**Unity Family Health Care**

Sarita Bowers, FNP David Bowers, FNP

1644 Valley Rd. Ste A

Berkeley Springs, WV 25411

Ph: 304-500-2567 Fax: 304-500-2748

**Patient Demographics**

Welcome to Unity Family Health Care, we are pleased to have you in our office. Please take a few minutes to fill out these forms as completely as you can. If you have any questions, we will be glad to help.

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First MI (Preferred)

Patient address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address City State Zip code

Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: M F Married: Y N

Work phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Wireless Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred contact method: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student status if dependent over 19 (for insurance) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Release of Information:**

Who may we release information to over phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who may we release medical records to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Policy 1** (Please provide card to reception)

Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Subscriber\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Policy 2** (Please provide card to reception)

Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Subscriber\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

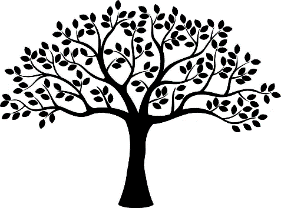
**Insurance Policy 3** (Please provide card to reception)

Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Subscriber\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Patient History

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies (please list your reaction):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications/Dosage/Prescriber**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you travelled outside of the continental United States recently? Yes No

If yes, where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use any assistive devices (i.e. hearing aids, glasses, walker, cane, prosthetic devices) Yes No

If yes, please list all assistive devices used:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal Medical History**: (Please circle all that apply)

ADHD Crohn’ Disease High Blood Pressure Parkinson’s Disease

Alcoholism COPD/Emphysema Kidney Stones Peripheral Vascular Disease

Allergies, Seasonal Dementia Kidney Disease Peptic Ulcer

Anemia Depression High Cholesterol Psoriasis

Anxiety Diabetes 1 or 2 HIV Pulmonary Embolism (PE)

Arrhythmia (Irregular heartbeat) Diverticulitis Hepatitis Rheumatoid Arthritis

Arthritis DVT (Blood clot) Irritable Bowel Syndrome Seizure Disorder

Asthma GERD (Acid reflux) Lupus Sleep Apnea

Bipolar Disorder Glaucoma Liver Disease Stroke

Bladder Problems/Incontinence Heart Disease Macular Degeneration Thyroid Disorder

Bleeding Problems Heart Attack Neuropathy Ulcerative Colitis

Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_ Hiatal Hernia Osteopenia/Osteoporosis

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any possible exposure to Hepatitis or HIV/Aids? Yes No

Other medical problems not listed above:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Family History**:

Father: Living age: \_\_\_\_\_ Deceased age: \_\_\_\_\_

Alcoholism Bipolar Disorder Depression High Cholesterol Osteoporosis

Anemia Cancer: \_\_\_\_\_\_\_\_\_ Diabetes 1 or 2 High Blood Pressure Stroke

Asthma COPD/Emphysema DVT (blood clot) Kidney Disease Thyroid Disorder

Arthritis Dementia Heart Disease Migraines

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother: Living age: \_\_\_\_\_ Deceased age: \_\_\_\_\_

Alcoholism Bipolar Disorder Depression High Cholesterol Osteoporosis

Anemia Cancer: \_\_\_\_\_\_\_\_\_ Diabetes 1 or 2 High Blood Pressure Stroke

Asthma COPD/Emphysema DVT (blood clot) Kidney Disease Thyroid Disorder

Arthritis Dementia Heart Disease Migraines

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Siblings:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney doctor, Dentist. Etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgical History**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Do you have any implants (i.e. pacemaker, joint replacements)? If yes, please list:**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social/Cultural History:**

Are you or have you ever been a smoker? Yes No If yes, amount/duration of use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you or have you ever used vaping products? Yes No If yes, amount/duration of use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

No

Are you or have you ever used recreational drugs? Yes No

Have you ever received a blood transfusion? Unknown Yes No

If yes, approximate year(s) ago: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you sexually active? Yes No

Education Level: Elementary High School Vocational College Graduate/Professional

Are there any vision problems that affect your communication? Yes No

Are there any hearing problems that affect your communication? Yes No

Are there any limitations to understanding or following instructions (either written or verbal)? Yes No

Are there any personal problems or concerns at home, work, or school you would like to discuss? Yes No

Are there any cultural or religious concerns you have related to delivery of care? Yes No

Are there any financial issues that directly impact your ability to manage your health? Yes No

Current Living Situation (Check all that apply):

Single Multi- Skilled

Family generational Homeless Shelter Nursing Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Household Household Facility

How often do you get the social and emotional support you need?

Always Usually Sometimes Rarely Never

Marital Status: Are you currently married? Yes No

Current Spouse: Not applicable Alive (Age \_\_\_\_\_\_\_\_) Deceased

Information: Health problems or cause of death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If alive, current employment status: Retired Unemployed Homemaker Employed – current occupation(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments (Please feel free to comment on any answers marked “yes” above):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Occupational and/or Military History:**

When did you begin working and what type of jobs have you held? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your current occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have your worked at your present job? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you satisfied with your present job? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If not, what is the cause of your dissatisfaction? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a veteran? Yes No If so, what branch of service? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Discharge\_\_\_\_\_\_\_\_\_\_

Were you involved in combat? Yes No

**Educational Needs:**

Are you interested in more information about a specific topic? Yes No

If yes, please clarify what information/education you would like to gain:

How to stop smoking Exercise Stress Safe sexual practices Nutrition Weight control Violent & abusive behavior Diabetes Cancer screening Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OB/GYN History:**

Date of last Pap smear: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STIs/STDs: Yes No

History of abnormal Pap smear? Yes No Have you had an HPV Vaccine? Yes No

Sexual Problems or concerns you wish to address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of LMP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Duration: \_\_\_\_\_\_\_\_Days Menstrual Cycle: Regular Irregular

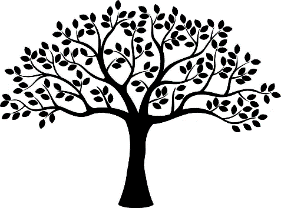
Menses monthly? Yes No Flow: Light Moderate Heavy

**Birth Control:**

Current birth control method: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Desired birth control method: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pregnancy History**:

Age at first childbirth? \_\_\_\_\_\_\_\_ Number of Pregnancies: \_\_\_\_\_\_\_ Full term: \_\_\_\_\_\_\_ Living: \_\_\_\_\_\_\_\_

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**HIPAA Privacy and Release of Information Authorization**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize **UNITY FAMILY HEALTH CARE, INC**. and its affiliates, its employees and agents, to use and disclose protected health information (e.g. information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, and member ID number) for the purpose of helping me to resolve claims and health coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, it’s employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

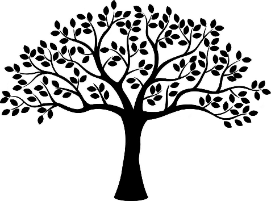
I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits, enrollment or payment for or coverage of services.

I have been advised of this practice’s Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority. **If applicable, Legal Representatives, sign below:**

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member’s behalf with respect to this authorization form.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Printed Name Date

 **Unity Family Health Care**

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**Consent for Procedure/Treatment**

I hereby authorize and direct Unity Family Health Care, Inc. and assistants, as necessary to perform quality care, to perform appropriate procedure/treatment(s) on me.

The nature and purpose of the procedure/treatment(s), alternative methods of treatment, and potential risks and complications will have been fully explained to me.

I acknowledge that no guarantees have been made to me as to the outcome of the procedure(s) and/or treatment(s).

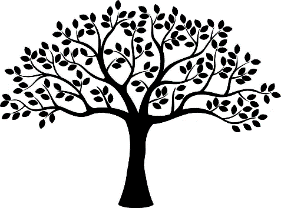
I grant this consent without duress, confusion, or pressure from my physician and/or staff, associates, or colleagues.

Patient/Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Unity Family Health Care**

Sarita Bowers, FNP David Bowers, FNP

1644 Valley Rd. Ste A

Berkeley Springs, WV 25411

Ph: 304-500-2567 Fax: 304-500-2748

**Office Policies**

* Refills: Please contact your pharmacy for refills. The pharmacy will contact us with the appropriate information. **Please allow 24 hours for this to take place**.
* Inclement weather: Staff will be in office if weather permits. If the staff deems it unsafe to travel, the office will delay opening or remain closed. The safety of our patients and staff is our priority. Should you have any questions about closures, please call the office phone number 304-500-2567 or check the office Facebook page for updates.
* No-shows: Failure to give 24-hour notice of an appointment cancellation may result in a fee of $25.
* Insufficient Funds: Should payment be returned for insufficient funds; your account will be charged a fee of $35.
* Late Arrivals: Patients arriving more than 15 minutes late for their appointment, may be rescheduled for another time. Our office staff will try to fit you into the current schedule; however, this is not always possible, and you may be required to wait or return at a later time.
* Cell Phone Usage: Providers will not conduct ANY exam if the patient or parent/guardian of a minor child is on their cell phone in the exam room. This includes playing games or listening to music. Feel free to use your phone when staff is not in the room. This ensures the best possible evaluation and care.
* Form Completion: Forms requiring a healthcare official to complete, including short term disability, social security, FMLA, medication administration, and letters requested by the patient, will cost $25 per form. Medical records requested will cost $25. Payment is due at time of delivery.
* Copays: Copays and outstanding balances are to be paid at the time of service.
* Children of Divorced Parents: Payments are due at the time of presentation, regardless of which parent accompanies the patient during the office visit.
* Current Patient Status: To be considered an active patient at Unity Family Health Care, you must be seen at least annually for a physical exam.
* Mutual Respect: We will treat patients and family members with respect and courtesy, and we appreciate the same in return for our staff members.
* Chronic Pain/Anxiety Management: This practice does **NOT** utilize narcotics, opiates, or benzodiazepines for chronic pain management or anxiety.
* Treatment Rooms: Due to limited room size, we request that individuals in patient rooms be limited to the patient and ONE parent/guardian if patient is a child unless otherwise arranged with staff. This is to ensure there is enough room for the provider and nurse in the treatment room.
* Termination: Patients may be terminated from practice at the providers discretion should the situation warrant.

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_**