Down East COMMUNITY
Our Health, Our Hospital

Today's Date: ____/____/____ Medical Record #_____

Patient full Name: _____Maiden Name_____
(Including middle initial)
Mailing Address: _____

City: _____ State: _____ Zip: _____

Date of Birth _____/_____/_____ SS #: _____-_____-_____

Home Phone: _____ Cell Phone: _____ Work Phone:_____

Advanced Directives: *Yes* type:_____or *NO* or *Unknown* Religion: _____

Race: _____ Language: _____ Ethnicity: *Hispanic* or *Non-Hispanic*

Sex: ___*M* or ___*F* Smoker: *YES* or *NO* *Marital Status: S M D W P X*

Emergency Contact(s):_____Ph #_____
Can we speak with the emergency contact regarding your medical information? YES or NO

MEDICATION ALLERGIES Y_____ N_____ Please list _____

Can we contact you via e-Mail.. Yes or No IF YES.. email address _____
Is it alright for us to leave messages for you on your home answering machine or cell phone? *YES* or *NO*

Was an Insurance Referral Obtained: *YES* or *NO* or *NOT NEEDED* **(If an insurance referral was not obtained from your PCP and is required by your insurance, you will be responsible for any charges)**
**Primary Care Physician:* _____

Patient's Employer: _____ Occupation:_____

1st Insurance Co: _____

Insured Name: _____Insured DOB: _____Effective Date: _____

Policy #: _____ Group #: _____Relationship to Patient: _____

2nd Insurance Co: _____

Insured Name: _____Insured DOB: _____Effective Date: _____

Policy #: _____ Group #: _____Relationship to Patient: _____

Prescription Plan: _____ Plan Number: _____

Preferred Pharmacy: _____ City: _____

Patient Signature _____

Rev 04/28/11

Milbridge Medical Center, PO Box 5, Milbridge, ME 04658 (207) 546-2391 fax (207) 546-3680

Down East Community Hospital
Physician Practice
PATIENT E-MAIL CONSENT FORM

Patient Name: _____

Patient DOB: _____

Provider/Practice:_____

Patient E-mail Address: _____

_____

1. RISK OF USING E-MAIL

Transmitting patient information by E-mail has a number of risks that patients should consider. These include, but are not limited to, the following:

a) E-mail can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
b) E-mail senders can easily misaddress an E-mail.
c) Backup copies of E-mail may exist even after the sender or the recipient has deleted his or her copy.
d) Employers and on-line services have a right to inspect E-mail transmitted through their systems.
e) E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
f) E-mail can be used to introduce viruses into computer systems.

2. CONDITIONS FOR THE USE OF E-MAIL

The Provider cannot guarantee but will use reasonable means to maintain security and confidentiality of E-mail information sent and received. The Patient and Provider must consent to the following conditions:

a) E-mail is not appropriate for urgent or emergency situations. The Provider cannot guarantee that any particular E-mail will be read or responded to.
b) E-mail must be concise. The Patient should schedule an appointment if the issue is too complex or sensitive to discuss via E-mail.
c) E-mail communications between patient and provider will be filed in the Patient's permanent medical record.
d) The Patient's messages may also be delegated to another provider or staff member for response. Office staff may also receive and read or respond to patient messages.
e) The Provider will not forward patient-identifiable E-mails outside of the DECH healthcare system without the Patient's prior written consent, except as authorized or required by law.
f) The Patient should not use E-mail for communication regarding sensitive medical information.
g) It is the Patient's responsibility to follow up and/or schedule an appointment if warranted.
h) Recommended uses of patient-to-provider E-mail should be limited to:
   a. Appointment requests
   b. Prescription refills
   c. Requests for information
   d. Non-urgent health care questions
   e. Updates to information or exchange of non-critical information such as laboratory values, immunizations, etc.

3. INSTRUCTIONS

To communicate by E-mail, the Patient shall:

a) Avoid use of his/her employer's computer.
b) Put the Patient's name in the body of the E-mail.
c) Put the topic (e.g., medical question, billing question) in the subject line.
d) Inform the Provider of changes in the Patient's E-mail address.
e) Take precautions to preserve the confidentiality of E-mail.
f) Contact the Provider's office via conventional communication methods (phone, fax, etc.) if the patient does not receive a reply within a reasonable period of time.

4. PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of E-mail between the Provider and me. I consent to the conditions and instructions outlined here, as well as any other instructions that the Provider may impose to communicate with me by Email. I agree to use only the pre-designated e-mail address specified above. Any questions I may have had were answered.

_____

Patient or Personal Representative Signature

Date_____

Original – to be retained in Medical Record Copy-to be given to Patient/Personal Representative

PAST MEDICAL HISTORY

MILBRIDGE MEDICAL CENTER

Name:_____

DOB:____/____/____

Please check below if you have or have had any of the following.

	When?
O Asthma	_____
O Atrial Fibrillation	_____
O Anemia	_____
O Anxiety	_____
O Autoimmune Disorder	_____
O Blood Transfusions	_____
O Brain Tumor	_____
O Cerebrovascular disease	_____
O Cirrhosis	_____
O CVA / Stroke	_____
O C O P D	_____
O Colon Cancer	_____
O Coronory Heart Disease	_____
O Crohn's Disease	_____
O C H F	_____
O Depression	_____
O Diabetes - Type 1	_____
O Diabetes - Type 2	_____
O Diverticulitis	_____
O D V T	_____
O GI Bleed	_____
O G E R D	_____
O Hyperlipidemia	_____
O Hypertension	_____
O Hyperthyroidism	_____
O Hypothyroidism	_____
O Hepatitis A	_____
O Hepatitis B	_____
O Hepatitis C	_____
O Infertility	_____
O Kidney Disease	_____
O Kidney Stone	_____
O Liver Disease	_____
O Heart Attack	_____
O Osteoarthritis	_____
O Osteoporosis	_____

	When?
O Rheumatoid Arthritis	_____
O Seizure Disorder	_____
O Thyroid Disorder	_____
O Tuberculosis	_____
O Valvular Heart Disease	_____
O Urinary Tract Infections	_____
O Varicose Veins	_____
O OTHER _____	

Comments:

Please answer the following.

TOBACCO USE

O I have never smoked Tobacco

O I am a former Tobacco User

O I Currently smoke _____ packs of Tobacco per week.

O I have never used smokeless tobacco

O I am a former smokeless tobacco user

O I currently use smokeless tobacco _____times per week

ALCOHOL USE:

O I currently consume alcohol.

How many drinks per week? _____

EXERCISE

O I currently Exercise _____ times per week

O I do not Exercise.

CAFFEINE CONSUMPTION

O I drink caffeine _____ times per day

O I do not drink caffeine.

MILBRIDGE
MEDICAL CENTER

Name:_____
DOB:____/____/____

Past Surgical History:

Please check below if you have had any of the following and indicate when and where the procedure was performed.

	Date	Where
○ Abdomen Surgery		
○ Amputation		
○ Aortic Valve Replacement		
○ Appendectomy		
○ Back Surgery		
○ Bronchoscopy		
○ C A B G		
○ Carpal Tunnel		
○ Cataract		
○ Cholecystectomy		
○ Colon		
○ Gastric Bypass		
○ Hemorrhoidectomy		
○ Hip Replacement		
○ Kyphoplasty		
○ Mitral Valve Replacement		
○ Nephrectomy		
○ Pacemaker		
○ Prostate		
○ Rotator Cuff Repair		
○ Tonsillectomy		
○ Urinary Incontinence		

○ Other _____

Screening Exams and Immunizations

Please indicate date and facility where were performed:

	Date	Location
Colonoscopy		
Pneumovax Vaccine		
Shingles Vaccine		
Flu Vaccine		
Mammogram		
Bone Density		

MILBRIDGE
MEDICAL CENTER

Name:_____
DOB:___/___/___

Family History

It is very important that we know history of diseases or conditions in your family. Please check off if you have any of the following in your family and note who in your family has the condition and age diagnosed

O Family History Unknown

	Relative(s):	Age Diagnosed:
O Alcoholism		
O Anxiety		
O Arthritis		
O Asthma		
O Birth Defects		
O Bleeding Disorders		
O Breast Cancer		
O Colon Cancer		
O Depression		
O Diabetes		
O Heart Disease		
O High Cholesterol		
O Hypertension		
O Kidney/Renal disease		
O Lung Cancer		
O Lung Disease		
O Melanoma		
O Migraines		
O Osteoporosis		
O Ovarian Cancer		
O Seizures		
O Stroke/CVA		
O Thyroid Disorder		
O Uterine Cancer		
O Other Cancer		
O Other Medical Issue		