PATIENT INFORMATION

Today's Date: ______________________________ Date of Birth: ______________

Patient's Name: ______________________________ Maiden Name: ______________

Address: ______________________ City: ______________ State: ________ Zip: ________

Home Phone: (   )______________________ Social Security #: ______________

Marital Status: S M W D (circle one) Spouse's Name: ______________ Date of Birth: ________

Patient's Employer:______________________ Occupation: ______________

Address: ______________________ City: ______________ State: ________ Zip: ________

Work Phone Number: ______________________

IN CASE OF EMERGENCY PLEASE GIVE NAME AND PHONE NUMBER OF PERSON YOU WOULD LIKE NOTIFIED.

Name: ______________________________ Phone: ______________

MEDICAL INSURANCE INFORMATION

Primary Insurance Company Name: ______________________________

Subscriber's Name:______________________ Relationship to patient: ______________

I.D.#: ______________________ Group Number: ______________

Subscriber's Employer: ______________________________

Secondary Insurance Company Name: ______________________________

Subscriber's Name:______________________ Relationship to patient: ______________

I.D.#: ______________________ Group Number: ______________

Subscriber's Employer: ______________________________

INSURANCE AUTHORIZATION AND ASSIGNMENT (PLEASE READ AND SIGN)

I request that payment of authorized insurance/Medicare benefits be made on my behalf to the provider of service(s) for any services furnished me. I authorize any holder of medical information about me to release to Health Care Financing Administration and its' agents any information needed to determine these benefits of the benefits payable to related services. I hereby authorize payments be made directly to the provider of the service(s) for the medical benefits. I hereby authorize the provider of service(s) to release any medical information necessary to process my claim. I hereby authorize that photocopies of this form be valid as the original. (*I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.)

Date: ______________ Patient's Signature: ______________________________

If you are under the age of 18, please complete the following section:

Father's Name: ______________________ Phone Number: ______________

Address: ______________________ City: ______________ State: ________ Zip: ________

Employer: ______________________________

Mother's Name: ______________________ Phone Number: ______________

Address: ______________________ City: ______________ State: ________ Zip: ________

Employer: ______________________________

Medical History

DATE: ____________________

NAME ____________________ AGE __________ BIRTHDATE ____________________

ADVANCE DIRECTIVE NOTIFICATION FORM

I HAVE EXECUTED AN ADVANCE DIRECTIVE. ☐ NO ☐ YES

I HAVE DISCUSSED THIS ADVANCE DIRECTIVE WITH MY PRIMARY CARE PHYSICIAN. ☐ NO ☐ YES

ALLERGIES TO MEDICATIONS, X-RAY DYES, OR OTHER SUBSTANCES ☐ NO ☐ YES

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS

Please circle if you have had problems with or are presently complaining of any of the following:

1. High blood pressure
2. Diabetes
3. Cancer
4. Heart disease
5. Chest pain/chest tightness
6. Shortness of breath
7. Swollen ankles
8. Palpitations
9. Lightheadedness
10. Frequent urination
11. Rheumatic fever
12. Asthma
13. Bronchitis
14. Pneumonia
15. Persistent cough
16. T.B.
17. Hay fever
18. Abdominal discomfort
19. Indigestion
20. Nausea
21. Vomiting
22. Constipation
23. Diarrhea
24. Blood in stool
25. Ulcers
26. Change in bowel habits
27. Unexplained weight gain/loss
28. Hemorrhoids
29. Gall bladder disease
30. Colitis
31. Hepatitis or jaundice
32. Thyroid disease
33. Head or neck radiation
34. Headache
35. Kidney diseases
36. Kidney stones
37. Difficulty urinating
38. Arthritis
39. Low back problems
40. Skin diseases
41. Blood disorders
42. Venereal diseases
43. Anxiety
44. Depression
45. Anemia
46. Alcohol abuse
47. Drug abuse
48. Gout
49. ____________________
50. ____________________

GYNECOLOGIC AND OBSTETRIC HISTORY

AGE OF ONSET OF PERIODS: __________ FREQUENCY: ____________ LENGTH OF PERIOD: ____________________

PREGNANCIES: ________________ BIRTHS: ______________ MISCARRIAGES: ____________________

PROLONGED OR ABNORMAL BLEEDING: ☐ NO ☐ YES (PLEASE DESCRIBE):____________________

LEAKAGE OF URINE: ☐ NO ☐ YES (PLEASE DESCRIBE):____________________

PELVIC PAIN: ☐ NO ☐ YES (PLEASE DESCRIBE):____________________

ABNORMAL DISCHARGE: ☐ NO ☐ YES (PLEASE DESCRIBE):____________________

HISTORY OF ABNORMAL PAP SMEAR: ☐ NO ☐ YES (TYPE OF TREATMENT): ____________________

PLEASE LIST AND SUPPLY THE DATES OF:

OPERATIONS: ____________________ ____________________ ____________________

____________________ ____________________ ____________________

HOSPITALIZATIONS OTHER THAN FOR SURGERY: ____________________

____________________ ____________________ ____________________

Immunization history - have you had:

Hepatitis B? ☐no ☐ yes When? ________

Other? ☐no ☐ yes When? ________

Pneumovax immunization? ☐no ☐ yes When? __________

Flu Immunization? ☐no ☐ yes When? __________

Tetanus immunization? ☐no ☐ yes When? __________

When was your last:

PAP SMEAR? ____________________ BREAST EXAM? ________________ STOOL CHECK FOR BLOOD? __________

MAMMOGRAM? ________________ CHOLESTEROL CHECK? __________ PROSTATE EXAM? ________________

This information is for use by your physician as part of your confidential medical record.

PATIENT NAME:________________________________ D.O.B. ____________ DATE: ____________

FAMILY HISTORY

Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	Which family members?	Approx. Age when diagnosed
Cancer (describe type)	____________	____________
Hypertension (high blood pressure)	____________	____________
Heart Disease	____________	____________
Diabetes	____________	____________
Strokes	____________	____________
Mental disease (anxiety, depression,etc.)	____________	____________
Drug or alcohol addiction	____________	____________
Glaucoma	____________	____________
Bleeding diseases	____________	____________
Other:____________	____________	____________

PREVENTION

1. Do you wear seatbelts? .... ☐ no ☐ yes If no, why not? ____________
2. Do you wear a bike helmet? .... ☐ no ☐ yes ☐ N/A
3. Do you smoke? .... ☐ no ☐ yes If yes, how many packs per day? ____________
4. Do you drink alcoholic beverages? .... ☐ no ☐ yes If yes, how much per week? ____________
5. Do you drink coffee? .... ☐ no ☐ yes If yes, how many cups per day? ____________
6. Do you drink tea? .... ☐ no ☐ yes If yes, how many cups per day? ____________
7. If there is a gun in your home, is it out of children's reach and unloaded? .... ☐ no ☐ yes ☐ N/A
8. Do you use drugs? (marijuana, cocaine, crack, etc.) .... ☐ no ☐ yes If yes, explain: ____________
9. Have you ever engaged in any activity which has put you at risk of getting AIDS? .... ☐ no ☐ yes If yes, explain: ____________
10. Do you wish to be tested for AIDS? .... ☐ no ☐ yes
11. Have you ever worked with chemicals, paints, asbestos, or other hazardous material? .... ☐ no ☐ yes If yes, explain: ____________
12. Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? .... ☐ no ☐ yes
13. Do you ever feel afraid of your partner? .... ☐ no ☐ yes
14. Do you have a "living will"? .... ☐ no ☐ yes
15. Do you have a donor card? .... ☐ no ☐ yes
16. Method of birth control?____________

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