

WELCOME

Thank you for trusting us with your health care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

A PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____ First Name _____ Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex M F Age _____ Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

B INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Birthdate _____ SS# _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with _____

_____ Name of Insurance Company(ies)

and assign directly to Dr. _____

all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to _____

_____ Name of Doctor or Clinic

for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____ Signature of Beneficiary, Guardian or Personal Representative

_____ Please print name of Beneficiary, Guardian or Personal Representative

_____ Date _____ Relationship to Beneficiary

C PHONE NUMBERS

Home (____) _____

Cell Phone (____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT:

Name _____

Home Phone (____) _____

Cell Phone (____) _____

Work Phone (____) _____ Ext _____

D FAMILY HISTORY

Date of last physical examination _____

What is your reason for visit? _____

| | | | | | | |
|-------------------|--|----------------------------------|--|----------------------------------|--|----------------------------------|
| ALIVE DECEASED | FATHER <input type="checkbox"/> <input type="checkbox"/> | Present health or cause of death | MOTHER <input type="checkbox"/> <input type="checkbox"/> | Present health or cause of death | SPOUSE <input type="checkbox"/> <input type="checkbox"/> | Present health or cause of death |
| BROTHERS | NO. ALIVE | HEALTH | | NO. DECEASED | | CAUSE OF DEATH |
| SISTERS | NO. ALIVE | HEALTH | | NO. DECEASED | | CAUSE OF DEATH |
| CHILDREN | NO. ALIVE | AGES & HEALTH | | NO. DECEASED | | AGES & CAUSE OF DEATH |

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES

Diabetes Cancer Bleeding tendency Kidney disease Tuberculosis
 Heart disease Stroke High blood pressure Nervous illness Allergy Other _____

E

MEDICAL HISTORY

All information is strictly confidential.

Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- Chills
- Depression/Nervousness
- Dizziness/Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Numbness
- Sweats

GASTROINTESTINAL

- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

EYE, EAR, NOSE, THROAT

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache/Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision – Flashes/Halos

MEN only

- Erection difficulties
- Lump in testicles
- Penis discharge
- Sore on penis
- Other _____

WOMEN only

- Abnormal Pap Smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge
- Other _____

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- Arms Hips
- Back Legs
- Feet Neck
- Hands Shoulders

CARDIOVASCULAR

- Chest pain
- High/Low blood pressure
- Irregular/Rapid heart beat
- Poor circulation
- Swelling of ankles
- Varicose veins

SKIN

- Bruise easily
- Hives
- Itching/Rash
- Change in moles
- Scars
- Sore that won't heal

GENITO-URINARY

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

Check (✓) conditions you have or have had in the past.

- AIDS
- Appendicitis
- Arthritis
- Asthma
- Bleeding Disorders
- Breast Lump
- Cancer
- Cataracts
- Chemical Dependency
- Chicken Pox
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Heart Disease
- Hepatitis
- Herpes
- High Cholesterol

- HIV Positive
- Kidney Disease
- Liver Disease
- Measles
- Migraine Headaches
- Multiple Sclerosis
- Mumps
- Pacemaker
- Pneumonia

- Polio
- Prostate Problem
- Rheumatic Fever
- Scarlet Fever
- Stroke
- Thyroid Problems
- Tuberculosis
- Ulcers
- Venereal Disease

Describe serious illnesses or operations _____

MEDICATIONS/ALLERGIES

List medications you are currently taking _____

Pharmacy Name _____

Phone (____) _____

List allergies to medications or substances _____

HEALTH HABITS

Check (✓) which you use and how much:

- Caffeine _____
- Street Drugs _____
- Tobacco _____
- Other _____

Check (✓) if your work exposes you to:

- Stress
- Heavy Lifting
- Hazardous Substances
- Other _____

Your occupation _____

F

SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Reviewed By

Date