PATIENT INFORMATION – PLEASE PRINT

First Name: _____ MI_____

Last Name: _____

Date of Birth: ____/____/____ Male ____ Female _____ SSN: _____-_____-_____

Mailing Address:

_____

How may we contact you?

Home Phone: (____) _____ Cell _____

Work Phone: (____) _____

Email: _____

I AUTHORIZE HERITAGE HEALTH TO CONTACT ME AT THE ABOVE EMAIL ADDRESS REGARDING MY PROTECTED HEALTH INFORMATION AND CARE: (PLEASE INITIAL) _____YES _____NO

Which phone number is preferred? (Please circle) Home Cell Work

Pharmacy: _____

EMERGENCY CONTACT

Name: _____ Relationship _____Phone #: _____

INSURANCE

Primary Insurance:

Insurance Company Name: _____

ID#: _____ Group #: _____

Subscriber: _____

DOB: _____ SSN: _____

Relationship to patient: _____

Secondary Insurance:

Insurance Company Name: _____

ID#: _____ Group #: _____

Subscriber Name: _____

DOB: _____ SSN: _____

Relationship to patient: _____

Please read the following information below. Your signature below applies to the service rendered in conjunction with all your visits at Heritage Health.

CONSENT TO TREATMENT

I, the undersigned, consent to outpatient care at Heritage Health, encompassing routine diagnostic procedures, examination and medical treatment including but not limited to routine laboratory work(such as blood, urine and other studies) heart tracing and administration of medications prescribed by the provider. I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medical staff including physicians, nurse practitioners, physician's assistants, medical assistants or their designees as is necessary in the medical staff's judgement. I authorize Heritage Health to release any information necessary to file and settle insurance claims, including any third party insurances. I understand that I am personally financially responsible to Heritage Health for all charges not covered by assignment including copays, coinsurance, deductibles and ineligibility.

PATIENT RIGHTS AND RESPONSIBILITIES

I, the undersigned, have received the Patient Rights and Responsibilities form. I understand and agree to abide by the conditions for treatment at Heritage Health.

PATIENT'S CONSENT FOR HERITAGE HEALTH TO SHARE PROTECTED HEALTH INFORMATION

WITH OTHER NAMED PARTIES

In addition to our normal operational disclosures of privacy information, please identify to whom we may release your health care information. Each name must be identified. These should be people who help you with your health care needs and may need to be knowledgeable about your condition, treatment, and options. It is still the responsibility of the below named parties to request this information.

Name: **Relationship:**

_____ _____

_____ _____

_____ _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Heritage Health's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be made available to me upon request.

Signature of Patient or Legal Guardian: _____

Date: _____

Print Name: _____ **DOB:** _____

Idaho High School Activities Association
Idaho Health Examination and Consent Form

It is required that all students complete a History and Physical examination prior to his/her first 9th and 11th grade practice in the interscholastic (9-12) athletic program in the State of Idaho. The exam is at the expense of the student and may not be taken prior to May 1 of the 8th and 10th grade years. This examination is to be done by a licensed physician, physician's assistant or nurse practitioner under optimal conditions. Interim history forms are required during the 10th and 12th grade years and must be submitted to the principal prior to the first practice.

Name_____ Home Address_____ Phone_____
Grade_____ Sports_____
Personal Physician_____ Physician's Phone Number _____
Date of Birth_____ Sex_____ School_____

History Form

Fill in details of "YES" answers in space below:

	YES	NO
1. A. Have you ever been hospitalized?	____	____
B. Have you ever had surgery?	____	____
2. Are you presently taking any medication or pills?	____	____
3. Do you have any allergies (medicine, bees, other stinging insects)?	____	____
4. A. Have you ever passed out during or after exercise?	____	____
B. Have you ever been dizzy during or after exercise?	____	____
C. Have you ever had chest pain during or after exercise?	____	____
D. Do you tire more quickly than your friends during exercise?	____	____
E. Have you ever had high blood pressure?	____	____
F. Have you ever been told you have a heart murmur?	____	____
G. Have you ever had racing of your heart or skipped beats?	____	____
H. Has anyone in your family died of heart problems or a sudden death before age 50?	____	____
5. Do you have any skin problems? (itching, rash, acne)	____	____
6. A. Have you ever had a head injury?	____	____
B. Have you ever been knocked out or unconscious?	____	____
C. Have you ever been diagnosed with a concussion?	____	____
D. Have you ever had a seizure?	____	____
E. Have you ever had a stinger, burner, or pinched nerve?	____	____
7. A. Have you ever had heat cramps?	____	____
B. Have you ever been dizzy or passed out in the heat?	____	____
8. Do you have trouble breathing or cough during or after exercise?	____	____
9. Do you use special equipment, pads, braces, mouth or eyeguards?	____	____
10. A. Have you had problems with your eyes or vision?	____	____
B. Do you wear glasses, contacts, or protective eyewear?	____	____

11. Were you born without a kidney, testicle, or any other organ? _____

12. Have you ever sprained/strained, dislocated, fractured/broken, or had repeated swelling or other injuries of any of your bones or joints?

____ Head	____ Neck	____ Chest	____ Back	____ Hip
____ Shoulder	____ Elbow	____ Forearm	____ Wrist	____ Hand
____ Thigh	____ Knee	____ Shin/Calf	____ Ankle	____ Foot

13. Have you ever had any other medical problems such as:

____ Mononucleosis	____ Diabetes	____ Asthma	____ Hepatitis
____ Headaches (frequent)	____ Eye Injuries	____ Other	

14. Have you had a medical problem or injury since your last exam? _____
15. When was your last tetanus shot? _____
When was your last measles immunization? _____
16. When was your first menstrual period? _____ When was your last menstrual period? _____
What was the longest time between periods last year? _____
Explain "YES" answers here: _____
_____
_____

Consent Form

(Parent or Guardian and Student Permission and Approval)

I hereby consent to the above named student participating in the interscholastic athletic program at his/her school of attendance. This consent includes travel to and from athletic contests and practice sessions. I further consent to treatment deemed necessary by physicians designated by school authorities for any illness or injury resulting from his/her athletic participation. I also consent to the release of any information contained in this form to carry out treatment and healthcare operations for the above named student.

PARENT OR GUARDIAN SIGNATURE_____ DATE:_____

This application to compete in interscholastic athletics for the above school is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules and regulations of the State Association.

SIGNATURE OF STUDENT_____ DATE:_____

PHYSICAL EXAMINATION FORM

Height_____ Weight _____ BP _____/_____ T_____ Pulse_____ R_____

Visual Acuity R 20 /_____ L 20 /_____ Corrected: Y N Pupils _____

	Normal	Abnormal
Ears, Nose, Throat	_____	_____
Cardiopulmonary		
Pulses	_____	_____
Heart	_____	_____
Lungs	_____	_____
Skin	_____	_____
Abdominal	_____	_____
Genitalia	_____	_____
Musculoskeletal	_____	_____
Neck	_____	_____
Shoulder	_____	_____
Elbow	_____	_____
Wrist	_____	_____
Hand	_____	_____
Back	_____	_____
Knee	_____	_____
Ankle	_____	_____
Foot	_____	_____

CLEARANCE / RECOMMENDATIONS

Clearance:

_____ A. Cleared for all sports and other school-sponsored activities.

_____ B. Cleared after completing evaluation / rehabilitation for:
_____

_____ C. *NOT* cleared to participate in the following IHSAA sponsored sports:

Baseball	Wrestling	Golf	Softball
Track	Cross Country	Basketball	Football
Soccer	Tennis	Volleyball	

NOT cleared for other school-sponsored activities:
(Example: *Swimming*) 1. _____ 2. _____ 3. _____

_____ D. Student is *NOT* permitted to participate in high school athletics.
Reason: _____
_____
_____

Recommendation:_____
_____

Examiner's Signature: _____ Date: _____
(*This Physical form must be signed by a licensed physician, physician assistant or nurse practitioner*)

Address: _____ Phone: (_____)_____