Patient Medical History Form

Date	Child's Name	Nickname	DOB	M F

Previous Physician/Office	Request for Records Transfer Complete Y N	Date of Last Physical

Mother's Name	Occupation	Age	Father's Name	Occupation	Age

Birth History

Birth weight _____ Preg # _____ Mom's age _____
Was the baby born on time? _____ Early? _____ Late? _____
If early, how many weeks gestation? _____
Did mother have any illness or problems with her pregnancy? ☐ Y ☐ N
Explain _____

During pregnancy, did mother:
Smoke ☐ Y ☐ N Drink alcohol ☐ Y ☐ N
Use drugs or medications ☐ Y ☐ N
What _____ When _____

Was the delivery ☐ Vaginal? ☐ Cesarean?
If Cesarean, why? _____
Did your baby have any problems right after birth? ☐ Y ☐ N
Explain _____

Was initial feeding ☐ Breast Milk? ☐ Formula?
Did your baby go home with mother from the hospital? ☐ Y ☐ N
Explain _____

Current and Past History

Is your child currently on any medication? ☐ Y ☐ N Explain _____
Does your child have any serious or chronic illnesses? ☐ Y ☐ N Explain _____
Has your child had serious injuries or accidents? ☐ Y ☐ N Explain _____
Has your child had any surgery? ☐ Y ☐ N Explain _____
Has your child ever been hospitalized? ☐ Y ☐ N Explain _____
Is your child allergic to any medicine or drugs? ☐ Y ☐ N Explain _____
Has your child had any reactions to immunizations? ☐ Y ☐ N Explain _____

Does Your Child Have, or Ever Had:

Asthma, recurrent cough, bronchitis, or pneumonia ☐ Y ☐ N Explain _____
Nasal allergies or eczema ☐ Y ☐ N Explain _____
Frequent ear infections or sore throats ☐ Y ☐ N Explain _____
Problems with ears or hearing ☐ Y ☐ N Explain _____
Problems with eyes, vision, or teeth ☐ Y ☐ N Explain _____
Frequent headaches or other neurologic problems ☐ Y ☐ N Explain _____
Frequent abdominal pain ☐ Y ☐ N Explain _____
Constipation requiring doctor visits ☐ Y ☐ N Explain _____
Bladder/kidney infection or bed-wetting (after 5 years old) ☐ Y ☐ N Explain _____
Any heart problem or heart murmur ☐ Y ☐ N Explain _____
Anemia or bleeding problem ☐ Y ☐ N Explain _____
Thyroid or other endocrine problem ☐ Y ☐ N Explain _____
Diabetes ☐ Y ☐ N Explain _____
ADHD ☐ Y ☐ N Explain _____
Mental health issues (anxiety, depression) ☐ Y ☐ N Explain _____
Use of alcohol or drugs ☐ Y ☐ N Explain _____

Any other medical or mental health issues/problems _____

Does your child see any specialists? ☐ Y ☐ N If yes, Who? _____
For what reason or diagnosis? _____

Has your child ever received Occupational Therapy, Physical Therapy, Speech Therapy? ☐ Y ☐ N Explain _____

Is your child in special or resource classes in school? ☐ Y ☐ N Explain _____

Do you have any other issues or concerns not listed above? _____

Household Information

Please List All Those Living in the Child's Home

Name	Relationship to Child	DOB

Child Care: _____

Smokers in household? ☐ Y ☐ N Pets in household? ☐ Y ☐ N

Are there siblings not listed? If so, please list their names and ages and where they live. _____

If mother and father are not living together or if child does not live with parents, what is the child's custody status? _____

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home? _____

Family Medical History (Parents, Siblings, Grandparents, Aunts & Uncles)

Have Any Family Members Had The following:

Alcohol/Drug Abuse	☐ Y ☐ N	Who_____	Comments_____
Allergies	☐ Y ☐ N	Who_____	Comments_____
Anesthesia Risk	☐ Y ☐ N	Who_____	Comments_____
Arthritis	☐ Y ☐ N	Who_____	Comments_____
Blood Disease	☐ Y ☐ N	Who_____	Comments_____
Cancer	☐ Y ☐ N	Who_____	Comments_____
Diabetes	☐ Y ☐ N	Who_____	Comments_____
Genetic	☐ Y ☐ N	Who_____	Comments_____
Gastroenteritis	☐ Y ☐ N	Who_____	Comments_____
Genitourinary	☐ Y ☐ N	Who_____	Comments_____
Heart	☐ Y ☐ N	Who_____	Comments_____
Hypertension	☐ Y ☐ N	Who_____	Comments_____
Lipids	☐ Y ☐ N	Who_____	Comments_____
Neurologic Diagnosis	☐ Y ☐ N	Who_____	Comments_____
Psychiatry	☐ Y ☐ N	Who_____	Comments_____
Ophthalmology	☐ Y ☐ N	Who_____	Comments_____
Respiratory	☐ Y ☐ N	Who_____	Comments_____
Skin	☐ Y ☐ N	Who_____	Comments_____
Stroke	☐ Y ☐ N	Who_____	Comments_____
Thyroid	☐ Y ☐ N	Who_____	Comments_____
Negative Family History	☐ Y ☐ N	Who_____	Comments_____

Additional Family History/Comments _____

Initial Review (initials/date):

Capital Medical Clinic

4701 Normal Blvd
Lincoln, NE 68506

Name_____Date of Birth_____SSN_____

Address_____City_____State_____Zip Code_____

Single Married Widowed Race_____Ethnicity_____

Male Female Other Orientation_____

Ok to send Automatic Text Reminders for Appointments? YES NO

Home# _____ Cell# _____ Work#_____

Employer_____City_____State_____Zip Code_____

Emergency Contact_____Relationship_____Phone_____

Additional Contact _____Phone_____

Person Financially Responsible Guarantor_____

Acesss to Patient Portal : YES NO **Email**:_____

Patient portal provides access to your lab results, personal health record, view upcoming appointments, Send and receive messages to and from your provider. Sign in with your email or go to our website.

You will be automactically opted in unless you choose to opt-out.

Allow us to access your Pharmacy History :
You consent to authorize your provider to view records of medications you've filled at pharmacies.
(This will help prevent drug-to-drug interactions for medications prescribed by other medical providers).
Opt- out ☐

Please list pharmacies you use:

_____

I HEARBY REQUEST AND AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO CAPITAL MEDICAL CLINIC, LLP, FOR SERVICES PROVIDED. I FURTHER AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION TO ANY CARRIER LISTED ON THE CLAIM FOR PURPOSES THIS, ANY RELATED MEDICARE, OR ANY INSURANCE CLAIMS. I ACCEPT RESPONSIBILTY FOR ALL SERVICES NOT PAID FOR BY MEDICARE OR MY INSURANCE COMPANY, SERVICES SHOWN ON YOUR BILLING STATEMENT , SERVICES SHOWN ON YOUR BILLING MAY BE DENIED BY MEDICARE PART B "NON-PROFESSIONAL ADMINISTRATIVE PERSONNEL" AS MEDICALLY UNNESCESSARY EVEN THOUGH, BASESD ON CURRENTLY ACCEPTED STANDERDS OF CARE, THE DOCTORS FEEL THAT IT IS MEDICALLY NECESSARY. IN THE EVENT MEDICARE SHOULD DENY PAYMENT,YOU WILL BE PERSONALLY AND FULLY RESPONIBLE FOR PAYMENT TO THE PHYSICIAN. ALSO, I ACKNOWLEDGE THAT SOME OR ALL PATIENT INFORMATON MAY BE TRANSMITTED ELECTRONICALLY TO ALL APPROPRIATE PARTIES.

SIGNATURE_____**Date** _____

CAPITAL MEDICAL CLINIC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO HIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Commitment to Your Privacy Capital Medical Clinic ("we," "us," or "our practice") is dedicated to protecting the privacy of your health information. We are required by law to maintain the privacy of your protected health information ("PHI"), to provide you with this Notice describing our legal duties and privacy practices with respect to PHI, and to notify you following a breach of unsecured PHI. We are required to abide by the terms of the Notice currently in effect.

This Notice applies to all records of your care generated by Capital Medical Clinic, whether made by our physicians, physician assistants, or other office staff, and applies to services provided by Lisa Peterson, MD; Gary Van Ert, MD; Dorothea Jacobsen, MD; Uma Nooka, MD; Kurt Schmeckpeper, PA-C; and Tracy Dziacky, PA-C, along with all other members of our workforce.

How We May Use and Disclose Your Health Information

For Treatment We may use and disclose your health information to provide, coordinate, or manage your care and any related services. For example, a physician treating you may share information with a physician assistant, nurse, or other staff member involved in your care, or with another provider to whom we refer you.

For Payment We may use and disclose your health information to obtain payment for services we provide to you. For example, we may share information with your health insurance plan to determine eligibility for benefits or to bill and collect payment for treatment we provided.

For Health Care Operations We may use and disclose your health information for our operations, which are necessary to run our practice and ensure our patients receive quality care. Examples include quality assessment and improvement activities, staff and student training, licensing, credentialing, and business planning.

Other Permitted or Required Uses and Disclosures We may also use or disclose your health information, without your written authorization, for the following purposes:

- Appointment reminders and information about treatment alternatives or health-related benefits and services.
- As required by federal, state, or local law, including reporting as required by workers' compensation laws.
- For public health activities, such as reporting disease, injury, vital events, or adverse reactions to medications.
- To a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.
- In response to a court or administrative order, subpoena, discovery request, or other lawful legal process.
- For law enforcement purposes, such as identifying or locating a suspect, fugitive, witness, or missing person, as permitted by law.
- To coroners, medical examiners, or funeral directors as necessary for them to carry out their duties.
- For research purposes, subject to review and approval by an institutional review board or privacy board and applicable safeguards.
- To avert a serious and imminent threat to your health or safety or the health or safety of others.
- For specialized government functions, including military and veterans' activities, national security, and protective services.

Any use or disclosure not described in this Notice will be made only with your written authorization. You may revoke an authorization at any time, in writing, except to the extent we have already relied on it.

Substance Use Disorder Treatment Records (42 CFR Part 2)

Federal law provides special confidentiality protections for records relating to the treatment of substance use disorders that are subject to 42 CFR Part 2. If our practice receives or maintains records of this kind — for example, through a referral, a care coordination arrangement, or information shared by another provider — those records receive heightened protection.

To the extent we hold substance use disorder patient records that are subject to 42 CFR Part 2, we will not use or disclose information from those records in civil, criminal, administrative, or legislative investigations or proceedings brought against you unless you have consented in writing or a court has issued an order accompanied by a subpoena or other legally binding process compelling the disclosure.

Please also be aware that once your health information has been disclosed in a manner permitted by this Notice, it may be redisclosed by the party who received it, including information originating from substance use disorder treatment records, and at that point it may no longer be protected by the HIPAA Privacy Rule.

Uses and Disclosures Requiring Your Written Authorization

Certain uses and disclosures of your health information will be made only with your written authorization, including:

- Most uses and disclosures of psychotherapy notes where applicable.
- Uses and disclosures of your health information for marketing purposes.

- Disclosures that constitute a sale of your health information.

If you provide us with authorization to use or disclose your health information, you may revoke that authorization in writing at any time, except to the extent we have already taken action in reliance on it.

Your Rights Regarding Your Health Information

Right to Inspect and Copy You have the right to inspect and obtain a copy of your health information that we maintain, with limited exceptions. Requests should be made in writing to our office. We may charge a reasonable, cost-based fee for copies.

Right to Request Amendment You have the right to request that we amend your health information if you believe it is incorrect or incomplete. We may deny your request in certain circumstances, and we will provide you with a written explanation if we do.

Right to an Accounting of Disclosures You have the right to request a list of certain disclosures we have made of your health information, excluding disclosures made for treatment, payment, health care operations, and certain other purposes.

Right to Request Restrictions You have the right to request a restriction on certain uses and disclosures of your health information. We are not required to agree to every request, but we must comply with a request to restrict disclosure to a health plan for payment or operations purposes if the information pertains solely to a service you paid for in full, out of pocket.

Right to Request Confidential Communications You have the right to request that we communicate with you about your health information by an alternative means or at an alternative location, and we will accommodate reasonable requests.

Right to a Paper Copy of This Notice You have the right to obtain a paper copy of this Notice at any time, even if you agreed to receive it electronically.

Right to Be Notified of a Breach You have the right to be notified in the event that we, or a business associate, discover a breach of your unsecured health information.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this Notice and give you a copy of it.
- We will not use or share your information other than as described here unless you provide written authorization, which you may revoke at any time.

Changes to This Notice

We reserve the right to change this Notice and to make the revised or changed Notice effective for health information we already have as well as any information we receive in the future. A current copy of this Notice will be posted in our office and on our website, and will be available upon request.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our Privacy Official or with the Secretary of the U.S. Department of Health and Human Services. You will not be penalized or retaliated against for filing a complaint.

Our Privacy Official (Office Administrator) may be reached at: Capital Medical Clinic, 4701 Normal Blvd., Lincoln, Nebraska 68506, (402) 488-5050.

U.S. Department of Health and Human Services: Office for Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. 20201, (877) 696-6775, www.hhs.gov/ocr/privacy/hipaa/complaints/.

Contact Information

Practice	Capital Medical Clinic, LLP – Family Practice
Privacy Official	Office Administrator
Address	4701 Normal Blvd., Lincoln, Nebraska 68506
Phone	(402) 488-5050
Website	www.capitalmedicalclinicllp.com
Office Hours	Monday – Friday, 8:00 a.m. – 5:00 p.m.
Effective Date	August 1, 2026

Document No.	Effective Date	Revision	Supersedes
CMC-HIPAA-201	August 1, 2026	1.0	N/A (New Document)

CAPITAL MEDICAL CLINIC

Family Practice

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Federal law requires Capital Medical Clinic to make a good faith effort to obtain your written acknowledgment that you have received a copy of our Notice of Privacy Practices, which describes how your health information may be used and disclosed and explains your rights regarding that information.

By signing below, I acknowledge that:

- I have received a copy of Capital Medical Clinic's Notice of Privacy Practices.
- I have had the opportunity to review it and ask questions.
- I understand that a current copy of the Notice is available at the front desk and on the practice website at any time.

Patient Name (Printed)

Patient / Legal Representative Signature

Date

Relationship to Patient (if signed by a legal representative)

FOR OFFICE USE ONLY — GOOD FAITH EFFORT DOCUMENTATION

Complete this section only if the patient did not sign above.

Reason acknowledgment was not obtained (circle one):

- Patient refused to sign
- Patient was unable to sign due to emergency circumstances
- Other (describe below)

Staff Member Name (Printed)

Staff Member Signature

Date

Document No.	Effective Date	Revision	Related Document
CMC-HIPAA-201A	August 1, 2026	1.0	CMC-HIPAA-201

Capital Medical Clinic
4701 Normal Blvd Lincoln, NE 68506
Phone 402 -488-5050 Fax 402 488-5001

Authorization to Release Private Health Information (PHI)

I hereby authorize Capital Medical Clinic to release my PHI (private health information) to the following people. This authorization will remain in effect until I complete a new Authorization to Release PHI form.

Name: _____ phone number_____ relationship_____

Name: _____ phone number_____ relationship_____

Name: _____ phone number_____ relationship_____

Name: _____ phone number_____ relationship_____

Privacy Protection:

OK to call you at work?	Y	N	N/A
OK to speak to your spouse about medical and billing information?	Y	N	N/A
Ok to leave medical and billing information on your voicemail?	Y	N	N/A

_____

Patient signature, signature of parent/guardian of minor patient or POA Date:

_____

Please print your name and date of birth (please use your legal name or name on your insurance card)

AUTHORIZATION FOR USE and/or DISCLOSURE
of
PROTECTED HEALTH INFORMATION

PATIENT INFORMATION:

Name of Patient: _____ Date of Birth: _____ SS#: _____

Street Address: _____ City: _____ State: ___ Zip: _____

Phone Number: Home: _____ Cell: _____ Work: _____

I authorize the release of my Protected Health Information between the following entities:

***Circle Selection*: TO or FROM**

Capital Medical Clinic, LLP
4701 Normal Blvd.
Lincoln, NE 68506
Phone (402) 488-5050 Fax (402) 488-5001

***Circle Selection*: TO or FROM**

_____
Name of Doctor/Facility

_____
Street Address

_____
City, State, Zip Code

_____
Phone Number Fax Number

INFORMATION TO BE DISCLOSED: *Identify below the specific information you are authorizing to be disclosed:*
☐ Complete Medical Record
☐ Other: _____

FOR THE FOLLOWING DATES: From: _____ To: _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE AND/OR FEDERAL LAW
I hereby specifically authorize the release of data and information relating to: (please check all that apply)

☐ HIV/AIDS related testing and results ☐ Mental/Behavioral Health Conditions ☐ Chemical Dependency (Drug/Alcohol Abuse)

Signature: _____ Date: _____

PURPOSE FOR DISCLOSURE: *Please provide specific purpose for disclosure or check applicable category.*

☐ Continuing Care ☐ Transfer to New Provider ☐ Insurance/Claim Purposes ☐ Legal ☐ Personal Use ☐ Disability Determination

☐ Workers Compensation ☐ Other: _____

You have the right to revoke this authorization at any time in accordance with our Notice of Privacy Practices. Revocation must be made in writing and presented to Capital Medical Clinic, LLP. Revocation will not apply to information that has already been disclosed in response to this authorization. Unless otherwise revoked, this authorization will expire one year from the date signed.

_____ _____
SIGNATURE OF PATIENT/LEGAL REP **DATE**

_____ _____
If signed by Personal Representative, Print Name Relationship to Patient

_____ _____ _____
Power of Attorney – Print Name **Signature** **Date**
(Please provide *Capital Medical Clinic, LLP* with a copy of the POA)

Consent Form for Preauthorization to Treat Minors

For families who are ongoing patients of Capital Medical Clinic: it may be more convenient to have prior authorization for medical care delivered directly to minors without a parent having to be present prior to treatment. Please review the following authorization for treatment and complete the information if you want to authorize such treatment in advance.

AUTHORIZATION:

I (we) request and authorize Capital Medical Clinic and its personnel to deliver medical care to my (our) child (ren) listed below:

PLEASE PRINT

Name: _____
DOB: _____
Name: _____
DOB: _____
Name: _____
DOB: _____

Please try to contact me (us) regarding health care of my (our) child (ren) at the following:

Parent's name: _____
Phone (office/home): _____
Parent's name: _____
Phone (office/home): _____
Other (relationship): _____
Phone (office/home): _____

Signature: _____ Date: _____
PRINT name and relationship: _____

NOTE: If there are any special parental or custodial relationships (such as custody with one parent only, legal custody/guardianship with not- parent, etc.), please explain below with your signature, printed name and phone number at which you can be contacted.

Capital Medical Clinic

4701 Normal Blvd Lincoln, Nebraska 68506 Ph: 402 488-5050 Fax: 420 488-5001

The patient portal is intended to improve patient engagement by enhancing communication between patients and their healthcare provider, along with streamlining access to medical records. The patient portal directly connects patients to their own electronic health records, enabling immediate access to personal medical records and facilitating to a communication between providers and patients.

Why should I use the patient portal?
The patient portal provided to secure means to manage your health and wellness. The portal simplifies your life by enabling you to:

- Review your medications
- Obtain lab results
- Access your Personal Health Record
- View your past or upcoming appointments.
- Receive interactive health alert and messages from your doctor
- Send messages to your provider
- Access multiple patient portal accounts from a single location, i.e. minor children, spouse (with consent), etc.

By opting in, you agree to receive your lab results and additional health communications through the patient portal. Please monitor the portal in the days following your appointment. If you don't receive communication within 5 days of your appointment, please contact our office. In addition, you may receive a questionnaire to fill out prior to upcoming appointments.

Portal set up:
An email will be sent to your inbox with a link to the portal. Sign in with your email (username) and password. Once you have sign and using temporary password, you will be able to create your own password.

Select one of the following options below by putting initials in front of your choice and completing the information

☐ I agree to **OPT IN** for easy secure access to my health record through the CMC patient portal.

☐ I prefer to **OPT OUT** of the Capital Medical Clinic patient portal.

Email address: _____

Name: _____ DOB _____

Signature: _____

Date: _____

Capital Medical Clinic, LLP
4701 Normal Blvd, Lincoln, NE 68506
Phone: 402 488-5050 Fax: 402 488-5001

CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribe Program

ePrescribing is a way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

• **Formulary and benefit transactions** - Gives the health care provider information about which drugs are covered by your drug benefit plan.

• **Fill status notification -** Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.

• **Medication history transactions -** Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplication of therapy.

The medication history information would include medications prescribed by your health care provider at Capital Medical Clinic as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS. ***As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.***

Consent

By signing this consent form you are agreeing that your provider at Capital Medical Clinic may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to Capital Medical Clinic to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Please list all pharmacies you use:_____

_____

_____

_____Print Patient Name _____ Patient DOB

_____Signature of Patient or Guardian _____Today's Date

_____Relationship to Patient