Mark C. Engasser, MD PA
6600 France Ave. S Suite 615
Edina, MN 55435
952-920-4333

PATIENT NAME:_____
LAST FIRST MIDDLE
If patient is minor, Parent Guardian:_____

Address _____City _____State _____zip _____

Home Phone _____Cell _____Work _____

Date of Birth _____Age: _____Sex: M or F SocialSecurity#_____

E-Mail Address _____

Employer _____Address _____

Referring Physician _____Primary Physician _____

Marital Status (circle) Single Married Widowed Divorced Other _____

Reason for appointment/area to be examined _____RT ___ LT ___

Recent tests _____

We need your help to remain a certified Electronic Health Record (EMR) user. In order to comply with government requirements for use of a certified EMR, we are now required to request and record the following information.

Primary Language _____ Race _____

Ethnicity (circle) Hispanic or Latino Non-Hispanic or Latino

Primary Insurance _____ Policy Holder _____ DOB __/__/__
Group # _____ ID/Policy # _____
Insurance Address _____
Secondary Insurance _____ Policy Holder _____ DOB __/__/__
Group # _____ ID/Policy # _____
Insurance Address _____

[ ] Work Comp [ ] Auto Insurance Carrier _____
Carrier Address _____
Claim # _____ Date of Injury _____
Contact Name _____ Phone _____
Employer at time of Injury _____

PATIENT NAME:_____

Past History – Do you have a personal history of any of the following, please circle all that apply

General	NONE	Cancer, Diabetes, Hepatitis, Thyroid Disease, AIDS/HIV, High Cholesterol, Other:_____
Heart	NONE	Heart Disease, Blood Clots, High Blood Pressure, Pacemaker, Pulmonary Embolism, Heart Attack, Abnormal Rhythm, Bleeding Disorder, Other:_____
Lungs	NONE	Asthma, Emphysema, Bronchitis, Sleep Apnea, Other:_____
Gastrointestinal	NONE	Ulcers, Abdominal Surgery, Inflammatory Bowel Disease, Reflux/GERD, Other:_____
Neuro/Psyche	NONE	Neuropathy, Drug Addiction, Polio, Seizures, Nerve Injury, Psychiatric Disorder, Other:_____
Skin	NONE	Psoriasis, Delayed Wound Healing, Keloid, Recurrent Cyst, MRSA, Other:_____
Musculoskeletal	NONE	Rheumatoid Arthritis, Gout, Fracture, Sprains/Ligament Injury, RSD/CRPS, Fibromyalgia, Chronic Pain, Other:_____
Other	NONE	List:_____ _____

Past Hospitalizations/Surgical History – Please List

	Year

Medications – Please include prescribed/over the counter medications.

SEE PAGE 3 FOR EXTENSIVE CHECK LIST

Allergies- Please list allergy and symptom

Family History – Please check all that apply

	Father	Mother	_Brother _Sister	Grandmother __Paternal __Maternal	Grandfather __Paternal __Maternal
Arthritis					
Bleeding Disorder					
Blood Clots					
Cancer					
Diabetes					
Heart Disease					
Infectious Disease					

Social History-

Are you a smoker? Yes No Former Smoker Do you Drink Alcohol? Yes No Quantity____

Height _____ Weight _____ BP _____ Pulse _____

Mark C Engasser, MD PA

Patient Name _____ Date of Birth _____

Pharmacy _____ Street/City _____

Please check any current medications you are taking

Anti Depressant
__ Effexor (venlafaxine)
__ Cymbalta (duloxetine)
__ Prozac (fluoxetine)
__ Paxil (paroxetine)
__ Wellbutrin (bupropion)
__ Zoloft 9sertraline)

Anti Ulcer
__ Prilosec (omeprazole)
__ Prevacid (lansoprazole)
__ Nexium (esomeprazole)
__ Protonix (pantoprazole)
__ Tagament (cimetidine)
__ Zantac (ranitidine)

Allergy/Asthma
__ Allegra (fexofenadine)
__ Claritin (loratadine)
__ Singulair (monetlukast)
__ Zyrtec (cetirizine)
__ Albuterol Inhaler
__ Asthma-Steroid Inhaler

Blood Thinners
__ Aspirin
__ Coumadin (warfarin)
__ Refludan (lepirudin)
__ Ticlid (ticllipidine)
__ Plavix (clopidogrel)
__ Aggrastat (tirofiban)
__ Intefrilin (eptifibatide)

Cholesterol Lowering
__ Lipitor (atorvastatin)
__ Zocor (simvastatin)
__ Crestor (rosuvastatin)
__ Mevacor (lovastatin)
__ Niaspan (niacin)
__ Gemfibrozil
__ Zetia

Diabetes
__ Insulin (any type)
__ Glucophage (metformin)
__ Diabeta, Glynase/Micronase
__ Glucotrol (glipizide)
__ Glucagon
__ Avandia (rosiglitazone)
__ Precose (acarbose)

Cardiac/Hypertension
__ Capeten (captopril)
__ Lisinopril
__ Cozaar (losartan)
__ Diovan (valsartan)
__ Dyazide (hydrochlorothiazide)
__ Nifedipine
__ Verapamil
__ Diltiazem
__ Norvasc (amlodipine)
__ Inderal (propranolol)
__ Tenormin (atenolol)
__ Lopressor (metoprolol)
__ Toprol

Pain Medications
__ Darvocet
__ Fentanyl
__ Hydrocodone
__ Lyrica
__ MS Contin
__ Neurontin
__ Oxycodone
__ OxyContin
__Percocet
__ Tylenol #3
__ Vicodin
__ Vistaril
__ Zanaflex

Antibiotics
__ Amoxicillin
__ Augmentin (amoxicillin)
__ Bactrim (trimethoprim)
__ Biaxin (clarithromycin)
__ Cipro
__ Cleocin (clindamycin)
__ Doxycycline
__ Erythromycin
__ Keflex (cephalexin)
__ Levaquin (levofloxacin)
__ Lemisil (terbinafine)
__ Sporanox (itraconazole)
__ Zithromax (azithromycin)

Anti Inflammatory
__ Acetaminophen (Tylenol)
__ Celebrex
__ Naproxen (aleve)
__ Ibuprofen
__ Prednisone
__ Meloxicam

Osteoporosis Treatment
__ Actonel
__ Boniva
__ Fosamax

Reproductive
__ Birth Control Pills
__ Depo-Provera Injections
__ Hormone Replacement

Over the Counter/Herbal/Supplements: _____
_____
_____
_____
_____

Assignment of Benefits

I hereby request and authorize direct payment of benefits specified under my policy, any policy paying health care benefits to: Mark C. Engasser, MD PA.
This form also authorizes the release of any medical information necessary to process this claim. I understand I am financially responsible for charges not covered by this authorization and that if the injury or illness be such that it is not covered by the policy contract, I will be responsible for the payment of the entire bill.
I also will allow Dr. Engasser to know all prescriptions prescribed to me by other doctors, if necessary, and have permission to share medication history on our EMR/prescription site.
A photocopy or exact reproduction of this authorization shall have the same force and effect of this original.

DATE_____SIGNATURE_____
(If minor, parent or guardian signature)

Acknowledgement of Receipt of Notice

Under the Health Insurance Portability and Accountability Act of 1996(HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in this office's Notice Privacy Practices. This office is permitted to revise its Notice of Privacy Practices at any time. We will provide you with a copy upon your request.

By signing below, you are acknowledging that you have received a copy or read our Notice of Privacy Practices.

PATIENT NAME (please print) _____

PATIENT REPRESENTATIVE _____

IF REPRESENTATIVE, relationship to patient _____

DATE _____ SIGNATURE _____

OFFICE USE ONLY

I, _____, attempted to obtain the patient's acknowledgement of receipt of the Notice of Privacy Practices, but was unable to do so.

Reason _____

_____

SIGNATURE _____ DATE _____