MOUNT NITTANY®
PHYSICIAN GROUP

Welcome

Thank you for choosing Mount Nittany Physician Group to care for you. We hope to become your lifelong partner in health and wellness.

To prepare for your first appointment with us, please complete the attached forms and return them in the enclosed prepaid envelope before your first appointment.

Please arrive 15 minutes before your appointment, so that we can make sure that we have everything needed for your visit with us for the first time.

If you have any questions or concerns, please call 844.278.4600 or visit our new patient web page, **mountnittany.org/newpatient**.

Thank you. We look forward to meeting you soon!

New patient forms included:

- Authorization for Release/Request of Protected Health Information
- Patient Questionnaire

Patient Label

MOUNT NITTANY HEALTH

Authorization for Release/Request of Protected Health Information Mount Nittany Health

MR#:_____ Acct #:_____

I hereby authorize **Mount Nittany Health,** consisting of Mount Nittany Medical Center (MNMC) and Mount Nittany Physician Group (MNPG), to release or request my health information:

Patient Information: Name: _____Date of Birth: _____

Address: _____

Telephone: _____ E-mail: _____

Release Information To: Name: Mount Nittany Physician Group - Medical Records

Address: : 1850 E. Park Avenue, State College, PA 16803

Telephone: _____ Fax: 814-231-7532 E-mail: _____

Request Information From: Name:_____

Address: : _____

Telephone: _____ Fax: _____E-mail: _____

The information to be released or requested shall be *limited* to the following:
Location of service (check all that apply): ☐ MNMC ☐ MNPG (specific office if needed):_____

Dates of service: _____

☐ Medical Record (complete)
☐ Consultation Reports
☐ Discharge Summary
☐ Safety Plan
☐ Pertinent MNMC (H&P, Consultation, Operative, Pathology, Diagnostic)
☐ Pertinent MNPG (Office notes, labs, procedures)
☐ ED Mental Health Evaluation & Liaison Note _____
☐ History and Physical (H&P)
☐ Laboratory Test Results
☐ Operative Reports
☐ Office notes
☐ X-Ray, Imaging Reports
☐ ED Records
☐ Discharge Instructions
☐ Progress Notes
☐ Medication List
☐ Other (specify):_____

The purpose of the disclosure is as follows: ☐ Continuity of Care ☐ Legal ☐ Personal ☐ Other: _____

I authorize this information be released or requested in the following manner (check all that apply):
☐ Pick up ☐ Mail ☐ CD ☐ Fax: _____
☐ E-mail:_____ ☐ Verbal – Behavioral Health Staff Only

I understand that this release may also include (Check to approve release of):

☐ Information relating to AIDS or HIV infection

☐ Information relating to mental health or psychiatric care continuing care plan and/or treatment for substance and/or alcohol abuse or dependency: excludes Psychotherapy notes

The confidentiality of my records may be protected by the Pennsylvania Drug and Alcohol Abuse Control Act, the Pennsylvania Mental Health Procedures Act, and/or the Pennsylvania Confidentiality of HIV Related Information Act. To the extent I have checked any of the above boxes; my signature below authorizes the release of information protected by these Pennsylvania statutes.

White – Medical Record

Patient Label

MOUNT NITTANY HEALTH

Authorization for Release/Request of Protected Health Information Mount Nittany Health

MR#:_____ Acct #:_____

NOTICE OF DISCLOSURE

You may refuse to sign this authorization. You do not need to sign this authorization to receive services from MNH unless the only purpose for providing you with a service is to obtain information to disclose to someone else (e.g. examinations required to obtain certain licenses). If the services are related to research, you may be required to authorize the use or disclosure of your health information limited and related to the research services.

I understand that I may revoke this authorization at any time in writing, except to the extent that action based on this authorization has been taken. However, I also understand that health information disclosed pursuant to this authorization may be subject to re-disclosure because it is no longer protected by federal privacy laws. I fully understand the contents of this authorization and voluntarily consent to the release of the information as stated. Finally, I understand that I am entitled to obtain a copy of this authorization from the Mount Nittany Health upon request.

THIS AUTHORIZATION SHALL EXPIRE ONE (1) YEAR FROM THE DATE THIS AUTHORIZATION IS EXECUTED; OTHERWISE, AND UNLESS IT IS REVOKED EARLIER.

_____

Signature of Patient or Patient Representative | Print Name | Date | Time

_____

Witness Signature | Date | Time | Witness Signature | Date | Time

If Patient is unable to give consent or if a Verbal consent is given, two MNH employees must sign as Witnesses.

If signed by Patient Representative, state relationship and authority to do so: (check all that apply)

☐ Parent of Minor ☐ Incompetent ☐ Disabled ☐ Deceased ☐ Custodial Parent
☐ Legal Guardian ☐ Executor of Estate of Deceased ☐ Authorized Legal Representative
☐ Power of Attorney for Health Care ☐ Other: _____

☐ Revoked_____ _____ _____
Patient or Patient Representative | Date | Time

Office Use Only:

Photo ID Obtained: ☐ / ☐
Driver's License #:_____
Other:_____
Records Released on:_____
Records Released by:_____
Number of pages:_____

Received by:_____Date:_____Time:_____
Transmitted by:_____Date:_____Time:_____

White – Medical Record

MOUNT NITTANY PHYSICIAN GROUP

Adult Patient Questionnaire

Patient Name: _____Date of Birth:_____

Pharmacy
Retail: _____
Mail Order:_____

Preferred Method of Reminder Communication
I would like to receive reminder communication via:
☐Patient portal ☐ Cell phone ☐Home phone
☐Mail ☐Work phone

HEALTH CARE TEAM: Please List Other Health Care Providers

Name	Specialty

ACTIVE PROBLEMS/PAST MEDICAL HISTORY
Do you currently have any of the following medical problems? Place "X" in **ACTIVE** Problem column.
Have you had any of the following medical problems in the past? Place "X" in **PAST** Problem column.

	Active Problem	Past Problem		Active Problem	Past Problem		Active Problem	Past Problem
Acne	☐	☐	**Depression**	☐	☐	**Hyperlipidemia** (High cholesterol)	☐	☐
Alcohol Abuse	☐	☐	**Diabetes**	☐	☐	**Hypertension** (High Blood Pressure)	☐	☐
Anemia	☐	☐	**Drug Abuse**	☐	☐	**Hyperthyroidism**	☐	☐
Anxiety	☐	☐	**End Stage Renal Disease**	☐	☐	**Hypothyroidism**	☐	☐
Arthritis	☐	☐	**Fatty Liver**	☐	☐	**Kidney Stone**	☐	☐
Asthma	☐	☐	**Stomach Ulcer**	☐	☐	**Pacemaker**	☐	☐
Atrial Fibrillation	☐	☐	**Acid Reflux**	☐	☐	**Pneumonia**	☐	☐
Bleeding Disorder	☐	☐	**Glaucoma**	☐	☐	**Seizure**	☐	☐
Cancer _____	☐	☐	**Gout**	☐	☐	**Stroke (s)**	☐	☐
Cholecystitis (Gallbladder problem)	☐	☐	**Migraine Headache**	☐	☐	**Tuberculosis**	☐	☐
Chronic Kidney Disease	☐	☐	**Hearing Difficulty**	☐	☐	**Vision Problem**	☐	☐
COPD	☐	☐	**Heart Attack**	☐	☐		☐	☐
Congestive heart failure	☐	☐	**Hepatitis** (Liver problem)	☐	☐		☐	☐
Coronary Artery Disease (CAD)	☐	☐	**History of Blood Clots**	☐	☐		☐	☐

Have you ever had any other behavioral health or medical problems not listed previously? ☐ YES ☐ NO
If YES, please list: _____

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Patient Name: _____Date of Birth:_____

PAST SURGICAL HISTORY

List all of the ***operations or surgeries*** you have ever had ***including year if known***:

Type of Surgery	Year

FAMILY HISTORY

☐Family History Unknown

Is there any of the following in your immediate family? Check all that apply

	Mother	Father	Brother	Sister	Other:
Alcohol Abuse	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐
Cancer (Please list below)					
• _____	☐	☐	☐	☐	☐
• _____	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Drug Abuse	☐	☐	☐	☐	☐
Gallbladder disease	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Kidney Stones	☐	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐

Is there any family history of the following in your immediate family, grandparents, aunts or uncles? If so, what was their age at the onset?

*Breast Cancer ☐Yes ☐No Person/Age of onset_____
*Colon Cancer ☐Yes ☐No Person/Age of onset_____
*Heart Attack ☐Yes ☐No Person/Age of onset_____
*Ovarian Cancer ☐Yes ☐No Person/Age of onset_____
*Prostate Cancer ☐Yes ☐No Person/Age of onset_____

Patient Name: _____Date of Birth:_____

SOCIAL HISTORY

Marital Status (Check one): ☐Divorced ☐Married ☐Separated ☐Single ☐Widow

Living Situation: Please describe your living situation.
(Example: live alone, homeless, live with spouse, live with children , etc)
_____

Employment Status (Check one): ☐Employed ☐Homemaker ☐Retired ☐Unemployed
Occupation: _____

Smoking History (Select the choice that best describes):

☐Never a smoker
☐ Former smoker
Please mark amount smoked PER DAY
Smoked _____ ☐Pack(s) Cigarettes ☐Cigars ☐ Pipe
Started at age _____ Quit at age _____
☐Current cigar smoker
☐Current pipe smoker
☐Electronic cigarette smoker

Current cigarette smoker:
☐ Less than ½ pack per day since age _____
☐ 1/2 pack per day since age _____
☐ 1 pack per day since age _____
☐ 1.5 packs per day since age _____
☐ 2 packs per day since age _____
☐ 2.5 – 3 packs per day since age _____
☐ Greater than 3 packs per day since age _____
☐ Other_____

Are you exposed to second hand smoke? ☐Yes ☐No

Smokeless Tobacco History (Check one):

☐ Never used smokeless tobacco
☐ Former user of smokeless tobacco
☐ Smokeless tobacco use
Frequency: ☐Daily ☐_____Times/week ☐Less than weekly

Alcohol Usage (check one):

☐Consumes alcohol weekly How many drinks per week?_____ What type of alcohol? _____
☐Daily Alcohol Use How many drinks per day? _____ What type of alcohol? _____
☐No Alcohol Use
☐Rarely consumes alcohol

Illicit Drug Use–(check one):

☐Current drug use What types of drugs:_____
☐History of drug use When did you quit:_____ Drugs used:_____
☐No illicit drug use

Dental Care

*Do you have a dental checkup at least yearly? ☐YES☐NO

Patient Name: _____Date of Birth:_____

Exercise Habits (check one)

☐Exercise limited by physical condition
☐Exercise 1-2 times/week
☐Exercise 3-4 times/week
☐Exercise 5-6 times/ week
☐Exercise daily
☐Never exercises

COMMUNICATION NEEDS: Vision/ Hearing

***Other than needing glasses or contacts, do you have any visual impairment affecting reading? ☐Yes ☐No
Explain: _____

*Do you have difficulty hearing? ☐Yes ☐No
Explain: _____

ALLERGIES

Are you allergic to any medications? ☐YES ☐NO
If YES, please list:

Name	Type of Reaction

Please List all MEDICATIONS you are presently taking. Please include prescriptions, over the counter, vitamins, herbal and/or other supplements:

Name of Medication	**Strength (Ex 50 mg)**	**Directions (Ex. 1 pill twice daily)**	**Why do you take this medication?**	**Who prescribed this medication?**
ONLY COMPLETE THIS SECTION IF YOU ARE A NEW PATIENT				

Patient Name: _____Date of Birth:_____

Immunizations: Please complete the dates for any adult immunization that you have received if known.

Vaccine	**Date**		
Hepatitis B series	#1	#2	#3
Human Papillomavirus Vaccine (HPV)			
Influenza (annual)			
Meningitis Vaccine	Menactra	Trumenba	
Pneumonia Vaccine	Pneumovax	Prevnar 13	
Shingles Vaccine (Zostavax)			
TDaP (Tetanus, Diphtheria, Pertussis)			

Health Maintenance:

Please enter the most recent date when you had the following procedures/ tests if applicable:

Procedure	**Date**
Colonoscopy	
DEXA Scan	
Diabetic Eye Exam	
Diabetic Foot Exam	
Mammogram	
PAP smear	
Prostate Specific Antigen (PSA)	

Patient Signature _____ Date: _____

Person who completed form if patient unable_____

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