HUDSON HEADWATERS HEALTH NETWORK

Today's Date: ____ / ____ / _____

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Date of Birth: ____ / ____ / _____
Gender: ☐ Female ☐ Male ☐ Other _____

Please take a few moments to answer these questions about your past medical history. This will help us to serve you better. This information will be kept **CONFIDENTIAL**. Thank you.

ALLERGIES: Please list any medication allergies, reactions, and other allergies.

_____
_____
_____
_____

MEDICATIONS: Please list any prescription, over-the-counter medications, herbals and/or vitamins you are taking. Include dose, frequency and prescribing provider.

_____
_____
_____
_____

IMMUNIZATIONS/VACCINES: Please include a copy of child's immunization and vaccination history including facility, provider and date.

MEDICAL ILLNESSES: Please list any hospitalizations or medical illnesses. Note year.

_____
_____
_____
_____

SURGERY: Please list any operations you have had. Note year and provider name.

_____
_____
_____
_____

Continue to Page 2 →

Name: _____
Date of Birth: ____ / ____ / _____

SOCIAL HISTORY:
Parents' Name(s): _____
Parents' Marital Status: ☐ Married ☐ Unmarried ☐ Separated ☐ Divorced ☐ Other _____
Home situation: ☐ Both parents ☐ Mother ☐ Father ☐ Relatives ☐ Adoptive parents
☐ Foster parents ☐ Other _____
Do you have siblings? ☐ Yes ☐ No If yes, names and date of birth: _____
_____
Do you have pets? ☐ Yes ☐ No
Childcare: ☐ None ☐ Relative ☐ Private sitter ☐ Daycare/Preschool

Date of Last Dental Visit: ____ / ____ / _____ Year in school: _____
Date of Last Eye Exam: ____ / ____ / _____

Diet: ☐ Regular ☐ Vegetarian ☐ Vegan ☐ Gluten Free ☐ Diabetic ☐ Other _____

Do you exercise regularly/play sports? ☐ Yes ☐ No

How much caffeine or sweetened drinks do you consume per day? _____

How much screen time do you have per day? _____

Do you live with someone who smokes? ☐ Yes ☐ No

Are there smoke and carbon monoxide detectors in your home? ☐ Yes ☐ No

Do you use your seat belt or car seat routinely? ☐ Yes ☐ No

Do you use sunscreen routinely? ☐ Yes ☐ No Do you use insect repellent routinely? ☐ Yes ☐ No

Are there guns in your home? ☐ Yes ☐ No If yes, are they secure? ☐ Yes ☐ No

FAMILY HISTORY: Please note their health status and age, or age at death and cause.
Father: _____
Mother: _____
Siblings: _____

PREVIOUS PEDIATRICIAN/PRIMARY CARE PROVIDER: Include facility address and phone number.
_____
_____

OTHER DOCTORS YOUR SEE: Include reason, facility address and phone number.
_____
_____
_____
_____

Hudson Headwaters Health Network

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information

NEW YORK STATE DEPARTMENT OF HEALTH

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:

7. Purpose for Release of Information:

8. Unless previously revoked by me, the specific information below may be disclosed from: _____ (INSERT START DATE) until _____ (INSERT EXPIRATION DATE OR EVENT)

☐ All health information (written and oral), except:

_____

For the following to be included, indicate the specific information to be disclosed and initial below.	Information to be Disclosed	Initials
☐ Records from alcohol/drug treatment programs		
☐ Clinical records from mental health programs*		
☐ HIV/AIDS-related Information		

9. If not the patient, name of person signing form:	10. Authority to sign on behalf of patient:

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

_____ _____
SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW DATE

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

_____ _____ _____
STAFF PERSON'S NAME AND TITLE SIGNATURE DATE

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

HUDSON HEADWATERS
HEALTH NETWORK

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I understand and have been provided with a copy of Hudson Headwaters Health Network Privacy Practices that provides a more complete description of how the Network may use and disclose my protected health information in accordance with state and federal regulations for privacy and security. I further understand that Hudson Headwaters Health Network reserves the right to change its privacy practices. In the event of a change, a copy will be posted in a prominent location in the practice site, or upon my request, a copy will be sent to the address I have provided.

I, _____, date of birth _____, understand that as part of my health care, Hudson Headwaters Health Network originates and maintains paper and/or electronic records describing health history, symptoms, examination and test results, diagnoses, treatment, as well as plans for future care or treatment. I understand that this information serves as:

> A basis for planning my care and treatment.
> A means to facilitate coordination of care among the health professionals, including referrals, who contribute to my care.
> A source of information for applying my diagnosis and surgical information to my bill.
> A means by which a third-party payer can verify that services billed were actually provided.
> A tool for healthcare options of the Network such as assessing quality of care and reviewing competence of healthcare professionals.

I understand that Hudson Headwaters Health Network may send test results and correspondences associated with my care to the address I have provided. We may also leave messages at the telephone numbers I have provided either to confirm appointments or to request I call on medical, dental or billing items.

If you require a restriction on the above please see a staff member at the desk.

X_____ **X**_____

Patient's Signature or Signature of Patient Representative — Date

☐ Patient refused to sign.

HUDSON HEADWATERS
HEALTH NETWORK

RELEASE OF INFORMATION AND ASSIGNMENTS OF BENEFITS

I understand that my health information may be used or disclosed for the purposes of treatment, payment, and operations in accordance with state and federal regulations for privacy and security. I understand that this may include disclosures of information to my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment directly to HHHN for medical services rendered to myself and/or my dependents. I am responsible for understanding the limitations of my insurance coverage and to present any co-pay (co- insurance, deductible) or other personal obligations at the time service is rendered. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I give HHHN permission to disclose to a relative or friend my location and general condition, or other information directly relevant to that person's involvement in my care, to those I have named below: (please note: Certain medical conditions may require a separate release.)

_____

(please print first name, last name, and relationship)

Because Hudson Headwaters receives funding from the Federal Government we are required to collect information about income ranges. Please determine family size and check the appropriate income category box.

FAMILY SIZE	CATEGORY 1: ☐	CATEGORY 2: ☐	CATEGORY 3: ☐	CATEGORY 4: ☐
1	$0 - $11,769	$11,770 - $17,654	$17,655 - $23,539	$23,540 +
2	$0 - $15,929	$15,930 - $23,894	$23,895 - $31,859	$31,860 +
3	$0 - $20,089	$20,090 - $30,134	$30,135 - $40,179	$40,180 +
4	$0 - $24,249	$24,250 - $36,374	$36,375 - $48,499	$48,500 +
5	$0 - $28,409	$28,410 - $42,614	$42,615 - $56,819	$56,820 +
6	$0 - $32,569	$32,570 - $48,854	$48,855 - $65,139	$65,140 +
7	$0 - $36,729	$36,730 - $55,094	$55,095 - $73,459	$73,460 +
8	$0 - $40,889	$40,890 - $61,334	$61,335 - $81,779	$81,780 +
9	$0 - $45,049	$45,050 - $67,574	$67,575 - $90,099	$90,100 +
10	$0 - $49,209	$49,210 - $73,814	$73,815 - $98,419	$98,420 +

☐ Patient refused to answer.

X_____ **X**_____

Patient's Signature or Signature of Patient Representative — Date

☐ Patient refused to sign.