PATIENT INFORMATION

Please print clearly and complete all blanks

DATE:_____ REFERRED BY:_____ SEX:_____

NAME:_____ BIRTHDATE:_____
LAST FIRST MIDDLE

MAILING ADDRESS:_____
CITY STATE ZIP

TELEPHONE:_____ CELL PHONE:_____ WORK NUMBER:_____

SS #_____ MARITAL STATUS:_____ EMAIL:_____

EMPLOYER:_____ OCCUPATION:_____

EMPLOYER'S ADDRESS:_____

****

RACE (circle one): AMERICAN INDIAN – ALASKAN – ASIAN – BLACK – WHITE – HISPANIC

SMOKER STATUS (circle one): EVERY DAY – SOME DAYS – FORMER – NEVER

RELIGION:_____

****

NEXT OF KIN:_____ BIRTHDATE:_____

ADDRESS IF DIFFERENT:_____
ADDRESS CITY STATE ZIP CODE

RELATIONSHIP:_____ MALE_____ FEMALE_____ TELEPHONE:_____

****

EMERGENCY CONTACT:_____

ADDRESS IF DIFFERENT:_____
ADDRESS CITY STATE ZIP CODE

RELATIONSHIP:_____ MALE_____ FEMALE_____ TELEPHONE:_____

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RESPONSIBLE PARTY FOR BILLING (if other than patient):

NAME:_____ RELATIONSHIP TO PATIENT:_____

ADDRESS:_____
ADDRESS CITY STATE ZIP CODE

SS #:_____ BIRTHDATE_____ TELEPHONE:_____

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PRIMARY INSURANCE:_____ ID#:_____ GROUP#_____

NAME OF INSURED:_____ INSURED'S BIRTHDATE:_____

SECONDARY INSURANCE:_____ ID#_____ GROUP#_____

NAME OF INSURED:_____ INSURED'S BIRTHDATE:_____

All professional services rendered are charged to the patient's account. Necessary forms will be completed to expedite insurance claims for those plans which the physician files. The patient is responsible for all fees, regardless of insurance coverage.

I hereby assign to the physician all payments for medical services rendered and authorize the physician to release any medical information necessary to process claims and request payments from insurance companies or Medicaid payers. A photocopy of this assignment and authorization shall be considered as valid as the original.

SIGNATURE:_____ DATE:_____

Family Practice

History & Physical

Name_____ SS#_____ Date_____

Address_____ Occupation_____

Phone (home)_____ (work) _____ (mobile) _____

Date of birth_____ Age_____ Chief Complaint_____

Drug Allergies

_____

_____

_____

Current Medications

_____

_____

_____

_____

_____

_____

_____

_____

_____

Family History

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart disease	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐
Bleeding disorder	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐	☐	☐
Mental illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐

Hospitalization or Surgery

Reason	Date	Reason	Date

Women only Pregnant Yes No Planning pregnancy? Yes No

Medical History

☐Headache	☐Lactose intolerance	☐Depression
☐Shortness of breath	☐Gallbladder disease	☐Gout
☐Heart palpitations	☐Prostate disease	☐Scarlet fever
☐Heart murmur	☐Bowel irregularity	☐Chronic rashes
☐Chest pain	☐Incontinence	☐Rheumatic fever
☐Dizziness/fainting	☐Sexual/menstrual dysfunction	☐Mumps
☐Peripheral vascular disease	☐Venereal disease	☐Measles
☐Allergies/Hay fever	☐Frequent infections	☐Rubella
☐Asthma	☐Hepatitis	☐Polio
☐Bronchitis	☐Anemia	☐Diphtheria
☐Pneumonia	☐Arthritis	☐Tetanus
☐Ulcer	☐Osteoporosis	☐Other
☐GI disorder	☐Nervousness	☐Other

Habits

☐Smoke Packs daily_____
How long_____
Interested in stopping

☐Exercise routine_____
_____

☐Contact with blood/bodily fluid at work

☐Coffee Cups daily_____
Other caffeine_____

☐Alcohol Type_____
Amount_____

☐Diet Salt intake_____
Fat intake_____

☐Sleep Difficulty falling asleep_____
Continuity disturbance_____
Snoring_____
Early morning awakening___
Daytime drowsiness_____
Other_____