Patient Name: ______________

1017 Dupont Road, Ste B Louisville, KY 40207
Office/Appointments: (502) 947-2273 Fax: (502) 947-2274

New Patient

Today's Date:	**Primary Care Provider:**
Name:	**Date of Birth:**
Social Security:	**Email:**
Home Phone:	**Cell Phone:**
Work Phone:	**Pharmacy:**
Street Address:	
City: **State:** **Zip code:**	
Sex: _____M _____ F ____Non-binary	**Marital Status**: __Single __Married __Divorced __ Widowed

Primary Language:
Race: □ Black/African American □ White/Caucasian □ Hispanic/Latino Other: □ Decline to provide ethnicity

Medication Allergies:	
Food Allergies:	**Other Allergies:**

Your Medical History Check All That Apply	
□ Anemia □ Angina (Chest Pain) □ Anxiety □ Arthritis (Osteoarthritis/Rheumatoid) □ Asthma □ Benign Prostatic Hypertrophy (BPH) □ Bleeding Disorder □ COPD □ Cancer (type) __________________ □ Cataracts □ Chronic Back Pain □ Chronic UTI □ Congestive Heart Failure □ Coronary Artery Disease □ Depression □ Diabetes □ Diverticulosis □ Erectile Dysfunction □ Fibromyalgia □ GERD (Acid Reflux/Indigestion	□ GOUT □ Glaucoma □ Headache/Migraine □ Heart Attack □ Hepatitis/ Liver Disease □ High Blood Pressure □ High Cholesterol □ HIV/AIDS □ Inflammatory Bowel Disease □ Insomnia □ Irregular Heartbeat ________________ □ Osteoporosis □ Peptic Ulcer Disease □ Peripheral Vascular Disease □ Polyneuropathy □ Renal/Kidney Disease □ Seasonal Allergies □ Seizure Disorder □ Sleep Apnea □ Stroke/TIA
Your Surgical History Check All That Apply	
□ Appendectomy (Appendix) □ Angioplasty (Heart Stents) □ Back Surgery □ Cataract □ Cardiac Pacemaker □ Cesarean Section □ Colectomy □ Cholecystectomy (Gallbladder) □ Coronary Artery Bypass □ Exploratory Lap □ Gastric Bypass □ Inguinal Hernia Repair □ Hemorrhoidectomy □ Hip Surgery	□ Hysterectomy □ Knee Surgery □ Lithotripsy □ Lumpectomy □ Mastectomy □ Meniscal Repair □ Prostatectomy (Prostate) □ Tonsillectomy □ Tubal Ligation □ TURP □ Umbilical Hernia Repair □ Other: □ Other: □ Other: □ Other: □ Other:

Do You See any Specialists	
Cardiologist (Heart):	**Nephrologist (Kidney):**
Pulmonary (Lungs):	**Gastroenterologist:**
Orthopedic (Bones):	**Pain Management:**
Endocrinologist:	**Therapist/Psychiatrist:**
Neurologist:	**Rheumatologist:**

Other:	**Other:**
Family History (Please specify which family member this applies to (Father, Mother, Brother, Sister, or etc …)	
□ Diabetes ________________________________ □ Congestive Heart Failure ___________________ □ Heart Attack ____________________________ □ Stroke ________________________________ □ High Blood Pressure _______________________ □ High Cholesterol _________________________ □ Other type of Heart Disease _________________ □ COPD ___________________________________ □ Asthma _________________________________ □ Other type of Lung Disease _________________ □ Genetic (Hereditary) Disease _________________ □ Alzheimer's/Dementia _______________________ □ Mental Illness ____________________________	□ Breast Cancer □ Ovarian Cancer □ Cervical Cancer □ Uterine Cancer □ Colon Cancer □ Prostate Cancer □ Leukemia □ Melanoma Cancer □ Kidney Cancer □ Gastric Cancer □ Other type of Cancer ____________

Social History		
Yes	No	Social/Health Habits
		Have you smoke tobacco? _____ Past _____ Present How many years? ______ Packs Per Day ____
		Do you drink alcohol? How much per day?
		Do you use recreational drugs? What type?
		Do you consume caffeine? (Coffee, Tea, Soda) How much per day?
		Do you have any dietary restrictions? What kind?
		Do you exercise? How much? Daily _____ Weekly ______ Type of exercise?

Health Screenings & Immunizations			
Type	Date	Type	Date
Lung Cancer Screening (CT Scan of Lungs)		Pneumonia (PCV15, PCV, PPSV23)	
Colon Cancer Screening (Colonoscopy, Cologuard)		Tetanus (T-Dap)	
Breast Cancer Screening (Mammogram)		Influenza (Flu)	
Prostate Cance Screening (PSA)		Shingles Vaccine	
DEXA Scan (Bone Density)		COVID Vaccine (Moderna, Pfizer, Johnson & Johnson)	
Skin Cancer		COVID Vaccine Booster	
Last Physical Exam:	**Last Vision Exam:**	**Last Dental Exam:**	

Medication List – Please list all of your Medications				
Name of Medication:	Dosage:	How often do you take?	Provider that Prescribed:	The date that you started taking?

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Name of Medication:	Dosage:	How often do you take?	Provider that Prescribed:	The date that you started taking?

Additional Comments: ____

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Print Name: ________________________________ Date: ____________

Signature: ________________________________

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CONSENT TO TREAT

Name: ____

Date of Birth: ______________________________________

I consent to allow the providers of the Aset Primary Care to perform necessary medical examinations and tests to diagnose and treat my health conditions. I have the right to discuss any treatment with my provider. I am encouraged to ask questions about any concerns I have.

I acknowledge that Aset Primary Care is committed to protecting the privacy and confidentiality of my personal health information in accordance with applicable laws and regulations.

This consent is valid until I revoke it in writing.

_____________________ _______________________
Signature Today's Date

1017 Dupont Road, Ste - B   Louisville KY 40207
PH 502 947-2273   Fax 502 947-2274

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

____________________________ ____________ ________________

(Patient's Full Legal Name)   (DOB)   (Contact Phone #)

Address: __________________________ __________________

I, AUTHORIZE:

____

(Name of Hospital or Physician Practice to Disclose Information)

Disclose Information to: FAX 502 947-2274 (secured)

Recipient Name: Aset Primary Care ~ Address: 1017 Dupont Rd, Ste B ~ Louisville KY 40207

DISCLOSE THE FOLLOWING INFORMATION:

☒ I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following

☒ All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, and telephone messages

☒ All physical, occupational, and rehab requests, consultations, and progress notes.

☒ I understand the following: See CFR §164.508(c)(2)(i-iii)

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.

b. The information released in response to this authorization may be re-disclosed to other parties.

c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

________________________ _______________ ________________

Signature   Date   Signature of Witness

If an Individual is unable to sign this Authorization, please complete the information below

__________________ __________ _______ ____________

Name of Guardian/ Representative   Legal Relationship   Date   Witness