

# **Galbraith Family Medicine, LLC**

**44 Elm Street**

**Limerick, Maine 04048**

**Phone (207) 793-9586**

**Fax (207) 793-9587**

Dear Patient,

Welcome, and thank you for choosing Galbraith Family Medicine, LLC, for your care. We are committed to providing quality care to the entire family, with an emphasis on treating the whole person and on promoting healthy living to prevent disease. In this packet, you are given information that describes some important aspects of our practice and some of what you can expect during your visits with us. It also includes forms to complete to help us get to know you better.

In order to help us best serve your needs, please fill out the enclosed "Registration and Consent" form (1 page) and the "Patient History" form (3 pages). Please also read and sign the "Signature on File" form. To best serve you, these forms should be completed and returned to us *before* your visit so that we may enter this information into your chart. Also enclosed is the "Acknowledgment of Receipt of Notice of Privacy Practices" form which should be brought to your appointment where we can provide you with a copy of our Notice of Privacy Practices for your review prior to signing the acknowledgment.

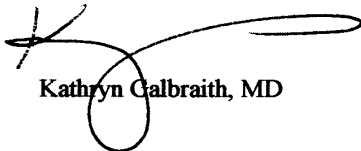
In this packet we have also included an "Authorization To Release Protected Health Information" form. This may be copied (if necessary), completed, and sent or hand-carried to your previous medical provider(s) so that we may obtain your records. As an alternative, you are welcome to mail the completed form to us along with your other forms and we will request the records for you. This is best done well ahead of your visit with us as it can take several weeks for records to be prepared and sent. We prefer to have your records in hand before we meet; please be aware that without your previous medical records, our first visit may be very limited in scope.

Please bring your insurance card with you to all of your appointments. Also bring your Co-Pay, if applicable, as payment is expected at the time of service. We submit a claim to your insurance for each visit as appropriate; you will be billed at a later date for any balance not covered by your insurance. For those without insurance or for those who prefer to forego the insurance claim process, we offer a 40% discount for full payment of the day's balance at the end of the visit.

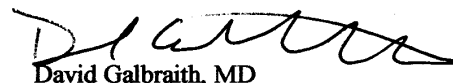
We look forward to seeing you. If, however, you are unable to keep your appointment, kindly let us know within 24 hours of your visit, and we will reschedule the appointment for a time that is more convenient for you.

If you have questions, please feel free to give us a call. Thank you for placing your trust in us.

Sincerely,



Kathryn Galbraith, MD



David Galbraith, MD

# Galbraith Family Medicine, LLC

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## REGISTRATION AND CONSENT FORM (Please Print)

### Patient Information

Primary Care Provider:    Dr. David Galbraith    Dr. Kathryn Galbraith

Patient Last Name	First	Middle	Date of Birth / /
Mailing Address			Social Security #
Street Address (if different from above)			Home Phone # ( )
City	State	Zip Code	Cell Phone # ( )
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widow/Widower			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Employer		Occupation	Work Phone # ( )
Emergency Contact		Phone # ( )	Relationship
Preferred Pharmacy			Race: <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> African American <input type="checkbox"/> Multiracial/Other _____

### Insurance Information (Please give your insurance card to the receptionist to make a copy)

Person Responsible for the Bill	Address if different from patient's	Phone # ( )
Relationship to patient	Responsible Person's Employer	This Employer's Phone # ( )
Name of Primary Insurance / CoPay \$	Group #	Policy #
Subscriber's Name	Subscriber's Social Security #	Relationship to patient
Name of Secondary Insurance / CoPay \$	Group #	Policy #
Subscriber's Name	Subscriber's Social Security #	Relationship to patient

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Galbraith Family Medicine, LLC. I understand that I am financially responsible for any balance and for any amounts that may not be covered by my insurance. I also authorize Galbraith Family Medicine, LLC, and/or insurance company to release any information required to process my claim.

I, or the guardian/representative of the patient, hereby give consent to Galbraith Family Medicine, LLC, and other individuals involved in this care to administer such diagnostic procedures and/or treatments as may be advisable to evaluate and treat illness or injury and promote good health.

I also understand that the provider responsible for this care has the responsibility to explain the purpose, benefits, and usual risks inherent to the diagnosis and treatment of any illness, injury or to the promotion of good health and preventative care, including alternative courses of treatment. I further understand that I have the right to refuse any suggested examinations, tests or treatments.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

Note to minors: If you are a minor who consents to health care services on your own behalf, but utilize your parent's or guardian's insurance policy to pay for your services, please know that your parent or guardian will receive an Explanation of Benefits describing the nature of the services provided and, as a result, these services will no longer be confidential. Please speak with our staff if you wish to pay for your services in another manner.

## Signature on File

I authorize the use of this form on all of my insurance submissions.

I authorize the release of medical and other information to all my insurance companies.

I authorize my doctor and his or her representatives to be my agents in helping me obtain payment from my insurance companies.

I authorize payment directly to my doctor and/or Galbraith Family Medicine, LLC.

I understand that I am responsible for my bill.

I understand that during the course of my treatment certain tests or consultations with specialists may be necessary and that I authorize the release of any pertinent medical information to the parties involved for these purposes.

I permit a copy of this authorization to be used in place of the original.

Signature \_\_\_\_\_

Name (printed) \_\_\_\_\_

Date \_\_\_\_\_

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**\*\*\*You may refuse to sign this acknowledgment\*\*\***

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

I have received a copy of the Notice of Privacy Practices, either in paper form or have had the opportunity to review a copy available in the office. I acknowledge that I have had an opportunity to ask questions about the Notice of Privacy Practices for Galbraith Family Medicine, LLC. This practice reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Galbraith Family Medicine, LLC.

\_\_\_\_\_  
Signature of Patient or Patient Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of person signing

\_\_\_\_\_  
Relationship

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**FOR OFFICE USE ONLY**

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Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Galbraith Family Medicine, LLC, attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign.
- Communication barriers prohibited obtaining the acknowledgment.
- An emergency situation prevented us from obtaining acknowledgment.
- Other (please specify)

\_\_\_\_\_  
Employee signature

\_\_\_\_\_  
Date

**Galbraith Family Medicine, LLC**  
**PATIENT HISTORY FORM**

Please Print

Today's Date: \_\_\_\_\_ Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Please list your ON-GOING, long-term medical problems (chronic illnesses):**

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**Please list PAST problems and surgeries you have had:**

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**Please list all current medications, vitamins, herbs, and over-the-counter medications you take: (Please use the back if needed)**

Name of Medication	Strength	When you take it

**Please list your MEDICATION ALLERGIES and your reaction to each:**

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**Please check the medical problems that run in your family (EXCLUDE YOURSELF) and write in who was affected:**

- |   |  |
|---|--|
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Heart attack prior to age 50_____ |
| <input type="checkbox"/> Breast_____              | <input type="checkbox"/> Diabetes (adult onset)_____       |
| <input type="checkbox"/> Colon_____               | <input type="checkbox"/> Stroke_____                       |
| <input type="checkbox"/> Melanoma_____            | <input type="checkbox"/> High cholesterol_____             |
| <input type="checkbox"/> Ovarian_____             | <input type="checkbox"/> Asthma_____                       |
| <input type="checkbox"/> Prostate_____            | <input type="checkbox"/> Depression or Anxiety_____        |
| <input type="checkbox"/> High blood pressure_____ | <input type="checkbox"/> Bipolar disorder_____             |
| <input type="checkbox"/> Migraine headaches_____  | <input type="checkbox"/> Alcoholism_____                   |
| <input type="checkbox"/> Osteoporosis _____       | <input type="checkbox"/> ADD/ADHD _____                    |
| <input type="checkbox"/> Other: _____             |  |

**Health habit history:**

Occupation: \_\_\_\_\_  
Marital status (circle):    Single    Married    Divorced    Widowed  
Do you have children? (circle) YES    NO    #daughters:\_\_\_\_\_ #sons:\_\_\_\_\_  
Do you use tobacco? (circle) YES(every day) YES(some days) NO(quit) NO(never)  
    If yes, how much per day:\_\_\_\_\_  
    If quit, what year did you quit:\_\_\_\_\_ #years smoked:\_\_\_\_\_ Ave. amount smoked:\_\_\_\_\_  
Do you drink alcohol? (circle) YES    NO  
    If yes, what type:\_\_\_\_\_ How often:\_\_\_\_\_ Amount:\_\_\_\_\_  
    If quit, what year did you quit:\_\_\_\_\_  
Do you drink caffeine? (circle) YES    NO  
    If yes, what types: \_\_\_\_\_ Amount per day: \_\_\_\_\_  
What is your activity level? (circle) Sedentary "Active" Moderate or vigorous exercise  
What is your birth control type? \_\_\_\_\_  
Do you have a living will or advanced directive? (circle) YES NO  
List your preferred language: \_\_\_\_\_  
Ethnicity (circle): Hispanic Non-Hispanic Other: \_\_\_\_\_

**Confidential health habit history:**

Do you use recreational drugs? (circle) YES NO  
    If yes, what types:\_\_\_\_\_ Frequency:\_\_\_\_\_  
Do you have a history of being abused as a child? (circle) YES NO  
Have you ever been a victim of domestic violence? (circle) YES NO  
Are you sexually active? (circle) YES NO  
    If so, do you engage in activity with (circle): Men Women Both  
    If so, do you use condoms? (circle) YES NO

**Health Maintenance (list approximate dates of your last visit):**

Colonoscopy:\_\_\_\_\_ Where was it done? \_\_\_\_\_  
Flu shot: \_\_\_\_\_  
Pneumonia shot: \_\_\_\_\_  
Tetanus shot: \_\_\_\_\_  
Mammogram:\_\_\_\_\_ Where was it done? \_\_\_\_\_  
Pap smear: \_\_\_\_\_ Where was it done? \_\_\_\_\_  
Bone density test: \_\_\_\_\_ Where was it done? \_\_\_\_\_

**Review of systems--if YES circle and list details:**

**Constitutional**

Weight gain or loss \_\_\_\_\_

Fever \_\_\_\_\_

Insomnia \_\_\_\_\_

Fatigue \_\_\_\_\_

**Gastrointestinal**

Abdominal pain \_\_\_\_\_

Blood in stool \_\_\_\_\_

Constipation \_\_\_\_\_

Diarrhea \_\_\_\_\_

Heartburn \_\_\_\_\_

Nausea \_\_\_\_\_

**Dermatological**

Acne \_\_\_\_\_

Excessive sun exposure \_\_\_\_\_

Change in mole \_\_\_\_\_

Skin lesion \_\_\_\_\_

**HEENT**

Headache \_\_\_\_\_

Itchy eyes \_\_\_\_\_

Visual loss \_\_\_\_\_

Ear pain \_\_\_\_\_

Ringing in ears \_\_\_\_\_

Dizziness \_\_\_\_\_

Nasal discharge \_\_\_\_\_

Nasal congestion \_\_\_\_\_

Postnasal drip \_\_\_\_\_

Snoring \_\_\_\_\_

Tooth pain \_\_\_\_\_

**Genitourinary**

Decreased stream \_\_\_\_\_

Painful urination \_\_\_\_\_

Urinary frequency \_\_\_\_\_

Blood in urine \_\_\_\_\_

Lots of urine \_\_\_\_\_

Urinary incontinence \_\_\_\_\_

**Respiratory**

Cough \_\_\_\_\_

Windedness with activity \_\_\_\_\_

Shortness of breath \_\_\_\_\_

Wheeze \_\_\_\_\_

**Musculoskeletal**

Joint pain \_\_\_\_\_

Muscle pain \_\_\_\_\_

**Hematological**

Easy bruising \_\_\_\_\_

Easy bleeding \_\_\_\_\_

**Vascular**

Cool extremity \_\_\_\_\_

Varicose veins \_\_\_\_\_

**Immunological**

Hives \_\_\_\_\_

**Metabolic/endocrine**

Hair loss \_\_\_\_\_

**Neurological**

Localized body weakness \_\_\_\_\_

Gait disturbance \_\_\_\_\_

Memory impairment \_\_\_\_\_

Seizures \_\_\_\_\_

**Psychiatric/emotional**

Difficulty concentrating \_\_\_\_\_

Anxiety \_\_\_\_\_

Depression \_\_\_\_\_

Irritability \_\_\_\_\_

Suicidal thoughts \_\_\_\_\_

Mood swings \_\_\_\_\_

**Reproductive**

Age when became postmenopausal \_\_\_\_\_

History of abnormal pap smear \_\_\_\_\_

Sexual dysfunction \_\_\_\_\_

Last menstrual period \_\_\_\_\_

**Cardiovascular**

Chest pain \_\_\_\_\_

Passing out \_\_\_\_\_

Ankle swelling \_\_\_\_\_

Irregular heart beat \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

## Authorization To Release Protected Health Information

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

I HEREBY AUTHORIZE GALBRAITH FAMILY MEDICINE, LLC, TO: (Please check)

- Obtain my protected health information from: \_\_\_\_\_
- Release my protected health information (PHI) to: \_\_\_\_\_
- Share my health information with: \_\_\_\_\_

Physician/Other \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Protected Health Information to be released:

I am changing doctors

- Medical records (may specify "all" or related to a specific condition): \_\_\_\_\_
- Billing records
- Records from time frame \_\_\_\_\_ to \_\_\_\_\_

I understand that the PHI released pursuant to this authorization may include records generated by another healthcare provider or facility.

Purpose of disclosure: \_\_\_\_\_ ( if used for marketing this will be stated and remuneration if involved will be disclosed)

I HAVE BEEN MADE AWARE THAT I MAY REFUSE TO DISCLOSE ALL OR PART OF MY HEALTH CARE INFORMATION, PARTICULARLY AS NOTED BELOW. I HAVE BEEN MADE AWARE THAT REFUSING DISCLOSURE MAY RESULT IN IMPROPER DIAGNOSIS OR TREATMENT, DENIAL OF COVERAGE FOR AN INSURANCE CLAIM, OR OTHER ADVERSE CONSEQUENCES.

(Check below any information you **do not** wish disclosed)

- Psychological or psychiatric problems* (Records generated at a mental health agency/facility or by a psychiatrist, clinical nurse specialist, social worker or psychologist)
- Substance abuse or chemical dependency* (Records generated by medical personnel whose primary function is treating this. I understand that PHI that includes alcohol or drug program information protected by federal law will require notice to the person receiving the information that it may not be shown to or shared with others without my express written permission.)
- HIV test results or status* (Maine law requires our practice to inform you that disclosing your HIV infection status may have consequences such as negative treatment in your personal life, at work, or by insurance companies, if this information is misused. Yet it can be important for providing you needed services and healthcare)
- Other* \_\_\_\_\_

CHECK ONE:

- I authorize the release of the requested records **without** information relating to the conditions checked above.
- I authorize the release of the requested records in their entirety directly to the party who requested this information regardless of content.

I have read this release and understand the information contained in this document. I understand that I am not required to sign this form and that Galbraith Family Medicine, LLC, will not condition treatment, payment of services, or eligibility for services on whether I sign this form. I understand that I may revoke this consent at any time except to the extent that action has been taken in reference to this request. I can revoke this consent at any time by written, signed and dated notice to this office but understand that doing so may be the basis for denial of health benefits or other insurance coverage or benefits. I understand that I have the right to access or copy the PHI described in this form by making a written request to above address to the Privacy Officer(s) of this practice, David or Kathryn Galbraith, and that a copying fee may be charged as permitted by law. I understand that PHI used or disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by confidentiality laws. This release is valid for this request only. I am entitled to a copy of this form upon request.

\_\_\_\_\_  
Signature of Patient or Legal Guardian  
(Signature is valid for 30 months from signature date unless specified here: \_\_\_\_\_.)

\_\_\_\_\_  
Date