PREVENTATIVE SERVICE HISTORY

SCREENING TEST	DATE	RESULTS: NORMAL/ABNORMAL
Bone Density Any fractures: __Yes __No		
Cholesterol/LDL		
EKG		
Diabetes: Hemoglobin A1C		
Diabetes: Foot exam		
Diabetes: Eye exam		
Colonoscopy		
Endoscopy		
Fecal Occult Blood Test		
Glaucoma screening		
Cataracts screening		
PAP/Pelvic Exam		
Mammogram screening		
Digital Rectal Exam (DRE)		
Prostate Specific Antigen (PSA)		

IMMUNIZATION NAME	DATE
PNEUMONIA VACCINE	
INFLUENZA VACCINE	
COVID19 VACCINE	
TETANUS VACCINE	

PATIENT CONSENT FOR TREATMENT

1. I voluntarily consent to all health care treatment and diagnostic procedures provided by **Goodwin Medical Center** and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other health care processes is not an exact science and I further state that I understand that no guarantee has been or can be made of the results of the treatment and examinations of **Goodwin Medical Center**.
2. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for the services rendered to me/the patients, treatment and health care operations and consistent with the **Goodwin Medical Center** of privacy practices.
3. I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.
4. I have received a copy of the HIPAA Policy, Financial Policy Notice and the Release of information. __Yes __No ____Initial

_____ _____ _____

Patient printed name | Patient signature | Date