited in blocking sensitive information at this time.

_____

Patient Initial

Acknowledgement to Opt-out of Sharing Information with a Health Information Exchange

I understand that I have the right to Opt-Out of having my patient information shared through the HIE. Unless I opt-out, any authorized provider, health plan or other entity that participates in the Health Information Exchange or is a member of a health information exchange that is connected to the HIE Boone participates in, can electronically access and share my health information through the HIE.

Boone will not discriminate against you if you choose to sign an Opt-Out Form and Boone does not require you to share information through the HIE in order to receive medical treatment.

By signing below, I opt-out of sharing my patient information with the HIE.

_____ _____

Patient Signature **Date**

If under 18 years, signature of Parent or Guardian

_____ _____ _____

Legal Representative Name **Date** **Relationship**

_____

Phone Number

BooneHealth
1600 E. Broadway, Columbia, MO 65201
573.815.8000 • www.boone.health

Patient Name:_____

Med Rec Number:_____ Acct Number:_____

Age:_____ Gender:_____ DOB:_____ Svc Date:_____

Consent to Treatment, Authorization of Benefits and Financial Responsibility

Consent to Treatment:

I know that I have the right to make decisions about my/my child's medical treatment. I consent to have the physicians and other health care workers at CH Allied Services, Inc. dba Boone Hospital Center, Boone Hospital Center's Visiting Nurses, Inc. dba Boone Home Care and Hospice, Boone Physician Services, LLC dba Boone Medical Group and CHAS Physician Services, LLC (collectively referred to herein as "Boone") provide medical treatment to me/my child. I understand the medical treatment is provided by physicians and health care workers who may be employees of Boone and other individuals allowed to provide care at Boone.

I consent to having photographs, videos, and other electronic images of me/my child taken and stored for treatment and education purposes. I understand that reasonable efforts will be made to protect the identity of me/my child.

Assignment of Benefits and Financial Responsibility:

I agree that the information I gave to apply for payment is correct for any third-party payers, including Medicare or Medicaid. I have been given a paper listing my rights as a Medicare or Medicaid patient. I know I can ask for a review of my/my child's record to find out about payment or charges I may owe if Medicare or Medicaid will not cover my charges.

If I receive Medicare, Medicaid or other insurance benefits, I know I am responsible to know what my insurance covers and that I can call my insurance plan if I have questions. I also understand I am responsible for any deductibles, co-insurance, and any non-covered charges. I know that I may receive separate bills for services provided by healthcare workers who are not employed by Boone who are authorized to provide care at Boone.

I authorize direct payment to Boone of all insurance benefits. I understand that I am responsible, subject to Boone's Financial Assistance Policy, to pay for portions of my/my child's bill not covered by insurance.

I also agree that I have received or have access to signs and/or brochures which contain information about:

- Advance Directives: What are they? Where can I get one? Do we need one?
- Privacy of my health care information and who may have access to my information
- How the hospital handles personal property (Hospital patients)
- I have been given the information regarding my right of choice in obtaining home care services (Home Care patients)
- Visiting/Office hours, Visitor/Office Policies and Behavior Rules
- The rights and responsibilities I/we have as a patient or family member and who to contact if I have questions

I have read this whole form, or had it read and explained to me, and I had the opportunity to ask questions.

_____ _____

Signature of Person Consenting to Treatment | Relationship to Patient

_____

Signature of Guarantor (if different than above)

THIS IS A PERMANENT PART OF THE MEDICAL RECORD.

FORM ID

BooneHealth

Patient Name:
Med Rec Number: Acct Number:
Age: Gender: DOB: Svc Date:

CONSENT TO RECEIVE AUTOMATED COMMUNICATIONS (E-MAIL, PHONE CALL, AND/OR TEXT MESSAGE)

By signing below, I hereby authorize CH Allied Services, Inc. dba Boone Hospital Center, Boone Hospital Center's Visiting Nurses, Inc. dba Boone Home Care and Hospice, Boone Physician Services, LLC dba Boone Medical Group and CHAS Physician Services, LLC, its service providers and affiliates (collectively referred to herein as "Boone"), to communicate with me via e-mail, phone call, and/or text message at the e-mail address and/or phone number provided below, including through auto-dialed, auto-generated and/or pre-recorded messages. I understand that such e-mails, calls, and/or text messages may include, without limitation, reminders about my upcoming appointments or rescheduling missed appointments, billing or payment information, or telemarketing (e.g., information about Boone's services or products). I understand that notifications may use an autodialer and/or prerecorded or artificial voice and may be repeated multiple times per appointment and may exceed contacts more than three times per week. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, notification of a pending or missed appointment.

I understand that my consent to communicate via e-mail, call, and/or text message is not a condition of my obtaining services from Boone.

I understand that communications sent via unencrypted e-mail or text message over an open network are inherently unsecure, and there is no assurance of confidentiality of information communicated in this manner. Nevertheless, I want Boone to communicate with me via e-mail, phone call, and/or text message as provided below:

I certify I am the user and/or subscriber of the e-mail address and/or phone number provided below, and I accept full responsibility for e-mails, phone calls, and/or text messages made or sent to or from this e-mail address or phone number.

I understand that e-mails and text messages have inherent privacy risks, especially when access to my computer or phone is not password protected or access is provided by my employer.

I understand there may be a delay when responding to e-mails and text message; therefore, if I have an urgent situation, I should not rely on e-mail or text message to request assistance, but should instead seek assistance by means consistent with my needs (e.g., by contacting my primary care provider or calling 911).

I understand that, in order to process and/or respond to my e-mails and/or text messages, individuals at Boone other than those directly involved in my care may need to read my e-mail and/or text messages and that any e-mail or text message and response thereto may become part of my medical record, as appropriate.

I agree to hold Boone harmless from any and all claims and liabilities arising from or related to e-mails, phone calls, or text messages made or sent to or from the e-mail address or phone number provided below.

I agree to notify Boone in writing in the event my e-mail address or phone number changes.

PATIENT NAME

E-MAIL ADDRESS (IF CONSENTING TO E-MAIL COMMUNICATIONS)

PHONE NUMBER (IF CONSENTING TO PHONE CALLS)

PHONE NUMBER (IF CONSENTING TO TEXT MESSAGES)

Signature of Patient/Personal Representative

Relationship to Patient

FORM ID

BooneHealth

Patient Name:
Med Rec Number: Acct Number:
Age: Gender: DOB: Svc Date:

Health Insurance Portability and Accountability Act (HIPAA) - Release of Information

Patient's Name _____ Date of Birth: _____

I authorize my providers at BooneHealth to share information regarding my medical condition and care coordination with the following members of my support system:

Name: _____ Relationship: _____
Phone Number(s): _____ _____

Name: _____ Relationship: _____
Phone Number(s): _____ _____

Name: _____ Relationship: _____
Phone Number(s): _____ _____

Name: _____ Relationship: _____
Phone Number(s): _____ _____

Name: _____ Relationship: _____
Phone Number(s): _____ _____

_____ _____
Patient Signature **Staff Signature**

FORM ID

*** NO DISKS PLEASE ***

BooneHealth MEDICAL GROUP

*** NO DISKS PLEASE ***

Authorization for Release of Information

I hereby authorize/request (list facility)

_____

to release medical information of:

Patient Name: _____ _____ _____
(Last) (First) (M.I.)

Maiden/Former Name(s) (where applicable)**:** _____

Date of Birth (MM/DD/YYYY)**:** _____ **SSN:** _____

_____ _____
Patient's Street Address, City, State and Zip Code **Phone Number**

I request the following information be released:

- ☐ All Medical Records
- ☐ Primary Care Records (specify provider(s) or practice): _____
- ☐ Specialist Records (specify provider(s), practice or specialty): _____
- ☐ Laboratory Reports
- ☐ Pathology Reports
- ☐ Itemized Billing Statement
- ☐ Other (specify): _____

Test results and/or diagnosis and treatment information, if any, concerning substance use/abuse, psychiatric/behavioral health information, OBGYN records (include pregnancy test results), and AIDS/HIV and other communicable diseases contained within my medical records indicated above **will be released** through this authorization unless indicated below.

Please initial information you **DO NOT** want released:
_____ Substance Use/Abuse _____ Psychiatric/Behavioral Health _____ OBGYN Records
_____ AIDS/HIV and other communicable diseases _____ Other (specify): _____

This request is limited to the following date(s) of treatment:

- ☐ Date (MM/DD/YYYY): _____
- ☐ Dates From (MM/DD/YYYY): _____ To (MM/DD/YYYY): _____
- ☐ All Dates of Treatment

This medical information is for the purpose of:

- ☐ Self
- ☐ Further medical care
- ☐ Changing physicians
- ☐ Attorney review
- ☐ Disability
- ☐ Workers Comp
- ☐ Insurance Eligibility/Benefits
- ☐ Litigation
- ☐ Other (specify): _____

ATTENTION: Once this information has been released pursuant to this Authorization, it may no longer be protected by Federal and/or State law/regulations and may no longer be deemed "Confidential."

Revision Date: 04/09/2021

*** NO DISKS PLEASE ***

Release or mail to:

_____

Name of Individual/Physician/Facility/Agency

_____

Street Address, City, State and Zip Code

_____

Phone Number

OR

□ **Release to Patient at the Address listed on this form**

By signing below, I acknowledge and agree that:

- I understand that neither Boone Health nor any of its affiliated healthcare providers can make me sign this Authorization as a condition to getting treatment, making payments on any bills, or gaining enrollment or eligibility in any health insurance plan, unless the Federal Privacy Regulations allow it. I agree that I have received a signed copy of this Authorization if I chose to do it.
- I understand I may revoke this Authorization at any time except to the extent that prior action has been taken in reliance on this Authorization. This authorization will expire one (1) year from the date it is signed if I do not cancel it in writing prior to the expiration date. I understand if I want to cancel/revoke this Authorization, I must contact the clinic directly.
- If I am signing on behalf of a patient for whom I am the legal guardian or personal representative, I must attach a certified copy of my appointment as legal guardian or personal representative.

_____ _____

Signature of Patient/Legal Guardian/Personal Representative **Date**

_____

Print Name

_____

Relationship to Patient (If someone else signs on behalf of the patient, state your relationship to patient)

Practice/Provider Use Only:

Date Request Granted: _____

Other Disposition (Date/Action): _____

Revision Date: 04/09/2021