

# WELCOME

## 1 PATIENT INFORMATION

Date \_\_\_\_\_

Patient \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex:  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Single  Married  Widowed  Separated  Divorced

Patient SS# \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_

Spouse/Partner's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Occupation \_\_\_\_\_

Spouse/Partner's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Name of your primary physician, address & phone \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## 3 PHONE NUMBERS

Home \_\_\_\_\_ Work \_\_\_\_\_ Ext \_\_\_\_\_

Fax \_\_\_\_\_ Email \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

### IN CASE OF EMERGENCY, CONTACT

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

## 4 FAMILY HISTORY

Date of last physical examination \_\_\_\_\_

What is your reason for visit? \_\_\_\_\_

	FATHER <input type="checkbox"/> ALIVE <input type="checkbox"/> DECEASED	Present health or cause of death	MOTHER <input type="checkbox"/> ALIVE <input type="checkbox"/> DECEASED	Present health or cause of death	SPOUSE <input type="checkbox"/> ALIVE <input type="checkbox"/> DECEASED	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  
 Tuberculosis  Heart disease  Stroke  High blood pressure  Nervous illness  Allergy  Other  Diabetes  Cancer  Bleeding tendency  Kidney disease

## 2 INSURANCE

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature \_\_\_\_\_

Relationship \_\_\_\_\_

Date \_\_\_\_\_

### MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. \_\_\_\_\_ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature \_\_\_\_\_

Date \_\_\_\_\_

# 5

## 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

### MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

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

### GENITO-URINARY

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

### GASTROINTESTINAL

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

### CARDIOVASCULAR

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

### 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

### SKIN

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

### 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 \_\_\_\_\_

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 \_\_\_\_\_

# 6

## MEDICATIONS/ALLERGIES

List medications you are currently taking \_\_\_\_\_

Pharmacy Name \_\_\_\_\_ Phone \_\_\_\_\_

List allergies to medications or substances \_\_\_\_\_

# 7

## HEALTH HABITS

**HEALTH HABITS** Check (✓) which substances you use and describe how much you use.

- Caffeine \_\_\_\_\_
- Drugs \_\_\_\_\_
- Tobacco \_\_\_\_\_
- Other \_\_\_\_\_

Your occupation \_\_\_\_\_

**OCCUPATIONAL** Check (✓) if your work exposes you to the following:

- Stress
- Heavy Lifting
- Hazardous Substances
- Other \_\_\_\_\_

# 8

## SIGNATURES

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/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Reviewed By \_\_\_\_\_ Date \_\_\_\_\_