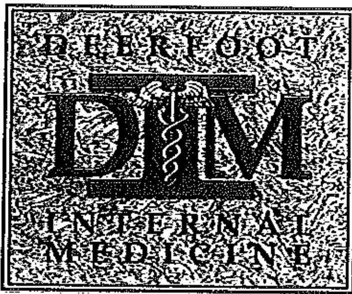


Vlad Prelipcean, M.D.
Octavian Popescu, M.D.
George Jolly, CRNP

Personal Information

Chart#: ____________________ DOB: ____________________ Today's Date: ____________________

SSN: __________________________ Gender: Male / Female DL#: ____________________

Race: ______________ Ethnicity: ____________________ Preferred Language: ____________________

Patient's Full Name: ____ Marital Status: ______________

Mailing Address: ____

City & Zip: ____

Patient Contact Numbers:

Home: ______________________________

Work: ______________________________

Cell: ______________________________

Emergency Contact:

Name: ______________________________

Relation: ______________________________

Phone: ______________________________

Email: ____

Preferred Pharmacy: ____

Phone: ____ Zip Code: ____________________

Preferred Pharmacy: ____

Phone: ____ Zip Code: ____________________

Insurance Carrier: ____

ID#______________________________ Group#______________________________

Secondary Insurance: ____

ID#______________________________ Group#______________________________

DEERFOOT
DIM
INTERNAL MEDICINE

Vlad Prelipcean, M.D.
Octavian Popescu, M.D.
George Jolly, CRNP

Medication Allergies

If you are allergic to any medications, please list them below; if none write NKA.

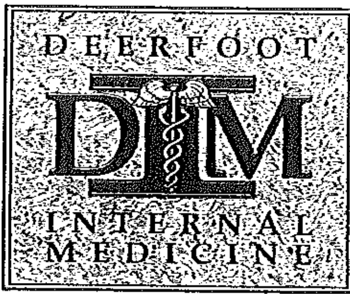
____

____

____

Current Medications

Medication Name	Dosage	When/How often taken



Vlad Prelipcean, M.D.

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Health History

	ADD/ADHD		Drug Addiction		Mental Illness (MMD or Bipolar)
	Anemia		Depression		Metabolic Syndrome
	Anxiety		Dyslipidemia		Menopause
	Anxious Depression		Erectile Dysfunctions		Nicotine Addiction
	Arthritis (Osteo or RA)		Eating Disorder		Obesity
	Alcoholism		Emphysema		Osteopenia
	Asthma		Eczema		Osteoporosis
	Atrial Fib		Chronic Fatigue or Narcolepsy		PCOS
	Alzheimer's or Dementia		Fibromyalgia		PPM (Permanent Pacemaker)
	BPH		Glaucoma		Parkinsonism
	Brain Tumor		GERD		Pneumonia
	Coronary Artery Disease		Gout		Prostate Problems
	Congestive Heart Failure		HTN (High Blood Pressure)		Peripheral Neuropathy
	Chronic Renal Failure		Hearing Loss		Psoriasis
	COPD		Heart Attack		Seizures
	CVA (Stroke)		Heart Murmur		Sickle Cell
	Chronic Kidney Disease		Irregular Heart Beat		Sleep Apnea
	Cirrhosis of Liver		Hemochromatosis		Thyroid Disease (Hypo or Hyper)
	Colon Polyps		Headaches (cluster, tension, migraines)		Ulcerative Colitis
	Chronic Constipation		Insomnia		Ulcers (Stomach)
	Crohn's		IBS		Vitamin B Deficiency
	Disc Degenerative Disease (T, C, L Spine)		Lupus		Vitamin D Deficiency
	Diabetes (Type I or Type II)		MVP (Mitral Value Prolapse)		STD (Chlamydia,Gonorrhea, Syphilis)
	Diabetic Neuropathy		Memory Loss	Other:	
	Diverticulosis		Measles		
	Cancer -Specify Type:				

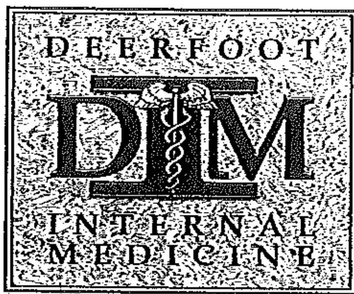
Pregnancy History: Living Children: ________Abortions: _________Pre-term: _________Term:__________ C-Section:_________
Infectious Diseases: ______ HIV + ______ Hep C+ ________ TB+

Health Maintenance

Bone Density	Year:	Doctor:	Result:
Cardio Stress Test	Year:	Doctor:	Result:
Colonoscopy	Year:	Doctor:	Result:
Mammogram	Year:	Doctor:	Result:
Pap Smear	Year:	Doctor:	Result:
PSA	Year:	Doctor:	Result:

Vaccines

Flu	Year:
TDAP	Year:
Pneumonia	Year:
Shingles	Year:



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Surgical History

	Ankle (L, R, or B)		Ear Tubes		Lumbar Spine Surgery
	Appendectomy		Foot Surgery (L, R, or B)		Lumpectomy
	Arm (L, R, or B)		Gastric Bypass		Mastectomy
	Arthroscopy		Heart Stents		Neck Surgery
	Back Surgery		Heart Surgery		Thoracic Spine Surgery
	Bladder Tack		Hemorrhoids		Thyroidectomy
	Breast Bx		Hernia Repair		Tonsillectomy
	Breast Implants		Hip Replacement (L, R, or B)		Tubal
	CABG		Hysterectomy (Partial or Total)		TURP
	Carpal Tunnel (L, R, or B)		ICD		Uterine Ablation
	Cataract Replacement (L, R, or B)		Knee Replacement (L, R, or B)		Vasectomy
	Cervical Spine Surgery		Laparoscopy		Varicose Veins
	C Section		Laparoscopic Cholecystectomy		Wrist (L, R, or B)
	Open Cholecystectomy		Laparotomy		Other:

Family History

Please list any medical conditions or complications beside each family member. If the family member is deceased, please list the age and cause. Please be detailed as possible.

-Father: ______________________________

-Mother: ______________________________

-Brother: ______________________________

-Sister: ______________________________

-Other Siblings: ______________________________

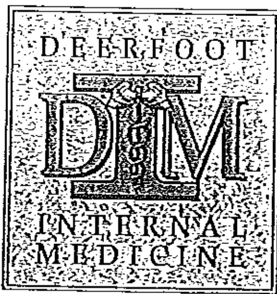
____

Social History

Do you have an Advance Directive? If yes, specify: DNR, Living Will, or Power of Attorney	Yes	No
Do you drink alcohol? If yes, how often: 3-7 a week, 8-14 a week, >14 a week, Socially, In the past If yes, specify: Beer, Liquor, or Wine	Yes	No
Do you intake caffeine?	Yes	No
Do you exercise regularly?	Yes	No
Are you sexual active?	Yes	No
Do you use recreational drugs? If yes, specify:	Yes	No
Highest Education Level: 6th grade, Jr. High, High School, College, Graduate School		
Occupation: Disabled, Employed (FT), Employed (PT), Retired, Student, Unemployed		
Do you use tobacco? Or Former user? If you are current or former smoker please answer the following: Amount: Type: Cigarettes, Cigar, Smokeless, or Other:	Yes	No
Are there smokers in the home?	Yes	No

Please circle any medical equipment you use at home:

CPAP, Glucose Strips, Glucometer, Hospital Bed, Nebulizers, Oxygen, Urological Supplies, Walker, and Wheelchair



VLAD PRELIPCEAN, M.D.
OCTAVIAN POPESCU, M.D.
GEORGE JOLLY, CRNP

New Privacy Act

Date:________________

Your Rights:

The following is a statement of your protected health information.

You have the right to inspect and copy protected health information:

Under federal law, however, you may not inspect or copy the following records; Psychotherapy notes, information compiled in a feasible anticipation of, or use in a civil, criminal, administrative action or preceding and protected health information that is subject to the law that prohibits access to protect health information.

You have the right to request a restriction of your health information:

This means that you may ask Deerfoot Internal Medicine not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, it will not be restricted. You then have the right to use another Health Professional.

You have the right to request and receive confidential communication from Deerfoot Internal Medicine by alternative means at an alternative location. You have the right to obtain a copy of this notice from us and if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information:

If we deny your request for amendment you have the right to file a statement of disagreement with Deerfoot Internal Medicine and we may prepare a rebuttal to your statement. We will provide you with a copy of any such rebuttal.

6725 Deerfoot Parkway, Pinson, AL. 35126
Phone (205)680-9898 * Fax (205) 680-3300

You have the right to receive an accounting of certain disclosures we may have made, if any, to your protected health information.

Deerfoot Internal Medicine reserves the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints:

You may complain to the Secretary of Health and Human Resources if you believe your PRIVACY rights were violated. You may also file a complaint by notifying our privacy contact of complaint. WE WILL NOT RETALIATE AGAINST YOU IF YOU FILE A COMPLAINT.

This notice was published and becomes effective 9/10/2015.

Deerfoot Internal ***Medicine*** *is required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone.*

Signature below is our only acknowledgement that you have received this NOTICE OF PRIVACY PRACTICES.

PRINT NAME:______________________________

SIGNATURE:______________________________

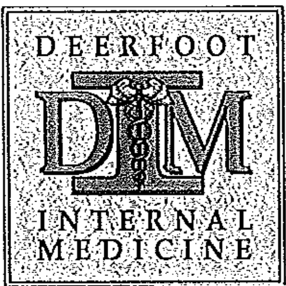
DATE:________________________

Please list the names of individuals, the relationship and phone number that we can contact or release information regarding your medical information.

Name:____________________**Relationship:**____________**Phone Number:**____________
Name:____________________**Relationship:**____________**Phone Number:**____________
Name:____________________**Relationship:**____________**Phone Number:**____________
Name:____________________**Relationship:**____________**Phone Number:**____________

Is it OK to leave a message or test results on your voicemail, answering machine or with a person listed above?

Circle one: YES or NO



Deerfoot Internal Medicine
6725 Deerfoot Parkway
Pinson, Alabama 35126

AUTHORIZATION FOR TEXT MESSAGING & EMAIL

CHART#____________________

I consent to receive appointment reminders and other healthcare information through text message and/or email from Deerfoot Internal Medicine. This is to remind you of appointments and to provide general information.

The CELL PHONE number I authorize to receive text messages:

(_____) __________-__________________________

Carrier:____

(Example: Verizon, AT&T, Sprint, T-Mobile)

The EMAIL I authorize:

____

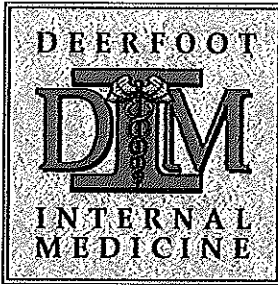
I understand Deerfoot internal Medicine is not responsible for any overages or text messaging charges. Your standard text messaging rates will apply.

This request to receive emails and/or text messages will apply to all future appointment reminders/health information unless I request a change in writing.

PRINT NAME:____

PATIENTS SIGNATURE:____

DATE:_____________________________



VLAD PRELIPCEAN, M.D.
OCTAVIAN POPESCU, M.D.
GEORGE JOLLY, CRNP

Patient Name: ________________________________ **Chart Number:**_____________

Effective January 1, 2020, you must provide our office with a current and correct copy of your insurance card. If you cannot, you will be responsible for any charges that may occur and may be asked to pay for your visit up front. Please assist us with the accuracy of your billing by cooperating with this request. All personal and insurance information changes should be provided when you sign in for your appointment.

There are some services the doctor requires which are necessary for the maintenance of good health that may **not** be covered by your insurance contract.

FOR EXAMPLE: Office Visits, Co-Pays, Deductibles, Forms, Laboratory Test, X-Rays, Immunizations, Eye Exam, Breathing Treatments, EKG, and other procedures as needed.

My signature below signifies that I agree to pay in full for any services **not** covered by my insurance.

Thanks for your help in this matter.

Sincerely,
Deerfoot Internal Medicine

Signature_____________________________Date:______________

6725 Deerfoot Parkway, Pinson, AL. 35126
Phone (205)680-9898 * Fax (205) 680-3300

VLAD PRELIPCEAN, M.D.
OCTAVIAN POPESCU, M.D.
GEORGE JOLLY, CRNP

Effective 11/9/2017

Our clinic can take you on as a new patient; but understand the doctors or nurse practitioner may not write all the medications you are currently on depending on their assessment after seeing you. Especially if you are on any kind of controlled medication such as: Pain medication, Anxiety medication, ADD/ADHD medications, or medication for Insomnia. Our doctors or nurse practitioner may not refill those medications at your appointment and you will be referred out to a pain management physician or psychologist/psychiatrist for refills on those medications.

Patient Signature:______________________________

Date:____________________

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