THUROW PRIMARY
Preventive Healthcare, S.C.
216 N. Green Bay Rd., Suite 103, Thiensville, WI 53092
Phone (262) 242-3966, Fax (262) 242-3993

# Patient Registration

PATIENT NAME: _____DOB: ___/___/_____ TODAY'S DATE: ___/___/_____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ SSN: _____-_____-_____ GENDER (circle one): M / F / T

HOME PHONE: _____-_____-_____ WORK: _____-_____-_____ CELL: _____-_____-_____

MARITAL STATUS (circle one): SINGLE / MARRIED / OTHER EMAIL: _____

STUDENT (circle one): FULL TIME / PART TIME / NA SCHOOL: _____

EMPLOYED (circle one): Y / N EMPLOYER: _____

PREFERRED PHARMACY: _____ CITY: _____PHONE: _____-_____-_____

HOW DID YOU HEAR ABOUT US?_____ _____

**RESPONSIBLE PARTY INFORMATION (insurance policy holder/parent/guardian)**

RESPONSIBLE PARTY (if other than self): _____

RELATIONSHIP: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____-_____-_____ DOB: _____/_____/_____ SSN: _____-_____-_____

**INSURANCE INFORMATION**

***PRIMARY CARRIER:*** _____

CARRIER ADDRESS: _____

ID#: _____ GROUP#: _____ EFF DATE: _____/_____/_____

POLICY HOLDER'S NAME: _____ DOB: _____/_____/_____

SSN: _____-_____-_____ RELATIONSHIP TO PATIENT (circle one): SELF / SPOUSE / CHILD / OTHER

***SECONDARY CARRIER:*** _____

CARRIER ADDRESS: _____

ID#: _____ GROUP#: _____ EFF DATE: _____/_____/_____

POLICY HOLDER'S NAME: _____ DOB: _____/_____/_____

SSN: _____-_____-_____ RELATIONSHIP TO PATIENT (circle one): SELF / SPOUSE / CHILD / OTHER

**EMERGENCY CONTACT**

NAME: _____ PHONE: _____-_____-_____ RELATIONSHIP: _____

**PLEASE REVIEW AND SIGN**

I understand that it is my responsibility to provide the necessary and correct information in order to have my services submitted to my insurance carrier for reimbursement. I understand that failure to do so will result in payment in full at the time any services are provided to me. I understand that services will be billed to my carrier. In the event that my insurance does not cover the services rendered or states that any portion is my responsibility (such as deductible, co-insurance, co-pay or non-covered benefits), I understand that it is due immediately. I authorize the release of any information concerning my (or my dependant's) healthcare, advice and treatment for the purpose of evaluating and/or administrating claims for insurance benefits. I authorize payment of insurance benefits, otherwise payable to me, directly to the provider. This will remain in force until I revoke this in writing.

**SIGNED:** _____ **DATED:** _____/_____/_____

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# New Patient Health History

Patient Name: _____ Date: _____

Please explain the **chief concern** for your visit:

_____

_____

**Past Medical History**
Please list any chronic conditions for which you take medicine (e.g., high blood pressure, diabetes, asthma, high cholesterol) and any other problems you have had in the past (e.g., hospitalizations, cancer)

_____

_____

_____

**Family History**

| | **Please list any significant chronic illnesses:** | **Age and cause at time of death, if applicable:** |
|---|---|---|
| **Paternal Grandfather** | | |
| **Paternal Grandmother** | | |
| **Maternal Grandfather** | | |
| **Maternal Grandmother** | | |
| **Father** | | |
| **Mother** | | |
| **Sibling M / F:** | | |
| **Sibling M / F:** | | |
| **Sibling M / F:** | | |

**Allergic Reactions**

| **Trigger (e.g., type of medication/bee sting)** | **Type of Reaction (hives, vomiting, etc…)** |
|---|---|
| | |
| | |

**Current Medications and Supplements** (please bring these with you to your first appointment)

| **Current Medications/Supplement:** | **Dosage (mg/pill):** | **How often taken:** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

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| | | |
|---|---|---|
| | | |

**Social History**

Marital Status (please circle): Married • Divorced • Single • Other

| **Children** | **Step Children** | **Age** | **Medical Condition(s)** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Habits**

Smoke:

- How much?_____
- How many years? _____ What year did you quit?_____

Alcohol:

- How many drinks per week? _____
- What type of alcohol? _____
- How many ounces per drink? _____

Do you have any history of drug use, currently or in the past? _____

If so, what type _____

Do you have any history of substance abuse or treatment for the same?_____

**Please list any of your hobbies or interests:**

_____

_____

_____

**Please list any exercise that you regularly participate in:**

| **Exercise type:** | **Frequency:** |
|---|---|
| | |
| | |
| | |
| | |

Do you currently work full-time/ part time? (circle one)

What type of work do you do?

_____

_____

_____

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**Past Surgical History**

| **Surgery:** | **Estimated date procedure occurred:** |
|---|---|
| | |
| | |
| | |
| | |

**Health Promotion**

| **Immunization:** | **Date of most recent:** |
|---|---|
| **Tetanus** | |
| **Flu vaccine** | |
| **Pneumovax 23** | |
| **Prevnar 13** | |
| **Zoster Vaccine** | |

| **Procedures:** | **Date of most recent:** | **If abnormal, what did it show?** |
|---|---|---|
| **Mammogram** | | |
| **Pap/pelvic** | | |
| **Colonoscopy** | | |
| **Dental Exam** | | |
| **Eye Exam** | | |

**Seatbelt use** YES • NO **Sunscreen use** YES • NO

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# Medical Records Release

_____ _____/_____/_____
Patient Name Date of Birth
_____-_____-_____ _____-_____-_____
Telephone Number Alternate Phone Number

Release From: Name _____
Address _____
_____
Phone (_____) _____-_____
Fax (_____) _____-_____

Release To: Thurow Primary Preventive Healthcare, SC
Sharon K. Thurow, FNP, BC
216 Green Bay Rd, Ste 101
Thiensville, WI 53092
Phone: 262-242-3966 Fax: 262-242-3993

This information is being disclosed for the purpose of continuing health care.

I ☐ do ☐ do not authorize the information to be faxed. If I do, please fax the information accordingly: health care covering the following period(s): ☐ All ☐ from____/____/____ to____/____/____

Please include the following records to be disclosed to Sharon K. Thurow, FNP, BC:

☐ History and Physical Exam ☐ Progress Notes ☐ Hospital Records
☐ X-Ray, Ultrasound, Diagnostic Test ☐ Lab Tests ☐ All medical records

I understand the specific information to be released may include AIDS or HIV, alcohol or drug abuse and mental health. I understand that if I request copies of records for a family member or myself, a review of this information with my health care provider is encouraged. I understand that if the health care provider does not feel it is in my best interest, I may designate another health care provider to receive these records. I accept responsibility for these copies and information contained herein. I also understand that there may be a fee for preparing and furnishing this information.

Unless otherwise indicated, this authorization will expire ninety (90) days from the date of signature. The health care provider and employees are release from any legal responsibility or liability for the health care of the above information to the extent indicated and authorized herein. I understand that his authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization for the purpose stated above.

_____ _____ ____/____/____
Signature of Patient or Legal Representative Relationship to Patient Date

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# Notice of Privacy Practices

By signing below, I acknowledge that I have been provided with a copy of the Thurow Primary Preventive Healthcare, SC Notice of Privacy Practices and have, therefore, been advised of how health information about me may be used and disclosed by Thurow Primary Preventive Healthcare, SC and how I may obtain access to and control this information.

_____ ____/____/____
Signature of Patient or Personal Representative Date

_____
Print name of patient or Personal Representative

_____
Description of Personal Representative

Please list anyone that you want to allow access to your pertinent medical information (i.e., family members, spouse, significant other):

_____
_____
_____

May we leave a message on an answering machine (circle one)? Yes / No
Preferred method of contact:

Home: (_____) _____-_____
Cell: (_____) _____-_____
Work: (_____) _____-_____
Email: _____

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**This portion is for office use only**

This section is to be completed in the event that written acknowledgement is not obtained.

We have made a good faith effort to obtain an individual's acknowledgement but the acknowledgement was not obtained for the following reason(s).
The individual refuses to sign or otherwise fails to provide an acknowledgement.
The individual was mailed a copy of the Notice and did not mail back his/her receipt of acknowledgement.

Completed by: _____ Date: ____/____/_____

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# Policy for Prescriptions of Scheduled Drugs

This policy is written and shall be implemented for the safety of both the patients and agents of Thurow Primary Preventive Healthcare, SC. It will be kept in the patient's medical record. Any patient issued a prescription for a scheduled medication will adhere to this policy. Failure to do so will result in cessation of any further scheduled prescriptions from all providers affiliated with Thurow Primary Preventive Healthcare, SC at the discretion of your prescriber. The following is a list of medications affected by this contract and the guidelines for follow-up with your provider for regular refills:

**Monthly follow-up required for:**

- Morphine*
- Oxymorphone / Opana ER
- Percocet* / Oxycodone-APAP*
- Hydrocodone* / APap-Vicodin* / Norco*
- Oxycodone HCl / Immediate Release Oxycodone
- Oxycodone ER* / OxyContin*
- Phentermine / Adipex-P (IV)
- Qsymia (IV)
- Belviq (IV)
- Nucynta

**Three month follow-up required for:**

- Buprenorephrine / Butrans Patch
- Alprazolam / Xanax
- Clonazapam / Klonopin

**(three month follow-up cont…)**

- Lorazepam / Ativan
- Diazepam / Valium
- Topical Ketamine
- Temazepam / Restoril
- Zolpidem / Ambien
- Codiene
- Lunesta / Eszopiclone
- Methylphenidate* /Adderall* (D-Amphetamine Salt)/Ritalin*
- Atomoxetine* / Straterra*
- Tramadol / Ultram (come in both Immediate and ER formulations)
- Belsomra
- Nuvigil / Armodafinil
- Concerta

Prescriptions will not, under any circumstance, be mailed to the patient or refilled before the medication is due. Prescriptions will be written on tamper proof paper and issued directly to the patient with the exception of a family member or close contact previously designated to pick the prescription up for the patient. The authorized person(s) must be stated below or will not be given the prescription. In addition to the patient, a maximum of two people can be designated to pick the up prescription.

The following persons are authorized to pick up my prescription:
1) _____ 2) _____

I, _____, will submit to urine samples, at random, to detect levels of currently prescribed medications in addition to other substances, controlled or uncontrolled. These screenings will ensure that I am receiving appropriate dosages for my pain control as well as not taking additional doses of medications and/or illicit drugs, including marijuana, which can put my health at risk. Urine samples must be provided at the Thurow Primary Preventive Healthcare, SC office on the date specified by my prescriber and will never be permitted to be completed at home. If I do not provide a sample on the random date selected, my prescriber reserves the right to deny any further medications for my treatment.

I understand taking illicit drugs in combination with any of the aforementioned scheduled medications, Thurow Primary Preventive Healthcare, SC. reserves the right to discharge me. As part of my treatment plan, it may be required for me to meet with an addiction specialist. In this event, I understand that I will not receive any more prescriptions for scheduled drugs from the practitioners at Thurow Primary Preventive Healthcare, SC.

Patient: _____ Date signed: ____/____/____