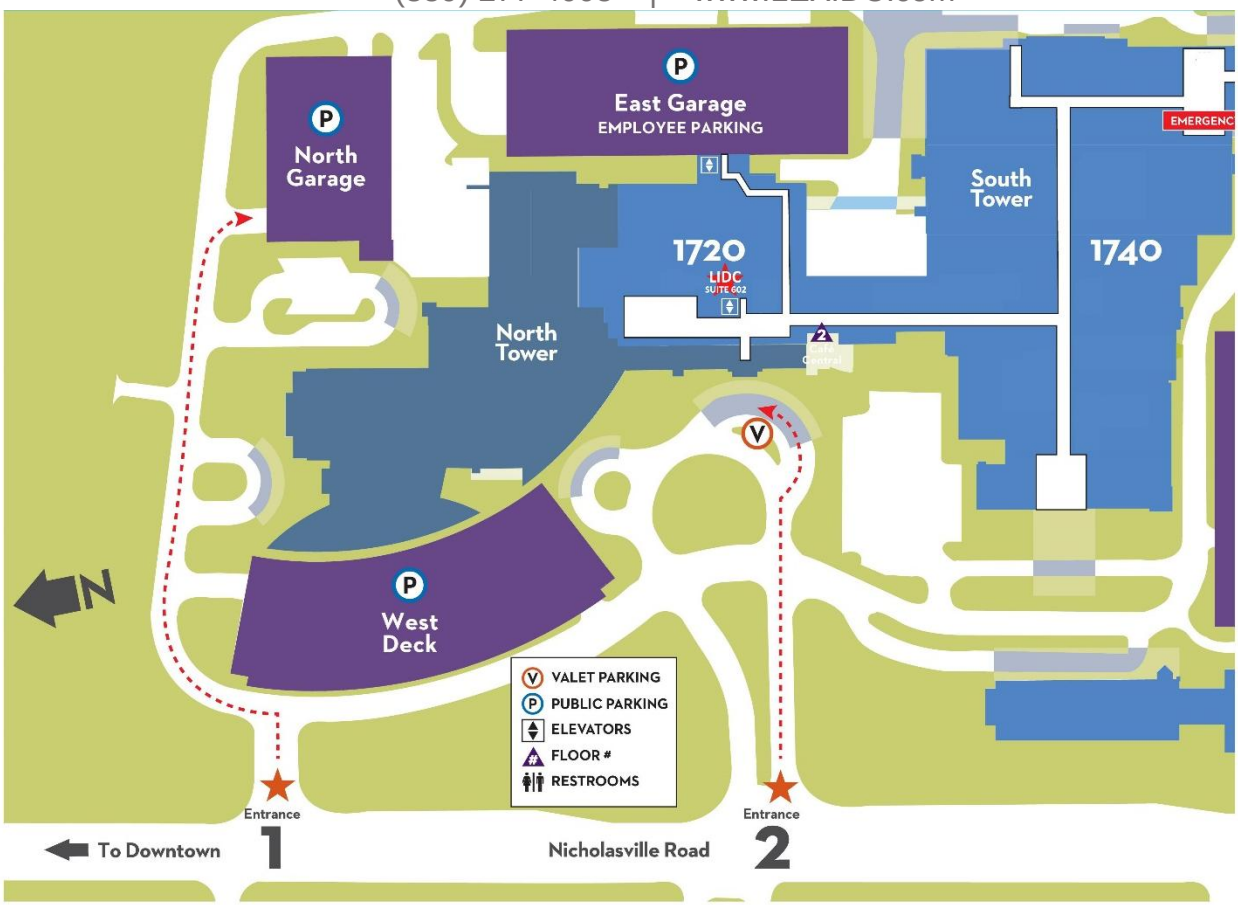
LEXINGTON INFECTIOUS DISEASE CONSULTANTS

1720 Nicholasville Road | Suite 602 | Lexington, KY 40503
(859) 277-4005 | www.LEXIDC.com



SELF PARKING

Use Entrance 1 (closest to Alumni Drive) and keep left toward the North Garage. After parking, enter the 1720 Building from the ground level, and take the elevator directly inside the double-doors to the first floor.

FREE VALET PARKING

Monday-Friday, 6:00 am to 6:00 pm

Use Entrance 2 Drive straight ahead toward the 1720 Building. Free Valet Parking is available under the awning *(keep right at the fork).*

GETTING TO BAPTIST HEALTH LEXINGTON

From Ashland

Take I-64 West to I-75 South to Man O' War - Exit 108. Right on Man O' War Blvd. to Alumni Drive. Right on Alumni Drive to Nicholasville Road. Left on Nicholasville Road. Baptist Health Lexington is ahead on the left.

From Louisville/Cincinnati

Take I-64 to Newtown Pike/Airport -Exit 115. Right onto New Circle Road - Circle 4. Left on Nicholasville Road - Exit 19. Continue on Nicholasville Road for approximately 2 miles. Baptist Health Lexington is ahead on the right.

From Knoxville

Take I-75 North to Man O' War- Exit 108. Left on Man O' War Blvd. to Alumni Drive. Right on Alumni Drive to Nicholasville Road. Left on Nicholasville Road. Baptist Health Lexington is ahead on the left.

From Danville/ Nicholasville (US-27)

Take US-27N/Nicholasville Road passing Fayette Mall and Southland Drive. Baptist Health Lexington is ahead on the right.

LEXINGTON INFECTIOUS DISEASE CONSULTANTS

For Office Use Only	
Date: _____	MD: _____
Chart: _____	INT: _____

NEW PATIENT REGISTRATION

Last Name: _____ First: _____ Middle: _____

Address: _____
Street APT# City State Zip

Phone: home_____ cell: _____ work: _____

Date of Birth: _____ Social Security Number:_____ Race:_____

Marital Status: Married Single Divorced Widow Employer: _____

Your Primary Care Physician: _____phone:_____

Physician requesting this Consultation: _____ phone: _____

Email Address: _____

Do you have a living will?	YES	NO
You have a durable power of attorney?	YES	NO
Do you have a healthcare surrogate?	YES	NO
Is this visit related to an injury?	YES	NO

Emergency Contact: _____ relationship: _____ phone: _____

HIPAA Authorization

In addition to my emergency contact, I authorize Lexington Infectious Disease Consultants to use and disclose the protected health information to the following person/s. I understand they must provide my birth date and the last four of my social when inquiring. **(It is not necessary to include other physicians on this list)**

Name	Relationship
_____	_____
_____	_____

This authorization for release of information covers the period of healthcare until ___/___/___

or

☐ No Expiration, unless revoked or terminated by the patient or patient's personal representative

Past Medical

History: _____

_____

_____

Past Surgical

History: _____

_____

_____

Family History

Please circle all that apply

Mother	Arthritis	Asthma	Heart Disease	Depression	Diabetes	Hypertension	Hyperlipidemia	Stroke
	Renal Disease	Thyroid Problems	Cancer (type) _____		Other _____			
Father	Arthritis	Asthma	Heart Disease	Depression	Diabetes	Hypertension	Hyperlipidemia	Stroke
	Renal Disease	Thyroid Problems	Cancer (type) _____		Other _____			
Sister	Arthritis	Asthma	Heart Disease	Depression	Diabetes	Hypertension	Hyperlipidemia	Stroke
	Renal Disease	Thyroid Problems	Cancer (type) _____		Other _____			
Brother	Arthritis	Asthma	Heart Disease	Depression	Diabetes	Hypertension	Hyperlipidemia	Stroke
	Renal Disease	Thyroid Problems	Cancer (type) _____		Other _____			
Maternal Grandmother	Arthritis	Asthma	Heart Disease	Depression	Diabetes	Hypertension	Hyperlipidemia	Stroke
	Renal Disease	Thyroid Problems	Cancer (type) _____		Other _____			
Maternal Grandfather	Arthritis	Asthma	Heart Disease	Depression	Diabetes	Hypertension	Hyperlipidemia	Stroke
	Renal Disease	Thyroid Problems	Cancer (type) _____		Other _____			
Paternal Grandmother	Arthritis	Asthma	Heart Disease	Depression	Diabetes	Hypertension	Hyperlipidemia	Stroke
	Renal Disease	Thyroid Problems	Cancer (type) _____		Other _____			
Paternal Grandfather	Arthritis	Asthma	Heart Disease	Depression	Diabetes	Hypertension	Hyperlipidemia	Stroke
	Renal Disease	Thyroid Problems	Cancer (type)		Other			

Social History:

Do you smoke? Y ___ N ___ How much?_____ How many years?_____

Do you drink Alcohol? Y ___ N ___

General	Eyes	Ears/Nose/Throat	Cardiovascular
__ *No symptoms*	__ *No Symptoms*	__ *No Symptoms*	__ *No Symptoms*
__ Fever	__ Blurred Vision	__ Earache	__ Chest Pains
__ Chills	__ Diplopia/Double Vision	__ Ear Discharge	__ Palpitations
__ Sweats	__ Irritation	__ Decreased Hearing	__ Syncope (fainting)
__ Night Sweats	__ Discharge	__ Watery Nasal Discharge	__ Shortness of Breath with Activity
__ Loss of Appetite	__ Vision Loss	__ Nosebleeds	__ Peripheral Edema
__ Fatigue	__ Eye Pain	__ Sinusitis	__ Artificial Valve
__ Weakness	__ Photophobia	__ Sinus Congestion	__ Vascular Graft
__ Malaise	__ Visual Changes	__ Sinus Drainage	__ Heart Murmur
__ Weight Loss	__ Visual Floaters	__ Sore Throat	__ Rheumatic Fever
__ Insomnia		__ Difficulty Swallowing	
__ Sleep Disorder		__ Hoarseness	
		__ Mouth Ulcers	
		__ Poor Teeth	

Respiratory	Gastrointestinal	Genitourinary	Muscles/Joints/Bones
__ *No Symptoms* __ Cough __ Cough with Deep Breath __ Shortness of Breath at rest __ Productive Sputum __ Blood In Sputum __ Respiratory Infections __ Recent Viral Infection	__ *No Symptoms* __ Vomiting __ Diarrhea __ Constipation __ Change in Bowel Habits __ Abdominal Pain __ Bright Red Blood in Stool __ Jaundice __ Gas/Bloating __ Rectal Pain/Burning __ Indigestion/Heartburn __ Difficulty Swallowing	__ *No Symptoms* __ Dysuria/Painful Urination __ Blood in Urine __ Discharge __ Urinary Frequency __ Urinary Hesitation __ Incontinence __ Flank Pain __ Testicular Pain __ Genital Sores __ Erectile Dysfunction __Prostate Problems __ History of Kidney Stones	__ *No Symptoms* __ Back Pain __ Joint Pain __ Joint Drainage __ Muscle Cramps __ Stiffness __ Sciatica __ Leg Pain at Night __ History of: __ Joint Trauma __ Joint Surgery __ Joint Injections __ Joint Surgery __ Gout

Skin	Neurologic	Mental Health	Endocrine
___ *No Symptoms* ___ Rash ___ Itching ___ Dryness ___ Suspicious Lesions ___ Cellulitis ___ Boils ___ Wound Drainage ___ Athlete's Foot ___ Psroiasis	___ *No Symptoms* ___ Stiff Neck ___ Paralysis ___ Decreased Sensation ___ Parasthesis ___ Numbness ___ Seizures ___ Loss of Consciousness ___ Tremors ___ Vertigo ___ Frequent Falls ___ Weakness ___ Transient Blindness ___ Frequent Headaches ___ Dizziness ___ Foot Tingling/Burning ___ Difficulty Walking ___ History of Head Trauma	___ *No Symptoms* ___ Depression ___ Anxiety ___ Memory Loss ___ Suicidal Ideation ___ Hallucinations ___ Paranoia ___ Phobia ___ Confusion ___ Nightmares ___ Troubling Dreams	___ *No Symptoms* ___ Diabetes ___ Thyroid ___ History of Steroid Use **Heme** ___ No Symptoms ___ Abnormal Bruising ___ Bleeding ___ Enlarged Lymph Nodes ___ History of Blood Clots

Travel/Exposure		
Exposure to: __ HIV __ EBV/Mono __ TB __ Sick Animals __ Sick People __ Small Children __ Caves __Bats __ Hunting/Wild Game __ Stagnant Water	Exposure to: __ Salt Water __ Marine Animals __ Animal Bites __ Tick Bites __ Cat Scratches __ Eating raw eggs __ Eating raw chicken __ Eating raw fish/shellfish	__ Blood Transfusion __ Needle Use/Puncture __ History of Antibiotic Use __ Recent Travel

PATIENT MEDICATION LIST

Patient Name: _____ DOB: _____

Pharmacy Name & Location: _____

Pharmacy Phone Number: _____

ALLERGIES: _____

Medication	*Dose*	*How Often?*	*Prescribing Doctor*

GENERAL CONSENT TO TREAT, PATIENT AUTHORIZATION, AND ACKNOWLEDGEMENT OF BENEFITS RELEASE

The following are the conditions for services provided by Lexington Infectious Disease Consultants for the patient whose name appears at the bottom of this page.

CONSENT FOR MEDICAL TREATMENT

I voluntarily consent to medical treatment and diagnostic procedures provided by Lexington Infectious Disease Consultants and its associated physicians, clinicians, and other personnel. I consent to the testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis, and drug testing if deemed advisable by my physician. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made as to the result of treatments or examinations.

AUTHORIZATION FOR RELEASE OF INFORMATION

The practice and physicians are authorized to release any medical information required in the processing of applications or submission of information for financial coverage, discharge planning and further medical treatment. This can include information referring to psychiatric care, sexual assault, or tests for infectious diseases including AIDS/HIV for services provided during this visit. I further understand Lexington Infectious Disease Consultants share an Electronic Health Record network. I also agree to the release of medical or other information about me to government (federal or state) regulatory agencies as required by law.

ASSIGNMENT OF INSURANCE BENEFITS

I guarantee payment of all charges made for or on account of the patient and I assign our rights in any insurance benefits or other funding to the physician and Lexington Infectious Disease Consultants. I understand that I am responsible for any charges not covered by insurance or other forms of benefits. I understand Lexington Infectious Disease Consultants can obtain my credit report for review in collection of this debt. In the event that this account is placed with a collection agency or attorney for collection, I shall pay all collection fees and costs, included reasonable attorney's fees. For Medicare beneficiaries: I have provided all necessary information for proper assignment of Medicare benefits.

WORKER'S COMPENSATION PATIENT RECORDS RELEASE AND AUTHORIZATION FORM

I understand that Kentucky's Worker's Compensation law provides that written information pertaining directly to a worker's compensation claim must be provided by a healthcare facility/physician to the insurance carrier, the employer, the employee, their attorneys, or the applicable State Workers' Compensation Commission.

I authorize Lexington Infectious Disease Consultants to provide copies of my medical records or to speak to duly authorize representatives of any of the above regarding my medical records, medical treatment, or condition.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the notice may be changed at any time.

Please Sign Here

I understand that I will be responsible for all bills due to incorrect information on this form.

_____Date:_____

Signature of Patient

POA Signature: _____*Date:*_____