Trailside Health
Lisa Miller, F.N.P.
Stefan Topolski, M.D.

111 Bridge St.
Shelburne Falls, Ma
413-625-6240

HELPFUL INFORMATION FORM

Welcome! Thank you for choosing our group. In order to serve you properly, we would like the following information. Please answer what you can. All information is confidential.

Patient Name____ Date_______________
FIRST MI LAST
Birthdate________________ Female___ Male___ SS#_______________(you may decline)
Address____ Home Telephone#_______________
City_______________________ State______ ZIP________ Work Telephone #_______________
Please circle your situation: Minor Single Married Widowed Divorced Separated
Occupation______________________________________ Employer________________________
Spouse's Name____________________________________ Spouse's Employer_______________
Spouse's Work Phone_________________ If patient is a student, name of school/college, city, state:
____
Person to contact in case of emergency___________________________ Phone#_____________
Address____
Relationship_____________________________ Pharmacy______________________________

THE INEVITABLE INSURANCE INFORMATION... but insurance is not necessary.
Circle here if SELF , then skip to the "Primary Insurance Co." in this section
Name of insured___________________________________ Relationship to patient___________
SS# of insured_________________________ (not required, but insurance won't pay without it)
Name of insured's employer____
Address of Employer____

Primary INSURANCE Co:____
Card#____________________________________ Group#_________________
What is your co-payment amount ? ___________ Effective Date ____________
Do you have ADDITIONAL INSURANCE ? YES_____ NO_____
If 'YES', please complete the following:
Secondary INSURANCE Co: ____
Card#____________________________________ Group#_________________
What is your co-payment amount ? ___________ Effective Date ____________
Name of insured___________________________________ Relationship to patient___________
SS# of insured_________________________ (not required, but insurance won't pay without it)
Name of insured's employer____
Address of Employer____

Authorization, release, & responsibility statement...
I authorize the release of information and payments and am responsible for supporting this community service as outlined in the Consent to Care agreement.

Signature of patient or parent of patient_______________________________ Date__________

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Consent to Care - Required by Your Government & Courts

I ____ am presenting myself for diagnosis and treatment by this not for profit group and I voluntarily consent to the rendering of such care including diagnostic procedures and medical treatment by its physician and authorized members or designees as may in their professional judgment be deemed beneficial or necessary. I acknowledge that no guarantees have been made to me as to the effect of any such examinations or treatment; I understand any special procedure or treatment involving appreciable risk will be explained to me and that I may at any time discuss or decline such treatment. [] No

I authorize this healer to provide a copy of my record for this visit and reports of any tests done during this visit to my other professional care givers to encourage continuity of care. [] No

I understand that with the increased use of electronic communication and technology relevant patient information may be faxed, electronically viewed, and collected by those directly involved in my care and I authorize release of such electronic information as required for my direct care and as proscribed by law for public health organizations and payment agencies. [] No

I authorize any group hospital insurance, Medicare, Medicaid or health and accident insurance carrier covering my situation to have access to and make copies of this healer's records pertaining to the case, and I authorize release of such information as may be necessary for the completion of health care claims to said carriers. [] No

I authorize the payments of medical benefits, as described in the policy identified in my medical record, directly to Trailside Health and its members. These payments are not to exceed the regular charges for the care provided. I hereby direct the insurance company to forward their payment to Trailside Health. [] No

I understand that I am financially responsible for any and all services rendered to this patient. I also understand that Trailside Health might bill any insurance carrier I designate and that failure of the insurance carrier to pay within thirty (30) days of billing will revert responsibility to me. [] No

I understand that my healing team includes physicians, nurses, counselors, educators and students all of whom have my full permission to discuss all of my health information including my mental health in order to provide comprehensive wholistic care and to constantly improve their care for my health. [] No

If I am unable to pay I have the right to barter in goods or services or arrange to support this not for profit health endeavor in whatever way I may to continue their healing service for me and my community.

My signature below is my acknowledgement (1) that I have read, understood and agreed to the foregoing and this office's HIPAA privacy policies, (2) that I hereby give my authorization and consent and (3) that I am bound by this agreement.

Signed____ Date_________________

Printed Name ____

If the patient is unable to sign or is a minor, please complete the following:

Patient is a minor ____ years of age or is unable to sign because _____________________________________

____

Next of Kin or Legal Guardian ______________________________Witness ______________________________

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Consent for Release of Information - from ANY source TO any

I, ______________________________ , authorize our prior healer ______________________________
(print your name) (your older healer)

and their authorized agents to release my medical records or designated portions thereof to my new healer:

____
(name)

____
(full address)

____

____

____ History & Physical ____ Progress Notes ____ Laboratory Results

____ Treatment Reports ____ Consultant Reports ____ Social Information

____ Complete Record ____ AIDS Testing ____ Substance Use

____ Other (Specify)____

Signed____ Date ________ Time _______ am/pm

Printed Name ___________________________________ Date of Birth ____________________

If the patient is unable to sign or is a minor, complete the following :
Patient is a minor ______ years of age or is unable to sign because__________________________
____

Next of Kin or Legal Guardian ____

Witness ____

Please give this page to your prior physician...

rev. 8 de diciembre de 2014

Welcome to Our Practice!

As a new patient, please fill out the information found below to the best of your ability.

Patient Name________________________________ Date of Birth______________ Today's Date_________________

Patient Medical History:

Have you ever had the following (check "no" or "yes". Leave blank if uncertain):

Measles __No__Yes
Mumps __No__Yes
Chickenpox __No__Yes
Whooping Cough __No__Yes

Scarlet Fever __No__Yes
Diphtheria __No__Yes
Smallpox __No__Yes
Pneumonia __No__Yes
Rheumatic Fever __No__Yes
Heart Disease __No__Yes

Venereal Disease __No__Yes
Anemia __No__Yes
Bladder Infection __No__Yes
Epilepsy __No__Yes
Migraine headaches __No__Yes

Tuberculosis __No__Yes
Diabetes __No__Yes
Cancer __No__Yes
Polio __No__Yes
Glaucoma __No__Yes
Hernia __No__Yes
Blood or plasma transfusions __No__Yes
Back Trouble __No__Yes
High or low blood pressure __No__Yes
Hemorrhoids __No__Yes
Asthma __No__Yes
Hives or eczema __No__Yes
Aids or HIV+ __No__Yes
Infectious mono __No__Yes
Bronchitis __No__Yes
Date of last chest x-ray:_________
Mitral Valve Prolapse __No__Yes

Stroke __No__Yes
Hepatitis __No__Yes
Ulcer __No__Yes
Kidney disease __No__Yes
Thyroid disease __No__Yes
Bleeding tendency __No__Yes
Any other disease __No__Yes
(please list):__________________

Medicine, food, or environmental **ALLERGIES** (Please list):Yes / No

Previous Hospitalizations/Surgeries/Serious Illnesses When Hospital, city, state
(include pregnancies)______________________________ ________________ ____________________

Pharmacy used ____

Medications (Include nonprescription, supplements):____

Patient Social History:

Marital status: _Single _Married _Domestic Partner _Separated _Divorced _Widowed
Who lives with you? ____
Use of alcohol: _Never _Rarely _Moderate _Daily / Average # of drinks per week ___________
Use of tobacco: _Never _Previously, but quit: ____________________ Current packs/day_______
Use of drugs _Never _Type/frequency: ____
Excessive exposure at home or work to: _Fumes _Dust _Solvents _Airborne particles _Noise
Occupation/hours worked:____
Do you do testicular or breast exams? _____What exercise do you do regularly?________________________
Do you use sunscreen?_______ Date of last eye exam________ Last dental exam______________

Family Medical History:

	Age	Diseases	If deceased, cause of death
Father			
Mother			
Siblings			
Spouse			
Children			

Patient Name____ Birthdate_____________
FIRST MI LAST

Review of Systems: Please indicate any personal history below.

CONSTITUTIONAL SYMPTOMS
Good general health lately __No__Yes
Recent weight change __No__Yes
Fever __No__Yes
Fatigue __No__Yes
Headaches __No__Yes

EYES
Eye disease or injury __No__Yes
Wear glasses/contact lenses __No__Yes
Blurred or double vision __No__Yes
Last eye exam __________

EARS/NOSE/MOUTH/THROAT
Hearing loss or ringing __No__Yes
Earaches or drainage __No__Yes
Chronic sinus problems or rhinitis __No__Yes
Nose bleeds __No__Yes
Mouth sores __No__Yes
Bleeding gums __No__Yes
Bad breath or bad taste __No__Yes
Sore throat or voice change __No__Yes
Swollen glands in neck __No__Yes

CARDIOVASCULAR
Heart trouble __No__Yes
Chest pain or angina pectoris __No__Yes
Palpitation __No__Yes
Shortness of breath walking or lying flat __No__Yes
Swelling of feet, ankles or hands __No__Yes

RESPIRATORY
Chronic or frequent cough __No__Yes
Spitting up blood __No__Yes
Shortness of breath __No__Yes
Wheezing __No__Yes

GASTROINTESTINAL
Loss of appetite __No__Yes
Change in bowel movement __No__Yes
Nausea or vomiting __No__Yes
Light headed or dizzy __No__Yes
Frequent diarrhea __No__Yes
Painful bowel movements or constipation __No__Yes
Rectal bleeding or blood in stool __No__Yes
Abdominal pain __No__Yes

GENITOURNARY
Frequent urination __No__Yes
Burning or painful urination __No__Yes
Blood in urine __No__Yes
Change in force of strain When urinating __No__Yes
Incontinence or dribbling __No__Yes
Kidney stones __No__Yes
Sexually transmitted disease __No__Yes
Sexual difficulty __No__Yes
Male – testicle pain __No__Yes
Female – pain with periods __No__Yes
Female – abnormal paps __No__Yes
Female – irregular periods __No__Yes
Female - vaginal discharge __No__Yes
Female - # of pregnancies __________
Female - # of miscarriages __________
Female – date of last pap smear __________
Female – date of last menstrual period __________
Female – age of first period __________

MUSCULOSKELETAL
Joint pain __No__Yes
Joint stiffness or swelling __No__Yes
Weakness of muscles or joints __No__Yes
Muscle pain or cramps __No__Yes
Back pain __No__Yes
Cold extremities __No__Yes
Difficulty walking __No__Yes

INTEGUMENTARY (SKIN, BREAST)
Rash or itching __No__Yes
Change in skin color __No__Yes
Change in hair or nails __No__Yes
Varicose veins __No__Yes
Breast pain __No__Yes
Breast lump __No__Yes
Breast discharge __No__Yes

NEUROLOGICAL
Frequent or recurring Headaches __No__Yes
Convulsions or seizures __No__Yes
Numbness or tingling Sensation __No__Yes
Tremors __No__Yes
Paralysis __No__Yes
Head injury __No__Yes

PSYCHIATRIC
Memory loss __No__Yes
Nervousness __No__Yes
Depression __No__Yes
Insomnia __No__Yes

ENDOCRINE
Glandular or hormone Problems __No__Yes
Excessive thirst or Urination __No__Yes
Heat or cold intolerance __No__Yes
Skin becoming drier __No__Yes
Change in hat or glove size __No__Yes

HEMATOLOGIC/LYMPHATIC
Slow to heal after cuts __No__Yes
Bleeding or bruising tendency __No__Yes
Anemia __No__Yes
Phlebitis __No__Yes
Past transfusions __No__Yes
Enlarged glands __No__Yes

ALLERGIC/IMMUNOLOGIC
History of skin/ other reaction to:
Penicillin __No__Yes
Morphine, Demerol, or other narcotics __No__Yes
Novocain or other Anesthetic __No__Yes
Aspirin or other pain Remedies __No__Yes
Tetanus, antitoxin, or other serums __No__Yes
Iodine, methiolate, or other antiseptics __No__Yes
Other drugs/medications:
____
____
____

Known food allergies:
____
____
____

Environmental allergies:
____
____
____
____
____

AUTHORIZATION & RELEASE
To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

X____ Date______________________
Signature of patient (or parent if minor)

Provider's Review/comments:____
____
____
____
Signature of Provider Date