

Dr. Heidi Freeman

Privacy Practices Notice (HIPAA)

Your Rights: Under the federal Health Insurance Portability and Accountability Act (HIPAA), you have the right to request restrictions on how we use or disclose your personal information for treatment, payment or health care operations. You also have the right to request restrictions on disclosures to family members or others who are involved in your health care or the paying of your care. To request a restriction you must sign a written request sent to: Heidi M. Freeman, M.D., 1035 Peach St., #301, San Luis Obispo, CA, 93401.

Access to your personal health information: You have the right to inspect and/or obtain a copy of your personal health information we maintain in your designated medical records, in our medical records department. You must sign a release of medical records consent form to obtain these records.

Family, Friends and Personal Representatives: With your approval, we may disclose to family members, close personal friends, or another person you identify your personal health information relevant to their involvement with your care or paying for your care. If you are unavailable, incapacitated or involved in an emergency situation, and we determine that a limited disclosure is in your best interest, we may disclose your personal health information without your approval. We may also disclose your personal health information to the public or private entities to assist in disaster relief efforts.

Other uses and disclosures: We are permitted or required by law to use or disclose your personal health information, without your authorization, in the following circumstances, including for any purposes required by law:

- For public health activities (reporting of disease, injury, birth, death or suspicion of child abuse or neglect, for example);
- To government authority if we believe an individual is a victim of abuse, neglect or domestic violence.
- For health oversight activities (for example, audits, inspections, licensure actions or civil, administrative or criminal proceedings or actions);
- For judicial or administrative proceedings (for example, pursuant to a court order, subpoena or discovery request);
- For law enforcement purposes (i.e., reporting wounds or injuries or for identifying or locating suspects, witnesses or missing people);
- To avert a serious threat to health or safety under certain circumstances
- For military activities if you are a member of the armed forces: or an inmate or individual confined to a correctional institution;
- For compliance with workers compensation.

We will adhere to all state and federal laws or regulations that provide protections to your privacy. We will only disclose AIDS/HIV-related information, genetic testing information and information pertaining to your mental condition or any substance abuse problems as permitted by law.

Patient signature _____

Date _____

Heidi Freeman, M.D.
REGISTRATION FORM

(Please Print)

| | | | | | | | | | |
|--|---------------------------------|---|--|---------------------------------------|--------------|---|---|---|------|
| Today's date: | | | | Primary Care Physician: | | | | | |
| PATIENT INFORMATION | | | | | | | | | |
| Patient's last name: | | First: | | Middle: | | <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. | <input type="checkbox"/> Miss <input type="checkbox"/> Ms. | Marital status (circle one) Single / Married / Other | |
| Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No | | If not, what is your legal name? | | | Maiden name: | | Birth date: / / | | Age: |
| Street address: | | | | Social Security no.: | | | Home phone no.: () | | |
| or P.O. box: | | City: | | State: | | ZIP Code: | | Cell phone no.: () | |
| Occupation: | | Employer: | | Employer address: | | | Employer phone no.: () | | |
| Chose clinic because/Referred to clinic by (please check one): | | | | <input type="checkbox"/> Dr. | | | <input type="checkbox"/> Insurance Plan | <input type="checkbox"/> Hospital | |
| <input type="checkbox"/> Family | <input type="checkbox"/> Friend | <input type="checkbox"/> Close to home/work | | <input type="checkbox"/> Yellow Pages | | <input type="checkbox"/> Other | | | |
| Is it okay to contact you by email for non-emergency reasons? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | Email address: | | | | | |

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|--|--|-------------------------------|---------------------------------|--------------------------------|--------------------------------|-------------------|-------------------------------|--|
| INSURANCE INFORMATION | | | | | | | | |
| (Please give your insurance card to the receptionist.) | | | | | | | | |
| Name of policyholder: | | Policyholder's S.S. no.: | | Birth date: / / | | | | |
| Occupation: | | Employer: | | Employer address: | | | Employer phone no.: () | |
| Primary insurance | | Group no: | | Policy no: | | Co-payment: \$ | | |
| Patient's relationship to policyholder: | | <input type="checkbox"/> Self | <input type="checkbox"/> Spouse | <input type="checkbox"/> Child | <input type="checkbox"/> Other | | | |
| Name of secondary insurance (if applicable): | | Policyholder's name: | | | Group no.: | | Policy no.: | |
| Patient's relationship to policyholder: | | <input type="checkbox"/> Self | <input type="checkbox"/> Spouse | <input type="checkbox"/> Child | <input type="checkbox"/> Other | | | |

| | | | | | |
|--|--|--------------------------|--|------------------------|--|
| IN CASE OF EMERGENCY | | | | | |
| Name of local friend or relative : | | Relationship to patient: | | Home phone no.: () | |
| | | | | Work phone no.: () | |
| <p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Heidi Freeman, M.D. or insurance company to release any information required to process my claims.</p> | | | | | |
| <hr/> <i>Patient/Guardian signature</i> | | | | <hr/> <i>Date</i> | |

| |
|-----------------------|
| ORIGINAL DATE: |
| DATES REVISED: |

Heidi Freeman, M.D.

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

| | |
|--|------------------------------------|
| NAME <i>(Last, First, M.I.):</i> | DOB: |
| MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed | |
| PREVIOUS OR REFERRING DOCTOR: | DATE OF LAST PHYSICAL EXAM: |

PERSONAL HEALTH HISTORY

| | | |
|--|--|---|
| CHILDHOOD ILLNESS: | <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio | |
| <i>Immunizations and dates:</i> | <input type="checkbox"/> Tetanus | <input type="checkbox"/> Pneumonia |
| | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Chickenpox |
| | <input type="checkbox"/> Influenza | <input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i> |

| LIST ANY MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED |
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SURGERIES

| Year | Reason | Hospital |
|------|--------|----------|
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OTHER HOSPITALIZATIONS

| Year | Reason | Hospital |
|------|--------|----------|
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|---|------------------------------|-----------------------------|
| HAVE YOU EVER HAD A BLOOD TRANSFUSION? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|---|------------------------------|-----------------------------|

LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS AND INHALERS

| Name the Drug | Strength | Frequency Taken |
|---------------|----------|-----------------|
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ALLERGIES TO MEDICATIONS

| Name the Drug | Reaction You Had |
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HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

| | | | | | |
|-----------------|---|---------------------------------------|---------------------------------------|---------------------------------------|---|
| Exercise | <input type="checkbox"/> Sedentary (No exercise) | | | | |
| | <input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf) | | | | |
| | <input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) | | | | |
| | <input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes) | | | | |
| Diet | Are you dieting? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | If yes, are you on a physician prescribed medical diet? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | # of meals you eat in an average day? | | | | |
| | Rank salt intake | <input type="checkbox"/> Hi | <input type="checkbox"/> Med | <input type="checkbox"/> Low | |
| | Rank fat intake | <input type="checkbox"/> Hi | <input type="checkbox"/> Med | <input type="checkbox"/> Low | |
| Caffeine | <input type="checkbox"/> None | <input type="checkbox"/> Coffee | <input type="checkbox"/> Tea | <input type="checkbox"/> Cola | |
| | # of cups/cans per day? | | | | |
| Alcohol | Do you drink alcohol? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | If yes, what kind? | | | | |
| | How many drinks per week? | | | | |
| | Are you concerned about the amount you drink? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Have you considered stopping? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Have you ever experienced blackouts? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Are you prone to "binge" drinking? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Do you drive after drinking? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tobacco | Do you use tobacco? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | <input type="checkbox"/> Cigarettes – pks./day | | <input type="checkbox"/> Chew - #/day | <input type="checkbox"/> Pipe - #/day | <input type="checkbox"/> Cigars - #/day |
| | <input type="checkbox"/> # of years | <input type="checkbox"/> Or year quit | | | |

| | | | |
|------------------------|---|------------------------------|-----------------------------|
| Drugs | Do you currently use recreational or street drugs? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Have you ever given yourself street drugs with a needle? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sex | Are you sexually active? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | If yes, are you trying for a pregnancy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | If not trying for a pregnancy list contraceptive or barrier method used: | | |
| | Any discomfort with intercourse? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Personal Safety | Do you live alone? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Do you have frequent falls? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Do you have vision or hearing loss? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Do you have an Advance Directive or Living Will? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Would you like information on the preparation of these? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

| FAMILY HEALTH HISTORY | | | | | |
|--|--|-----------------------------|--|--|-----------------------------|
| | AGE | SIGNIFICANT HEALTH PROBLEMS | | AGE | SIGNIFICANT HEALTH PROBLEMS |
| FATHER | | | Children | <input type="checkbox"/> M <input type="checkbox"/> F | |
| MOTHER | | | | <input type="checkbox"/> M <input type="checkbox"/> F | |
| Sibling | <input type="checkbox"/> M <input type="checkbox"/> F | | | <input type="checkbox"/> M <input type="checkbox"/> F | |
| | <input type="checkbox"/> M <input type="checkbox"/> F | | | <input type="checkbox"/> M <input type="checkbox"/> F | |
| | <input type="checkbox"/> M <input type="checkbox"/> F | | GRANDMOT HER <i>Maternal</i> | | |
| | <input type="checkbox"/> M <input type="checkbox"/> F | | GRANDFATH ER <i>Maternal</i> | | |
| <input type="checkbox"/> M <input type="checkbox"/> F | | | GRANDMOT HER <i>Paternal</i> | | |
| <input type="checkbox"/> M <input type="checkbox"/> F | | | GRANDFATH ER <i>Paternal</i> | | |

MENTAL HEALTH

| | | |
|---|------------------------------|-----------------------------|
| Is stress a major problem for you? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you feel depressed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you panic when stressed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have problems with eating or your appetite? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you cry frequently? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever attempted suicide? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever seriously thought about hurting yourself? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have trouble sleeping? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever been to a counselor? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

GYN History

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|---|------------------------------|-----------------------------|
| Age at onset of menstruation: | | |
| First day of last menstrual period: | | |
| Period every ____ days | | |
| Heavy periods, irregularity, spotting, pain, or discharge? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Number of pregnancies ____ Number of live births ____ Number of miscarriages or abortions ____ | | |
| Are you pregnant or breastfeeding? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you had a D&C, hysterectomy, or Cesarean? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any urinary tract, bladder, or kidney infections within the last year? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any blood in your urine? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any problems with control of urination? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any hot flashes or sweating at night? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Experienced any recent breast tenderness, lumps, or nipple discharge? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Date of last pap and rectal exam: | | |

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|---------------------------------------|------------------------------|-----------------------------|
| Date of last mammogram: | | |
| Any abnormal mammogram in the past? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any breast biopsies? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Date of last colonoscopy: | | |
| Date of last bone density evaluation: | | |
| Date of last cholesterol evaluation: | | |
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OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

| | | |
|------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> Skin | <input type="checkbox"/> Chest/Heart | <input type="checkbox"/> Recent changes in: |
| <input type="checkbox"/> Head/Neck | <input type="checkbox"/> Back | <input type="checkbox"/> Weight |
| <input type="checkbox"/> Ears | <input type="checkbox"/> Intestinal | <input type="checkbox"/> Energy level |
| <input type="checkbox"/> Nose | <input type="checkbox"/> Bladder | <input type="checkbox"/> Ability to sleep |
| <input type="checkbox"/> Throat | <input type="checkbox"/> Bowel | <input type="checkbox"/> Other pain/discomfort: |
| <input type="checkbox"/> Lungs | <input type="checkbox"/> Circulation | |

Heidi Freeman, M.D.
1035 Peach St., #301
San Luis Obispo, CA 93401
(805)543-1475 Phone
(805)543-1463 Fax

Authorization to Release Medical Records

I HEREBY AUTHORIZE DISCLOSURE OF MEDICAL INFORMATION OBTAINED DURING THE COURSE OF MY EVALUATION AND/OR TREATMENT.

Patient's Name: _____

Date of Birth: _____ Social Security Number: ____ - ____ - ____

Signature: _____ Date: _____

I authorize:

Physician or Medical Group

Street Address

City

State

Zip Code

Phone

Fax

To release my health information to:

Heidi Freeman, M.D.
1035 Peach St., #301
San Luis Obispo, CA 93401

To include:

| | | |
|--|---|--|
| <input type="checkbox"/> All Medical Records | <input type="checkbox"/> Mammogram Reports | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> History and Physicals | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> All Pap Smears |
| <input type="checkbox"/> Ultrasound Reports | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Other: |
