CIGNA ONSITE HEALTH PATIENT INFORMATION FORM

Check one of the following:

Attach copy of front and back of Insurance card

All Cigna Insurance ☐ Other Insurance (Any Non-Cigna) ☐ FFS/Self Pay ☐

PATIENT INFORMATION

LAST NAME	FIRST	M.I.	DATE OF BIRTH	SEX	
				M	F
STREET ADDRESS	CITY	STATE	ZIP CODE	PATIENT PHONE ( )	
RESPONSIBLE PARTY	RELATION TO RESPONSIBLE PARTY		PATIENT EMAIL ADDRESS		
RESPONSIBLE PARTY STREET ADDRESS	CITY	STATE	ZIP CODE	RESPONSIBLE PARTY PHONE ( )	
LANGUAGE	ETHNICITY		RACE		

INSURANCE COVERAGE/OWNER OF INSURANCE POLICY

LAST NAME	FIRST	M.I.	DATE OF BIRTH	RELATIONSHIP TO PATIENT	
STREET ADDRESS	CITY		STATE	ZIP CODE	
EMPLOYER	EMPLOYER ADDRESS (STREET, CITY, STATE, ZIP CODE)				
WORK PHONE ( )	HOME PHONE ( )		INSURANCE CARRIER		
INSURANCE CO. ADDRESS		INSURANCE CO. PHONE		POLICY / ID #	GROUP #

Is the patient covered under any other health coverage? Yes ☐ No ☐ If yes, complete Additional Healthcare Insurance section.

ADDITIONAL HEALTHCARE INSURANCE (Medicare Part B – FFS, Supplemental, All Other Insurance)

LAST NAME	FIRST	M.I.	DATE OF BIRTH	RELATIONSHIP TO PATIENT	
STREET ADDRESS	CITY		STATE	ZIP CODE	
EMPLOYER	EMPLOYER ADDRESS (STREET, CITY, STATE, ZIP CODE)				
WORK PHONE ( )	HOME PHONE ( )		INSURANCE CARRIER		
INSURANCE CO. ADDRESS		INSURANCE CO. PHONE		POLICY / ID #	GROUP #

IN CASE OF AN EMERGENCY CONTACT

LAST NAME	FIRST	M.I.	RELATIONSHIP	HOME PHONE ( )

Your signature below indicates:

1. (If you have insurance) You authorize Cigna Onsite Health (COH) to release medical or other information as requested by your insurance company to have your medical claims paid.

2. (If you have insurance) You authorize direct payment of medical benefits by your insurance company to COH for any services furnished to you and otherwise payable to you.

3. Your agreement to pay any and all final balance due to COH for services you receive which are your responsibility and/or are denied by your insurance company.

Patient/Parent or Legal Guardian Signature _____ Date _____

Cigna Onsite Health Adult Medical History

Name *(First, Last)* _____ *Please Check* ☐ **Male** ☐ **Female** ____/____/____ **Today's Date**

Date of Birth ____/____/____

Preferred Pharmacy Name _____

Preferred Pharmacy Address _____

Street Address *City* *State* *Zip code*

Pharmacy Phone ( ) -

Pharmacy Fax ( ) -

Primary Care Physician Name _____

Primary Care Address _____

Street Address *City* *State* *Zip code*

PCP Phone ( ) -

PCP Fax ( ) -

Primary Care Giver Name _____

Care Giver Relationship to You

☐ Father ☐ Mother ☐ Spouse ☐ Significant Other ☐ Adult Child ☐ Legal Guardian

☐ Case Worker ☐ Family Member ☐ Friend ☐ Care Coordinator ☐ Other: _____

Contact Phone Number ( ) -

Additional Phone Number ( ) -

Marital Status

☐ Married ☐ Domestic partnership ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Employment Status

☐ Full - Time Employed ☐ Part - Time Employed ☐ Student ☐ Homemaker ☐ Self-Employed ☐ Retired

Female Only

Date of Last Period _____

Do you have regular periods? ☐ Yes ☐ No

What age did you start your menstrual period? _____

Have you ever been pregnant? ☐ Yes ☐ No

Of Pregnancies? _____

Have you ever had an abnormal pap? ☐ Yes ☐ No

*If yes, date and description*_____

Food Allergies *Please check all that apply.*	**Reaction to Food Allergies, if any.** *Please list any reactions to the allergy.*	**Medication Allergies** *Please check all that apply.*	**Reaction to Medication Allergies, if any.** *Please list any reactions to the allergy.*
☐ No Food Allergies		☐ No Medication Allergies	
☐ Wheat		☐ Penicillin	
☐ Gluten		☐ Sulfa Drugs	
☐ Eggs		☐ Codeine Derivatives	
☐ Nuts		☐ NSAIDs	
☐ Soy		☐ Phenytoin	
☐ Fish		☐ Carbamazepine	
☐ Shellfish		☐ Other _____	
☐ Other_____		☐ Other _____	

Medications *(List all your current medications/supplies)*	**Dose and Directions**

Please check all that apply

Immunizations	**Date** *(MM/YYYY)*	**Screenings**	**Date** *(MM/YYYY)*
☐ Measles/Mumps/Rubella		☐ Mammogram	
☐ Influenza (Flu Shot)		☐ Cholesterol Screening	
☐ Pneumococcal		☐ Colonoscopy	
☐ Polio		☐ Bone Density	
☐ Hepatitis B		☐ Other_____	
☐ Tetanus Booster or TDAP		☐ Other_____	
☐ Other_____			

Do you ever had or been diagnosed with any of the following conditions? *(Please check all that apply.)*	**Date of Diagnosis** *(Please enter the date MM/YYYY)*	**Are you currently being treated for this condition?** *(Please check Y or N)*	
☐ Allergies _____		☐ Yes	☐ No
☐ Anemia		☐ Yes	☐ No
☐ Arthritis		☐ Yes	☐ No
☐ Cancer _____		☐ Yes	☐ No
☐ COPD		☐ Yes	☐ No
☐ Diabetes		☐ Yes	☐ No
☐ Hepatitis _____		☐ Yes	☐ No
☐ High Blood Pressure		☐ Yes	☐ No
☐ High Cholesterol		☐ Yes	☐ No
☐ Heart Disease		☐ Yes	☐ No
☐ Kidney Disease		☐ Yes	☐ No
☐ Liver Disease		☐ Yes	☐ No
☐ Lung Disease		☐ Yes	☐ No
☐ Mental Health Disorder		☐ Yes	☐ No
☐ Migraines		☐ Yes	☐ No
☐ Seizures		☐ Yes	☐ No
☐ Sleep Apnea		☐ Yes	☐ No
☐ Skin Disease _____		☐ Yes	☐ No
☐ Tuberculosis		☐ Yes	☐ No
☐ Ulcer		☐ Yes	☐ No
☐ Other_____		☐ Yes	☐ No

Cigna

Past Surgeries/Hospitalizations *(MM/YYYY)*		
☐ Appendectomy _____	☐ D & C _____	☐ Inguinal hernia repair _____
☐ Breast biopsy _____	☐ Debridement of wound, burn, or infection _____	☐ Low back pain surgery _____
☐ Carotid endarterectomy _____	☐ Free skin graft _____	☐ Mastectomy _____
☐ Cataract surgery _____	☐ Hemorrhoidectomy _____	☐ Partial colectomy _____
☐ C-section _____	☐ Hysterectomy _____	☐ Prostatectomy _____
☐ Cholecystectomy _____	☐ Hysteroscopy _____	☐ Partial mastectomy _____
☐ Coronary artery bypass _____		☐ Tonsillectomy _____
		☐ Other _____

Family History	☐ **Adopted, Family History Unknown**		☐ **Unknown Family History**
☐ **Mother** ☐ **Unknown**	☐ **Father** ☐ **Unknown**	☐ **Sister** ☐ **Unknown**	☐ **Brother** ☐ **Unknown**
If deceased note cause.	**If deceased note cause.**	**If deceased note cause.**	**If deceased note cause.**
Age of Death	**Age of Death**	**Age of Death**	**Age of Death**
☐ Anemia	☐ Anemia	☐ Anemia	☐ Anemia
☐ Alcoholism	☐ Alcoholism	☐ Alcoholism	☐ Alcoholism
☐ Asthma	☐ Asthma	☐ Asthma	☐ Asthma
☐ Cancer	☐ Cancer	☐ Cancer	☐ Cancer
☐ Diabetes	☐ Diabetes	☐ Diabetes	☐ Diabetes
☐ Heart Disease	☐ Heart Disease	☐ Heart Disease	☐ Heart Disease
☐ High Blood Pressure	☐ High Blood Pressure	☐ High Blood Pressure	☐ High Blood Pressure
☐ Kidney Disease	☐ Kidney Disease	☐ Kidney Disease	☐ Kidney Disease
☐ Liver Disease	☐ Liver Disease	☐ Liver Disease	☐ Liver Disease
☐ Depression	☐ Depression	☐ Depression	☐ Depression
☐ Migraines	☐ Migraines	☐ Migraines	☐ Migraines
☐ Obesity	☐ Obesity	☐ Obesity	☐ Obesity
☐ Seizure (Epilepsy)	☐ Seizure (Epilepsy)	☐ Seizure (Epilepsy)	☐ Seizure (Epilepsy)
☐ Stroke	☐ Stroke	☐ Stroke	☐ Stroke
☐ **Other** *(please list)*	☐ **Other** *(please list)*	☐ **Other** *(please list)*	☐ **Other** *(please list)*

Please check all that apply

Do you wear glasses? ☐ Yes ☐ No

Do you wear contacts? ☐ Yes ☐ No

Do you get at least 6-7 hours of sleep at night? ☐ Yes ☐ No

During the past month, have you often been bothered by little interest or pleasure in doing things? ☐ Yes ☐ No

During the past month, have you often been bothered by feeling down, depressed, or hopeless? ☐ Yes ☐ No

Exercise?
☐ Does not exercise
☐ Exercises daily
☐ Exercises occasionally
☐ Exercises rarely

Exercise Type?
☐ Aerobics/Classes
☐ Running/Walking/Jogging
☐ Weight Training
☐ Other_____

If you exercise, how many minutes per day? _____

Do you drink caffeine? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

How many alcoholic drinks do you have in a typical week? ☐ 1-4 ☐ 4-10

Is using alcohol a concern for you or others? ☐ Yes ☐ No

Tobacco use? ☐ Tobacco non-user ☐ Former tobacco user ☐ Tobacco user

What types of tobacco do you use?
☐ Cigarette
☐ Cigar
☐ Pipe
☐ Snuff/Chew
☐ Vape

How often do you use tobacco per day?
☐ 1-10
☐ 10-20
☐ 20-40
☐ 40+

Do you use regularly or have you used any of the following recreational drugs?

- ☐ None (I do not use recreational drugs)
- ☐ Marijuana (Cannabis, pot)
- ☐ Cocaine
- ☐ Heroin
- ☐ Crack
- ☐ Methamphetamines(Crank)
- ☐ Other_____

Authorization for the Release of Information

I. Information about Use or Disclosure

By signing this authorization, I authorize the use or disclosure of my protected health information ("PHI") as described below.

Patient Name:	Date of Birth: / /
Address:	Phone number (provide one): Home: Cell:

If covered under a medical plan, please provide the following information:

Member/Participant Identification Card ("ID Card") Number:	Policy, Group or Account Number on ID Card:
Subscriber Name:	Subscriber's Employer:
Subscriber's Relationship to Patient:	

I authorize Cigna Onsite Health, LLC ("COH"), Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company and their affiliates and agents (collectively referred to as "Cigna") to use and disclose my PHI for the purpose identified below.

I authorize COH, Cigna, my medical plan or its vendor(s), to receive my PHI for the purpose identified below.

Purpose of the use and disclosure:
COH, my medical plan and Cigna, an administrator of my medical plan will use and disclose PHI to provide health management or to administer an incentive program. This authorization will allow reporting of health data at the aggregate level only (de-identified data which does not include my name or other identifiable information) to my employer or health plan for the purpose of creating health program improvements, and identifiable data to my employer only for the purpose of incentive programs.

For purposes of this Authorization, PHI includes but is not limited to the following:
Pharmacy and prescription drug information, laboratory test results, disease and health management information, visit notes, results of analytical models, health advocacy program participation, eligibility benefits information, biometric data, vaccinations, genetic testing information, demographic and claims information, Point of Service information such as location information, provider name, etc., alcohol or drug abuses treatment program information, psychotherapy notes, communicable disease- related and HIV-related information.

II. Important Information About Your Rights

I understand that:

- This authorization is voluntary and I may refuse to sign it.
- I may revoke this authorization by sending a written request to Cigna Onsite Health, LLC, 25600 N. Norterra Drive, Phoenix, Arizona 85085-8200. A revocation form is available from the onsite health center staff. The revocation will not have any effect on actions that COH or Cigna took before it received the revocation notice.
- I am not required to sign this authorization as a condition to receiving treatment or payment for health care, enrolling in a health plan or eligibility for benefits.
- A copy of this authorization and notation concerning the persons or agencies to whom disclosures are made shall be included with original health records.
- This authorization expires twelve (12) months from the date of signature.

III. Signature of Patient or Patient's Representative

Signature of Patient **X**	Date: / /
Signature of Personal Representative or Parent/Guardian **X**	Date: / /
Printed Name of patient's personal representative:	
Relationship if the person signing is other than Patient whose information is to be used and disclosed:	

Please note: If the State in which services are provided permits minors to obtain care without parent/guardian's consent, please obtain the minor's signature to consent to authorize information disclosure of those services.

The information used or disclosed pursuant to the authorization may be re-disclosed by the recipient and, upon re-disclosure, no longer be protected by federal privacy laws.

We recommend that you keep a copy of your completed form for your records. Cigna and Cigna Onsite Health, LLC will retain a copy which will be made available upon your request.

Cigna Onsite Health General Consent for Medical Treatment

Patient Name: _____ Date of Birth: _____
Member ID: _____

I, the patient named above (or his or her representative), hereby voluntarily consent to care encompassing routine non-invasive medical care, tests, procedures, drugs and other services and supplies under the general and specific instruction of my clinician, assistant, designees or consultants, as may be necessary in the judgment of my clinician. I understand that I am authorizing "routine" services only and not complex diagnosis or therapeutic procedures. Except for an emergency or in extraordinary circumstances, I understand that additional consents will be obtained by the clinician if more invasive services are to be performed.

I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made as to the results of any examination or treatment in this clinic. I understand that my medical records may be maintained in an electronic health record (EHR) and authorize access to my records by persons involved in my care.

I understand and acknowledge that the COH clinic does not participate in the Medicare program or state Medicaid programs and that the diagnostic, care and treatment services provided by us will not be billed to Medicare or state Medicaid programs for reimbursement.

RIGHT TO REVOKE

My consent shall remain in effect until revoked in writing. I understand that I have the right to revoke this General Consent prior to treatment by providing written notice to the COH clinic where I am receiving treatment. It is understood that treatment will be denied if this General Consent for Treatment is not signed or revoked.

_____ _____
Signature of Patient or Legally Authorized Representative **Date**

Mobile Phone Number:_____ **Alternate Phone Number:**_____

_____ **Patient Unable to Sign due to:**_____
Relationship to Patient:

_____

_____ _____ _____
Witness **Date** **Time**

Acknowledgement of Privacy Practices and Non-Discrimination Services

Patient Name: _____ Date of Birth: _____
Member ID: _____

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been given a copy of the Cigna Onsite Health's (COH) Notice of Privacy Practices. I understand that COH reserves the right to change the terms of its Notice provisions and that I can obtain a copy upon request.

_____ Patient to initial if refusing acknowledgement

_____ _____
Signature of Patient or Legally Authorized Representative — Date

_____ _____
Relationship to Patient — Patient Unable to sign due to

_____ _____ _____
Witness — Date — Time

NOTICE OF NON-DISCRIMINATION AND LANGUAGE SERVICES ASSISTANCE

I acknowledge that I have received a copy of the Non-Discrimination and Language Assistance Services Notice pursuant to the Patient Portability and Affordable Care Act, Section 1557, 45 CFR Part 92.

_____ Patient to initial if refusing acknowledgement

_____ _____
Signature of Patient or Legally Authorized Representative — Date

_____ _____
Relationship to Patient — Patient Unable to sign due to

_____ _____ _____
Witness — Date — Time