



MOUNT NITTANY
PHYSICIAN GROUP



Welcome

Thank you for choosing Mount Nittany Physician Group to care for you. We hope to become your lifelong partner in health and wellness.

To prepare for your first appointment with us, please complete the attached forms and return them in the enclosed prepaid envelope before your first appointment.

Please arrive 15 minutes before your appointment, so that we can make sure that we have everything needed for your visit with us for the first time.

If you have any questions or concerns, please call 844.278.4600 or visit our new patient web page, mountnittany.org/newpatient.

Thank you. We look forward to meeting you soon!

New patient forms included:

- Authorization for Release/Request of Protected Health Information
- Patient Questionnaire

Patient Label



Authorization for Release/Request of Protected Health Information Mount Nittany Health Page 1 of 2

MR#: _____ Acct #: _____

I hereby authorize Mount Nittany Health, consisting of Mount Nittany Medical Center (MNNMC) and Mount Nittany Physician Group (MNNPG), to release or request my health information:

Patient Information: Name: _____ Date of Birth: _____ Address: _____ Telephone: _____ E-mail: _____

Release Information To: Name: _____ Address: _____ Telephone: _____ Fax: _____ E-mail: _____

Request Information From: Name: _____ Address: _____ Telephone: _____ Fax: _____ E-mail: _____

The information to be released or requested shall be limited to the following:

Location of service (check all that apply): [] MNNMC [] MNNPG (specific office if needed): _____

Dates of service: _____

- Medical Record (complete), Consultation Reports, Discharge Summary, Safety Plan, Pertinent MNNMC (H&P, Consultation, Operative, Pathology, Diagnostic), Pertinent MNNPG (Office notes, labs, procedures), ED Mental Health Evaluation & Liaison Note, History and Physical (H&P), Laboratory Test Results, Operative Reports, Office notes, X-Ray, Imaging Reports, ED Records, Discharge Instructions, Progress Notes, Medication List, Other (specify): _____

The purpose of the disclosure is as follows: [] Continuity of Care [] Legal [] Personal [] Other: _____

I authorize this information be released or requested in the following manner (check all that apply):

- [] Pick up [] Mail [] CD [] Fax: _____ [] E-mail: _____ [] Verbal - Behavioral Health Staff Only

I understand that this release may also include (Check to approve release of):

- [] Information relating to AIDS or HIV infection [] Information relating to mental health or psychiatric care continuing care plan and/or treatment for substance and/or alcohol abuse or dependency: excludes Psychotherapy notes

The confidentiality of my records may be protected by the Pennsylvania Drug and Alcohol Abuse Control Act, the Pennsylvania Mental Health Procedures Act, and/or the Pennsylvania Confidentiality of HIV Related Information Act. To the extent I have checked any of the above boxes; my signature below authorizes the release of information protected by these Pennsylvania statutes.

White - Medical Record



Patient Label



Authorization for Release/Request of Protected Health Information Mount Nittany Health Page 2 of 2

MR#: _____ Acct #: _____

NOTICE OF DISCLOSURE

You may refuse to sign this authorization. You do not need to sign this authorization to receive services from MNH unless the only purpose for providing you with a service is to obtain information to disclose to someone else (e.g. examinations required to obtain certain licenses). If the services are related to research, you may be required to authorize the use or disclosure of your health information limited and related to the research services.

I understand that I may revoke this authorization at any time in writing, except to the extent that action based on this authorization has been taken. However, I also understand that health information disclosed pursuant to this authorization may be subject to re-disclosure because it is no longer protected by federal privacy laws. I fully understand the contents of this authorization and voluntarily consent to the release of the information as stated. Finally, I understand that I am entitled to obtain a copy of this authorization from the Mount Nittany Health upon request.

THIS AUTHORIZATION SHALL EXPIRE ONE (1) YEAR FROM THE DATE THIS AUTHORIZATION IS EXECUTED; OTHERWISE, AND UNLESS IT IS REVOKED EARLIER.

Signature of Patient or Patient Representative Print Name Date Time

Witness Signature Date Time Witness Signature Date Time

If Patient is unable to give consent or if a Verbal consent is given, two MNH employees must sign as Witnesses.

If signed by Patient Representative, state relationship and authority to do so: (check all that apply)

- Parent of Minor, Incompetent, Disabled, Deceased, Custodial Parent, Legal Guardian, Executor of Estate of Deceased, Authorized Legal Representative, Power of Attorney for Health Care, Other:

Revoked Patient or Patient Representative Date Time

Office Use Only: Photo ID Obtained: Y / N, Driver's License #: , Other: , Records Released on: , Records Released by: , Number of pages: , Received by: , Date: , Time: , Transmitted by: , Date: , Time:

White - Medical Record



Adult Patient Questionnaire

Patient Name: _____ Date of Birth: _____

Pharmacy

Retail: _____

Mail Order: _____

Preferred Method of Reminder Communication

I would like to receive reminder communication via:

- Patient portal Cell phone Home phone
 Mail Work phone

HEALTH CARE TEAM: Please List Other Health Care Providers

Name	Specialty

ACTIVE PROBLEMS/PAST MEDICAL HISTORY

Do you currently have any of the following medical problems? Place "X" in **ACTIVE** Problem column.

Have you had any of the following medical problems in the past? Place "X" in **PAST** Problem column.

	Active Problem	Past Problem		Active Problem	Past Problem		Active Problem	Past Problem
Acne	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Hyperlipidemia (High cholesterol)	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension (High Blood Pressure)	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	End Stage Renal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Fatty Liver	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stone	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Atrial Fibrillation	<input type="checkbox"/>	<input type="checkbox"/>	Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Seizure	<input type="checkbox"/>	<input type="checkbox"/>
Cancer _____	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	Stroke (s)	<input type="checkbox"/>	<input type="checkbox"/>
Cholecystitis (Gallbladder problem)	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headache	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Difficulty	<input type="checkbox"/>	<input type="checkbox"/>	Vision Problem	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (Liver problem)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Disease (CAD)	<input type="checkbox"/>	<input type="checkbox"/>	History of Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

Have you ever had any other behavioral health or medical problems not listed previously? YES NO

If YES, please list: _____

Patient Name: _____ Date of Birth: _____

PAST SURGICAL HISTORY

List all of the *operations or surgeries* you have ever had *including year if known*:

Type of Surgery	Year

FAMILY HISTORY

Family History Unknown

Is there any of the following in your immediate family? Check all that apply

	Mother	Father	Brother	Sister	Other:
Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (Please list below)					
• _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gallbladder disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is there any family history of the following in your immediate family, grandparents, aunts or uncles? If so, what was their age at the onset?

*Breast Cancer Yes No Person/Age of onset _____

*Colon Cancer Yes No Person/Age of onset _____

*Heart Attack Yes No Person/Age of onset _____

*Ovarian Cancer Yes No Person/Age of onset _____

*Prostate Cancer Yes No Person/Age of onset _____

Patient Name: _____ Date of Birth: _____

SOCIAL HISTORY

Marital Status (Check one): Divorced Married Separated Single Widow

Living Situation: Please describe your living situation.

(Example: live alone, homeless, live with spouse, live with children , etc)

Employment Status (Check one): Employed Homemaker Retired Unemployed
Occupation: _____

Smoking History (Select the choice that best describes):

- Never a smoker
 Former smoker
 Please mark amount smoked PER DAY
 Smoked _____ Pack(s) Cigarettes Cigars Pipe
 Started at age _____ Quit at age _____
 Current cigar smoker
 Current pipe smoker
 Electronic cigarette smoker

Current cigarette smoker:

- Less than ½ pack per day since age _____
 1/2 pack per day since age _____
 1 pack per day since age _____
 1.5 packs per day since age _____
 2 packs per day since age _____
 2.5 – 3 packs per day since age _____
 Greater than 3 packs per day since age _____
 Other _____

Are you exposed to second hand smoke? Yes No

Smokeless Tobacco History (Check one):

- Never used smokeless tobacco
 Former user of smokeless tobacco
 Smokeless tobacco use
 Frequency: Daily _____ Times/week Less than weekly

Alcohol Usage (check one):

- Consumes alcohol weekly How many drinks per week? _____ What type of alcohol? _____
 Daily Alcohol Use How many drinks per day? _____ What type of alcohol? _____
 No Alcohol Use
 Rarely consumes alcohol

Illicit Drug Use—(check one):

- Current drug use What types of drugs: _____
 History of drug use When did you quit: _____ Drugs used: _____
 No illicit drug use

Dental Care

*Do you have a dental checkup at least yearly? YES NO

Patient Name: _____ Date of Birth: _____

Immunizations: Please complete the dates for any adult immunization that you have received if known.

Vaccine	Date		
	#1	#2	#3
Hepatitis B series			
Human Papillomavirus Vaccine (HPV)			
Influenza (annual)			
Meningitis Vaccine	Menactra	Trumenba	
Pneumonia Vaccine	Pneumovax	Prevnar 13	
Shingles Vaccine (Zostavax)			
TDaP (Tetanus, Diphtheria, Pertussis)			

Health Maintenance:

Please enter the most recent date when you had the following procedures/ tests if applicable:

Procedure	Date
Colonoscopy	
DEXA Scan	
Diabetic Eye Exam	
Diabetic Foot Exam	
Mammogram	
PAP smear	
Prostate Specific Antigen (PSA)	

Patient Signature _____ Date: _____

Person who completed form if patient unable _____

Created 6/23/15

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