BROADWAY
FAMILY MEDICINE, INC.

Rose S. Ebel, D.O.
Katelyn Mokros, PA-C
Morgan Rowe PA-C

Medical Records Release Authorization

I authorize: _____
(Name of Physician or Facility)

Address: _____

Phone: _____ **Fax:** _____

To release the medical records of:

Patient Name: _____

D.O.B. _____ **SS#:** _____

To: **Broadway Family Medicine, Inc.**
1470 N. Broadway, Suite 100
Lebanon, OH 45036
Phone (513) 932-1936 Fax (513) 932-3105

INFORMATION TO BE RELEASED:
_____**Pertinent office notes (last one year)**
_____**Specific dates of service from** _____ **to** _____
_____**Other information including; last lab, MRI, consults, medication list and x-rays, growth charts, vaccination records**

I understand that I may revoke this authorization at any time, except to the extent that action has been taken in reliance on it (e.g. probation, parole, etc.) and that in any event this authorization expires automatically as described below.

This authorization will expire 1 year from the date of my signature or as otherwise specified by date, event, or condition as follows:

_____

_____

This authorization *includes* release of information concerning HIV testing or treatment of AIDS, AIDS-related conditions, drugs, or alcohol abuse, drug related conditions, alcoholism, and/or psychiatric/psychological conditions.

This authorization may also include redisclosure of information supplied to the originating office by another provider for the purpose of continuity of care.

_____

Signature of Patient **Date**

_____

Witness Signature **Date**

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Privacy Information

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I _____, give my consent to use and disclose health information for treatment, payment or health care operations to the following individuals:

Name_____ Relationship_____DOB_____

Phone No._____

Name_____ Relationship_____ DOB_____

Phone No._____

Name___ _____ Relationship_____ DOB_____

Phone No._____

***Please specify if there is any personal health information you **DO NOT** want to be disclosed to those named above _____

CONTACT INFORMATION

E-mail address: _____
For patient portal use

Home number (including area code) _____ _____
Can we call you at this number? YES / NO
Can we leave a message on your voicemail to return our call? YES / NO
Can we leave a message on your voicemail stating lab results? YES / NO
Can we leave a message on your voicemail regarding appointments/ prescriptions? YES / NO
Can we leave a message with the person answering the phone to return our call? YES / NO

Work number (including area code) _____
Can we call you at this number? YES/ NO
Can we leave a message on your voicemail to return our call? YES / NO
Can we leave a message on your voicemail stating lab results? YES / NO
Can we leave a message on your voicemail regarding appointments/prescriptions? YES / NO
Can we leave a message with the person answering the phone to return our call? YES / NO

Cell number (including area code) _____
Can we call you at this number? YES / NO
Can we leave a message on your voicemail to return our call? YES / NO
Can we leave a message on your voicemail stating lab results? YES / NO
Can we leave a message on your voicemail regarding appointments/prescriptions? YES / NO

_____ _____
Signature (If patient is a minor, list your relationship) Date

*****Notify the office in writing of your request to change or update any of the above information*****

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Patient Medical Information

Name: _____
Date: _____
Date of Birth: _____

1. Please list your current **medications** and **dosages** also any **vitamins** and or **herbs.**

_____
_____
_____
_____

2. Do you have any **allergies** to **medications**? Please list them below:

_____
_____

3. **Past Medical History**. Please list any medical condition for which you see a doctor. (for example: high blood pressure, asthma, arthritis).

_____
_____
_____
_____

4. **Past Surgical History**. Please list any surgeries you have had in the past.

_____
_____
_____
_____

5. **Habits**

Alcoholic drinks/day or week_____
Packs Cigarettes/day or week_____
Cups of coffee/ day _____
Cans of pop/day _____

Meals/day_____
Veggies & fruits/day_____
Exercise/day or week_____
Sleep/night_____good/fair/poor

5. **Family History**. Are there any serious illnesses in your family:

Parents:_____
_____
Siblings:_____
_____

Patient Initials: _____ Physician Initials: _____

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Pharmacy and Physician Disclosure Form

Patient Name: _____ **DOB:** _____

Please list all the pharmacies where prescriptions have been filled for you within the past two years:

Name:	***Location:***

Please list the name(s) of all physicians who have treated you within the past two years:

Name:	***Specialty:***

X_____ _____

Patient/Responsible Party Signature **Date**

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Review of Systems

Have you had problems recently with any of these symptoms?

Constitutional		
Good Health Lately	No	Yes
Recent weight changes	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Eyes		
Eye disease	No	Yes
Blurred vision	No	Yes
Glaucoma	No	Yes
Ears/Nose/Mouth/Throat		
Hearing loss	No	Yes
Ringing in ears	No	Yes
Mouth sores	No	Yes
Bad taste	No	Yes
Sore tongue	No	Yes
Sore throat	No	Yes
Cardiovascular		
Chest pain	No	Yes
Shortness of breath	No	Yes
Swelling of ankles	No	Yes
Respiratory		
Chronic cough	No	Yes
Spitting up blood	No	Yes
Wheezing	No	Yes
Gastrointestinal		
Poor appetite	No	Yes
Difficulty swallowing	No	Yes
Heartburn	No	Yes
Nausea or Vomiting	No	Yes
Bloating	No	Yes
Belching	No	Yes
Regurgitation	No	Yes
Constipation	No	Yes
Diarrhea	No	Yes
Abdominal pain	No	Yes
Rectal discomfort	No	Yes
Rectal bleeding	No	Yes

Genitourinary		
Burning with urination	No	Yes
Blood in urine	No	Yes
Incontinence	No	Yes
Irregular periods	No	Yes
Number of pregnancies	_____	
Number of miscarriages	_____	
Musculoskeletal		
Joint pain or swelling	No	Yes
Back pain	No	Yes
Muscle pain	No	Yes
Skin		
Rash	No	Yes
Itching	No	Yes
Neurological		
Headaches	No	Yes
Seizures	No	Yes
Strokes	No	Yes
Numbness	No	Yes
Weakness	No	Yes
Psychiatric		
Memory loss or confusion	No	Yes
Insomnia	No	Yes
Depression	No	Yes
Nervousness	No	Yes
Endocrine		
Heat or cold intolerance	No	Yes
Excessive thirst or urination	No	Yes
Hematological		
Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes
Enlarged glands	No	Yes

Comments on any of the symptoms above:

Patient Signature: Physicians Signature:

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