

**Dear Patient:**

Because your medical record contains very important information for both yourself and your doctor, your doctor has made the important decision to invest in an Electronic Medical Record system. Every patient deserves to be treated knowing that the information in his or her chart is complete, timely and confidential. The doctors of Gulf Coast Physician Partners recognize that implementation of an electronic medical record system will benefit you by providing a very secure record along with many tools to assist the doctor with your plan of care.

What is an Electronic Medical Record?

The doctors and nurses who care for you will enter your vital signs, medications, diagnoses and other notes into a computer. Laboratory reports, x-ray, EKG, mammogram and other procedure results either come directly into your chart from the lab or hospital where they were performed or are scanned in after the doctor reviews them.

What are some of the benefits of an Electronic Medical Record?

- Alerts are provided if a medication that you are on will interact with a medication that is about to be ordered or is a drug you are allergic to.
- Real time interfaces ensure that your doctor sees results as soon as they are sent.
- The doctor receives high alert messages for results that are abnormal.
- Any tests that have been ordered but do not have a result can quickly be identified for follow-up.
- Your doctor can do a quick search to find out which immunizations you need to have updated.
- Tests recommended by your insurance plan for your age/gender can be tracked to ensure that you are receiving timely, pro-active care.

Is the Electronic Medical Record safe?

The security features of the EMR chosen by your doctor require anyone trying to access the system to sign in and enter their password. Unlike a paper record, once a person is logged onto the system they can only see the pieces of the chart they have security access to. Every time a caregiver moves from one part of the chart to another, an electronic footprint is left behind. This means that a record is being made of who opens your chart, where they went in it and what actions they took. Like a paper record, the information in your chart is never released to anyone without your authorization.

What happens to my old paper record?

Your doctor will continue to refer to your paper record for a period of time and then by law must keep it for at least 7 years.

In preparation for the conversion from paper to electronic records, several forms have been included in this packet for you to review, fill out and return to your doctor. The forms will be used to enter information into your new chart prior to your next scheduled visit. Timely completion and return will help ensure that your next visit goes smoothly.

We at the Gulf Coast Physician Partners' offices are excited about our new charting system and the knowledge that we are continuing to serve you with the best care available. If you have any questions or concerns please feel free to discuss them at your next visit.

Sincerely,

Gulf Coast Physician Partners

Immunizations: Please enter the month and year that you last received any of the following Immunizations.

Pneumonia _____
 Flu _____
 Zostavax _____
 Testanus _____

Family History: Enter the relationship under relative, the age if deceased, and any significant diseases or conditions known for that relative under Medical Problems.

<u>Relative</u>	<u>Relative Alive or deceased?</u>	<u>Any Medical Problems</u>	<u>If deceased, age at death</u>
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers	_____	_____	_____
Sisters	_____	_____	_____
Sons	_____	_____	_____
Daughters	_____	_____	_____
Maternal grandmother	_____	_____	_____
Maternal grandfather	_____	_____	_____
Paternal grandmother	_____	_____	_____
Paternal grandfather	_____	_____	_____

Medical History: Enter the year that you were diagnosed with any of the conditions listed below. If not listed please write in specific diagnosis under other and the year you were diagnosed.

<u>Condition</u>	<u>Year</u>
Anemia	_____
Angina	_____
Anxiety/panic disorder	_____
Arthritis	_____
Asthma	_____
Bursitis	_____
COPD/emphysema	_____
Depression	_____
Diabetes	_____
Diverticulosis	_____

<u>Condition</u>	<u>Year</u>
High blood pressure	_____
High cholesterol	_____
Hyperthyroidism	_____
Hypothyroidism	_____
Kidney failure	_____
Kidney infection	_____
Kidney stone	_____
Mental illness	_____
Migraines	_____
Paralysis	_____

<u>Condition</u>	<u>Year</u>
Epilepsy	_____
Gonorrhea	_____
Gout	_____
Hay Fever	_____
Heart attack	_____
Heart failure	_____
Heart murmur	_____
Hepatitis	_____
Herpes	_____
Jaundice	_____
Reflux	_____

<u>Condition</u>	<u>Year</u>
Paralysis	_____
Peripheral vascular disease	_____
Seizures	_____
Sexual problems	_____
Stomach ulcers	_____
Stroke	_____
Tuberculosis	_____
Varicose veins	_____
Cancer List Type:	_____

Other	_____

Surgical History: Please enter the year and the type of surgery that was done. If your surgical procedure is not listed below please write in under other.

Description Type Year Description Type Year
Example: Joint Replacement Knee 1992

1. _____
 2. _____
 3. _____
 4. _____

5. _____
 6. _____
 7. _____
 8. _____

Social History:

Advanced Directives:

Do you have a living will or advance directives? Yes No

Alcohol Use:

How do you rate your intake of alcoholic beverages? (Circle one of the following options)

Never Occasionally Moderate Heavy Previous Use Year quit: _____

Tobacco Use:

How do you rate your use of tobacco? (Circle one of the following options)

Non-Smoker Smoke cigarettes Smoke a Pipe Smoke Cigars Chew Tobacco Use Snuff

If you do smoke cigarettes, how many packs per day? _____

Would you like to quit? _____

Previous Smoker: what year did you quit? _____ # of years your smoked _____

Do you, or have you ever taken drugs other than over the counter medications that were not prescribed for you?

Yes No

If yes, please describe:

Caffeine Intake:

How do you rate your intake of caffeine from any source – Coffee, Tea, Sodas each day? (Circle one of the following options)

None 1-3 Cups/Glasses/Cans 4-6 Cups/Glasses/Cans More than 6 Cups/Glasses/Cans

Sexual Activity:

How would you describe your history of sexual activity? (Circle one of the following options)

Have never been sexually active Currently sexually active Not currently sexually active

If you use protection or birth control which method do you use: (Circle one of the following options)

Condom Foam/Jelly Implants Sponge Depo-Provera Shot Diaphragm

Pill Rhythm Partner had vasectomy Tubal Ligation Hysterectomy

Risk For Sexually Transmitted Disease:

Do you feel you are at risk for a sexually transmitted disease? Yes No

Exercise History:

List the type of exercise you do regularly and how often.

Living Situation:

How would you describe your current living arrangements? (Circle one or more of the following options)

Live Alone With parents With relatives With roommates With spouse

With caregiver With domestic partner In group home Assisted living facility

Nursing Home Receive hospice care Live with someone with TB

Most recent primary occupation: _____

Gynecological/Pregnancy/Birth History:

Do you have menstrual periods? Yes No

If no what year did you stop? _____

How many times have you been pregnant? _____

How many times did pregnancy result in live birth? _____

How many times did pregnancy result in one of the following?

Still born _____ Miscarriage _____ Abortion _____

Did you have any medical problems with your pregnancies? Yes _____ No _____

If yes, please describe: _____

Health Maintenance: (Please list date)

Last Pap smear: _____

Last mammogram: _____

Last bone density scan: _____

Last colonoscopy: _____

Last prostate exam/PSA blood test: _____

Last cholesterol: _____

Last blood glucose: _____

New Patient Information

Last Name _____ First _____ MI _____ Jr.,II, _____ Male
 Female

Alias/nickname _____ Birth Date _____ / / _____ - - _____
 Social Security # _____ Driver's License # _____

Address _____ City _____ State _____ Zip _____

() - _____ () - _____ () - _____
 Home Phone Work Phone Cell Phone

Please put a check mark by your primary contact #. This is where you will receive your reminder phone calls.

Marital Status:

Married Single Divorced Separated Widowed Life Partner

Race:

African American American Indian Asian Caucasian Hispanic

Emergency Contact Name _____ () - _____
 Phone # _____ Relationship to Patient _____

If the patient is under the age of 18 and/or requires legal guardianship, please fill out the section below for the responsible party.

Last Name _____ First _____ MI _____ Jr.,II, _____ Male
 Female

Alias/nickname _____ Birth Date _____ / / _____ - - _____
 Social Security # _____ Driver's License # _____

Address _____ City _____ State _____ Zip _____

() - _____ () - _____ () - _____
 Home Phone Work Phone Cell Phone

Please put a check mark by your primary contact #. This is where you will receive your reminder phone calls.

Marital Status:

Married Single Divorced Separated Widowed Life Partner

Race:

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☼ **If you would like to authorize someone other than yourself to discuss your medical information with this office, please request the appropriate form from the front desk.** ☼

Gulf Coast Physician Partners, P.A.

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been provided with a copy of GULF COAST PHYSICIAN PARTNERS' (the "Practice") Notice of Privacy Practices (the "Notice"). The Notice contains information regarding potential uses and disclosures of my protected health information (as that term is defined under the Health Insurance Portability and Accountability Act of 1996, "HIPAA") that may be made by the Practice, and of my rights and the Practice's legal duties with respect to my protected health information. I have had the opportunity to review the Notice and take a copy with me if I so choose.

Initial _____

Authorization to Pay Benefits to the Physician

I hereby authorize the office of Gulf Coast Physician Partners, P.A., to release any medical information required during the course of examination and treatment and permit payment directly to them any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, copayment, deductible and non-covered services.

Initial _____

Medicare Patients Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Gulf Coast Physician Partners, P.A., for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Initial _____

Date

Signature of Patients and/or Guardian, if patient is Minor