SARAH THIBODEAU APRN
417 HIGHLAND AVE UNIT 2
WATERBURY CT O6708

Patient Demographics Form

Last Name:_____ First Name:_____ M.I.:_____

Date of Birth:_____/_____/_____

Address:_____City:_____State:_____Zip:_____

Email Address: _____

Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐

Phone Number: (_____) _____-_____ Alternate Number: (_____) _____-_____

Person(s) we may contact in an emergency:

Name:_____ Phone number: (_____) _____-_____

Name: _____ Phone number: (_____) _____-_____

How did you hear about *SARAH THIBODEAU APRN*? (Please check all that apply)

☐ Friend ☐ Internet /Website ☐ Doctor:_____ ☐ Other:_____

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Patient History Form

PATIENT NAME:_____ AGE:_____ D.O.B. _____/_____/_____

CURRENT MEDICATIONS:_____

MEDICATION ALLERGIES:_____

SEASONALALLERGIES? ☐ Y ☐ N PLEASE LIST :_____

_____

Do you smoke? ☐ Y ☐ N If yes, how much and how long? _____

Do you drink alcohol? ☐ Y ☐ N If yes, how much and how long? _____

Do you have a history of addiction? ☐ Y ☐ N

Do you have a history of an eating disorder? ☐ Y ☐ N

IS THERE A FAMILY OR PERSONAL HISTORY OF ANY OF THE FOLLOWING?

	FAMILY	PERSONAL
Arthritis	☐	☐
Osteoporosis	☐	☐
High Blood Pressure	☐	☐
Heart Disease	☐	☐
Heart Attack	☐	☐
Pacemaker	☐	☐
High Cholesterol	☐	☐
Liver Disease	☐	☐
Diabetes	☐	☐
Anemia	☐	☐
Depression	☐	☐
Anxiety	☐	☐
Swelling in Ankles	☐	☐

	FAMILY	PERSONAL
Seizures/Epilepsy	☐	☐
Kidney/Bladder Problems	☐	☐
Chronic Fatigue	☐	☐
Frequent Headaches	☐	☐
Hormone Imbalance	☐	☐
Food Allergies	☐	☐
Asthma	☐	☐
Fibromyalgia	☐	☐
Polycystic Ovaries (PCOS)	☐	☐
Recent Weight Loss/Gain	☐	☐
Thyroid Problems	☐	☐
Obesity	☐	☐

Other:_____

If you answered "yes" to any of the above, please explain below:

_____

_____

_____

Please list any and all surgeries (including cosmetic) and the dates: _____

_____

_____

Please list any complications to the surgeries, if any:_____

_____

Date of your last physical examination:_____

FEMALES ONLY

Do you get regular PAP smears? ☐ Y ☐ N

Do you get regular breast exams and mammograms (if needed)? ☐ Y ☐ N

Do you use Birth Control? ☐ Y ☐ N If yes, what form? _____

Is there any chance you might be pregnant? ☐ Y ☐ N

MALES ONLY

Do you get yearly physicals to include prostate examinations? ☐ Y ☐ N

Primary Care Physician:_____

Other Physicians you see:_____

Pharmacy:_____

Pharmacy Address:_____

Pharmacy Phone Number:_____

The information above is correct to the best of my knowledge:

_____ _____/_____/_____

Patient/Parent/Guardian Signature Date

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HIPAA / Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my Protected Health Information. I understand that the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to read and review your Notice of Privacy Practices prior to signing this consent. *SARAH THIBODEAU* follows the guidelines as stated in our Notice of Privacy Practices. Please acknowledge by signing below that you have been provided a copy of SARAH THIBODEAU'S Notice of Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the organization's Privacy officer to obtain a current copy of the Notice of Privacy Practices. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Authorization for medical records/contact information

I authorize the release of photocopies of all medical records in the possession or control of *COREBELLA HEALTH LLC* to SARAH THIBODEAU and through the means indicated below. I understand that confidentiality cannot be guaranteed.

Primary Care Physician (as listed above): ☐ YES ☐ NO

Family Members (please list name and relationship): _____

Personal Electronic Devices:

Voicemail: ☐ YES ☐ NO

Email: ☐ YES ☐ NO (if YES, email address): _____

I have read the patient information sheet on weight loss and understand it. The opportunity has been provided for me to ask questions regarding the potential side effects of weight loss medication and these questions have been answered to my satisfaction. I understand that every precaution consistent with best medical practices will be carried out.

Patient Name: _____

Patient Signature: _____ Date: _____

Parent or Legal Guardian* Signature: _____ Date: _____

*as parent or legal guardian, I understand I must accompany my child during entire procedure and visit.

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I, _____, certify that I am not pregnant at this time, and if I
PLEASE PRINT FIRST & LAST NAME
do become pregnant I will immediately notify in*Wellness*.

_____ _____/_____/_____
PATIENT SIGNATURE DATE

_____ _____/_____/_____
WITNESSW DATE