

Patrick Hudson MD PA, Front Sheet - form to complete for an initial evaluation

PATIENT QUESTIONS (FRONT PAGE) - PLEASE COMPLETE ALL QUESTIONS AND SIGN PAGE 2

Today's date: _____ First name: _____ MI: _____ Last name: _____

Date of Birth: _____ Age: _____ Are you married or have a partner?: YES NO

Street Address: _____

City : ABQ Santa Fe other _____ State: NM other: _____ Zip: _____

Email: _____ @ _____

Social Security #: _____ Cell telephone #: _____

Home telephone #: _____ Work telephone # : _____

Employer: _____ Occupation: _____

Who referred you to our office?

Why are you seeing Dr. Hudson?

Do you suffer from any medication allergies? No Yes (please give details)

Do you take any medications? No Yes (please give details)

Do you take birth control pills? No Yes (please give details)

Have you ever had any operations? No Yes (please give details)

Do you suffer from any serious illnesses? No Yes (please give details)

Have you ever had bleeding problems? No Yes (please give details)

Have you had difficulty with an anesthetic? No Yes (please give details)

Do you suffer from diabetes? No Yes

Have you ever had a blood clot? No Yes (please give details)

Do you smoke cigarettes? No Yes (how many each day?)

(BACK PAGE)

Patient name: _____

Permission to take photographs

I give permission for Patrick Hudson and his designated assistants to take photographs of me before, during and after my treatment. These photographs may be used for recording my condition and for educational purposes as he sees fit. These photographs may **NOT** be used on the internet without additional permission from me.

Signature: _____ Date: _____

Witness: _____

Permission to release information, use email communication, receipt of HIPAA information

I give permission for Patrick Hudson and his designated assistants to release medical information to current, previous and future health care providers and insurance and medical loan companies, during and after my treatment.

I give permission for Patrick Hudson and his designated assistants to use electronic media, including FAX and/or email to communicate with me and provide information about my case to current, previous and future health care providers, surgery centers, hospitals and insurance companies, and medical loan companies, both during and after my treatment.

I agree that I have been given satisfactory information about HIPAA and my rights and obligations. I have been given an opportunity to review the HIPAA manual of Patrick Hudson MD PA. I have been given a copy of the *Notice of Privacy Practices* and I understand that this is available on the internet at <http://www.phudson.com>.

Signature: _____ Date: _____

Witness: _____

LEAVE THIS SECTION FOR DR. HUDSON