Health Professionals of Winfield

	Daisy M Matias, MD	Sapna Shah-Haque, MD
Kimberley Adams-McDarty, APRN	Angela Johnson, APRN	Laura Thielen, APRN

Please circle your preferred provider

Welcome to our Clinic

First Name Middle initial	Last Name
Date of Birth	Social Security Number

Gender: Male Female	Race	Marital Status: S M W D Separated
Preferred Contact Method: Email Phone Postal Patient Portal	Appointment Notification Contact Method: Email Text Call: Primary Cell Work	Email (required for patient portal)

Street Address	City	State	Zip

Primary Phone #	Work Phone #	Mobile/Other Phone #

Emergency Contact Last Name, First Name	Relationship	Phone #

Guarantor Name (if under 18)		Patient's Relationship to Guarantor
Date Of Birth	Social Security #	Address
Primary Phone #	Work Phone #	Employer

Insurance Information	Secondary Insurance Name
Insurance Company:	Insurance Company:
Policy #	Policy#
Group #:	Group #
Subscriber Name:	Subscriber Name:
Subscriber DOB:	Subscriber DOB:
Please Check here if **NO** Insurance:	Please Check here if **NO** Insurance:

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Patient Name:	DOB:

Patient Employer	Occupation	City, State,

PERSONAL MEDICAL HISTORY: PLEASE MARK ALL THAT APPLY

ADHD	COPD/Emphysema	High Cholesterol	Rheumatoid Arthritis
Alcoholism	Dementia	HIV	Seizure Disorder
Allergies, Seasonal	Depression	Hepatitis	Sleep Apnea
Anemia	Diabetes: 1 or 2	Irritable Bowel Syndrome	Stroke
Anxiety	Diverticulitis	Lupus	Thyroid Disorder
Arrhythmia	DVT	Liver Disease	Ulcerative Colitis
Arthritis	GERD	Macular Degeneration	Neuropathy
Asthma	Glaucoma	Osteoporosis	**Other not listed:**
Bipolar	Heart Disease	Osteopenia	
Bladder Problems	Heart Attack	Parkinson's Disease	
Bleeding Problems	Hiatal Hernia	Peripheral Vascular Disease	
Cancer:			
Headaches	High Blood Pressure	Peptic Ulcer	
Kidney Stones	Psoriasis	Crohn's Disease	
Kidney Disease	Pulmonary Embolism		

Allergies:

Drugs:
Food
Other: (bees, pets, etc.)

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Patient Name	DOB

Please List All Specialist you see for Chronic Conditions:
Example: Cardiologist

Specialist Name	Condition

SURGICAL HISTORY: PLEASE LIST ALL PRIOR SURGERIES AND APPROXIMATE DATES PERFORMED:

Surgery	**Date**

ADULT IMMUNIZATIONS:

Immunization	**No**	**Yes**	**Date: Month/Year**
Pneumococcal 13 (Prevnar 13)			
Pneumococcal 23 (Pneumovax)			
Tetanus and Diptheria (TD)			
Tetanus and diphtheria toxoids and acellular pertussis vaccine (TDAP)			
Zoster vaccine, recombinant (RZV)			
Zoster vaccine live			
Human papillomavirus vaccine (HPV)			

Patient Name:	DOB:

Last Pap smear	Date	Normal Abnormal
Last Menstrual Period	Date	Normal Abnormal
Colonoscopy or colon cancer screening	Yes / No Date:	Normal Abnormal
Mammogram	Yes / No Date:	Normal Abnormal
Dexa (Bone Density)	Yes / No Date:	Normal Abnormal
PSA (Prostate Specific Antigen)	Yes / No Date:	Normal Abnormal

	Frequency	Amount and type
Tobacco Use		
Alcohol Use		
Drug Use		
Caffeine		
Exercise		

Medication	Dosage	Frequency	Prescribed by: Name of Physician, NP or Behavioral Health

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Patient Name:	**DOB:**

Preferred Pharmacy:

Pharmacy Name:	**Address**	**Phone Number**

SOCIAL / CULTURAL HISTORY:

Education Level	Elementary	High School	Vocational	College	Graduate/Professional

Do you have any vision problems that affect your communication? Yes or No

Do you have hearing problems that affect your communication? Yes or No

Do you have any limitations to understanding and / or following instructions? Yes or No

Who lives in the home:

Number of Children:

List any family medical history:

Condition/Disease	Mother	Father	Sibling	Grandparent (maternal/paternal)

Who is your dentist?

Who is your Optometrist?

Do you have any other specialist?

Patient Name:	DOB:

Authorization to release information:
I authorize for information regarding my medical care to be released to the following person(s) if he or she so requests:

Name	Relationship to patient	Phone number

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I authorize the release of any information required for claim(s) submission to my insurance company(s). I also authorize those payments be made directly to Health Professionals of Winfield.

Signature: ____ Date: ______________________

Parent, if minor: ___________________________________ Date: ______________________

Thank you for choosing Health Professionals of Winfield as your primary care team!

This document serves as a notice to inform you of our office policy regarding controlled prescription medications. Health Professionals of Winfield, including Dr. Daisy Matias, Dr. Sapna Shah-Haque, Kimberley Adams-McDarty, APRN, Angela Johnson, APRN, and Laura Thielen, APRN, are limiting our prescribing of controlled substances. This decision has been made with a lot of thought and consideration, and also comes as a response to increased safety warnings from the FDA, increased scrutiny of the DEA and evidence-based practice models, wellness models, and the request of 3rd party payers. Therefore, your prescriptions for controlled substances will not likely be renewed by the above-mentioned providers. We are more than happy to coordinate your primary care needs, but you will need to establish care with a psychiatric specialist, pain management specialist, or other needed specialist of your choice in order to continue obtaining controlled substances.

We will be pleased to assist the specialist of your choice for chronic controlled substances by sending him or her a copy of your medical records, including information regarding your care history, diagnosis, and treatments we have provided.

We highly recommend contacting your medical insurance carrier for a list of contracting psychiatric management, pain management, or other providers that are within your insurance network.

Thank you for allowing us to provide care for your acute illnesses and primary care needs. Should you have any questions or concerns relating to this letter, please contact the office manager.

Sincerely,

Health Professionals of Winfield Staff

By signing, I acknowledge that I have personally reviewed and understand this document:

Signature: ____ Date: ______________________