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:____

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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:_______________________

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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.

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SIGNATURE:____DATE:_________________________________

Patient Name:______________________________ **DOB:**______________ **Date:**____________

	Age	State of Health	Age at Death	Cause of Death		Age	State of Health	Age at Death	Cause of Death
Father					Mother				
Brothers					Sisters				

Check (✓) if your blood relatives had any of the following.

☐ Arthritis, Gout	☐ Dialysis	☐ Kidney Disease	☐ Other ________
☐ Cancer	☐ Heart Disease, Strokes	☐ Kidney Stones	☐ Other ________
☐ Diabetes	☐ High Blood Pressure	☐ Tuberculosis	☐ Other ________

SOCIAL HISTORY		**OB/GYN HISTORY** (Please List Complications if Any)	
Check (✓) if your work exposes you to the following.	Check (✓) which substances you use and indicate how much you use per day/week.	# of Children	Date of last Menstrual period? ________ Date of last Pap Smear? ________
Hazardous substances Other	Caffeine Tobacco	# of Pregnancies	Date of last Mammogram? ________ Are you Pregnant? ________
Alcohol	Drugs	# of Miscarriages	

REVIEW OF SYSTEMS (Check (✓) the medical conditions you have or have had in the past year.

GENERAL	**GASTROINTESTINAL**	**GENTOURINARY**	**LYMPH/HEMATOLOGICAL**
☐ Chills / Fever	☐ Decreased Appetite	**<u>Men & Women</u>**	☐ Easy Bleeding
☐ Unexplained Hair Loss	☐ Increased Appetite	☐ Pain when urinating	☐ Low Platelets
☐ Weight Gain/Loss	☐ Constipation	☐ Passing water more than usual (day and/or night)	☐ Swollen glands (armpits or groin)
EYES	☐ Diarrhea	☐ Pain during intercourse	**ENDOCRINE**
☐ Vision Problems (Blurred/Loss)	☐ Nausea/Vomiting	☐ Bladder/urinary infection	☐ Thirsty all the time
☐ Eye Pain	☐ Stomach Pain	☐ Change in sex drive	☐ Increased facial hair (females only)
EAR, NOSE, MOUTH THROAT	**MUSCULOSKELETAL**	**<u>Women (only)</u>**	☐ Cannot stand temperature changes (heat/cold)
☐ Dizziness	☐ Joint Pain	☐ Irregular Menstruation	**SKIN**
☐ Dental Problems	☐ Numbness, tingling or weakness in arms or legs	☐ Increased/Decreased bleeding during menstruation	☐ Changes in Skin
☐ Sore Throat/Painful swallowing	☐ Limited motion of arms or legs	☐ 3 or more yeast infections in a year	☐ Rash (palm of hands, sole of feet)
CARDIOVASCULAR	☐ Swelling/Redness	☐ Vaginal Discharge	**ALLERGIES**
☐ Chest Pain	If so, where:	**<u>Men (only)</u>**	☐ Hives/skin rashes
☐ Heart Racing/Palpitations	**NEUROLOGICAL**	☐ Discharge from penis (drip)	☐ Allergic reaction to drugs
☐ Poor Circulation	☐ Arm/Leg Weakness	☐ Swelling in Scrotum	☐ Allergic reaction to food
☐ Fainting Spells	☐ New Headaches	**PSYCHIARIC**	**OTHER**
☐ Sudden Shortness of breath at night or lying down	☐ Headaches with Vision Changes	☐ Suicidal or homicidal thoughts	
RESPIRATORY	☐ Problems with Memory or Speech	☐ Seeing or hearing things (hallucinations)	
☐ Shortness of Breath		☐ Mood swings	
☐ Night Sweats			
☐ Cough/Coughing Up Blood			

PHYSICAL EXAM – DICTATED

Anything else you feel the doctor needs to know?____________________________________

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I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form. I consent to examination/treatment/surgery if indicated by the physicians of Tahlequah City Hospital.

Signature:________________________________ Date:______________

Reviewed by:______________________________ Date:______________

MEDICATION SUMMARY

PATIENT ____ DOB ______/______/______

PHARMACY _______________________________________PHARMACY PHONE # ________________

ALLERGIES ____

____

START DATE	MEDICATION/STRENGTH	DIRECTIONS	PRESCRIBED BY