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Patient Information Form

Name: Last, First MI	Date of Birth	Race	Gender	Marital Status M D S W
Local Address	Home Phone	E•Mail		
City, State, Zip	Work Phone	Cell Phone		
Employer	Social Security No.	Age		
Out of State Address	Occupation / Retired From?			
City, State, Zip	May we leave messages on your answering machine? Yes No			
Religious Preference	Primary Care Physician:			
Emergency Contact Relationship	Emergency Contact Number			
Pharmacy Name	Pharmacy Address			

Primary Insurance	Secondary Insurance
Address	Address
Customer Service Phone Number	Customer Service Phone Number
Policy or ID Number	Policy or ID Number
Group Number	Group Number
Subscriber's Name & Relationship to Pt.	Subscriber's Name & Relationship to Pt.

I authorize the release of medical records necessary to process claims for health insurance benefits and request that payments be made directly to my physician for services rendered. A copy of this authorization is as valid as the original. I acknowledge that my submission of this form is no guarantee that I will be accepted as a patient. I also understand that you **do not finance co-pays and deductibles**, which must be paid in full when invoiced. I acknowledge receipt of the Notice of Privacy Practices and have read and understand it.

COMMUNICATIONS REGARDING MY ACCOUNTS

Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any servicers and any collectors of my accounts, through various means such as 1) any cell, landline, or text number that I provide, 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communications.

Signature: _____Date:_____

Patient Name: _____

Past Medical History: Are you now or have you ever been treated for any of the following?

[ ] Coronary Artery Disease	414.01	[ ]Aortic Valve Disease	424.1
[ ]Mitral Valve Disease	424.0	[ ] Heart Valve Replaced?	V43.3
[ ]Elevated Cholesterol/Triglycerides	272.0	[ ]High Blood Pressure	401.1
[ ]Type II Diabetes	250.00	[ ]Asthma	493.90
[ ]Shortness of Breath	786.05	[ ]Sleep Apnea Syndrome	327.23
[ ]Emphysema / COPD	496	[ ]Do you use home oxygen?	Y N
[ ]Heartburn	530.81	[ ]Use of CPAP?	Y N
[ ]Hiatal Hernia	553.3	[ ]Gallstones	574.01
[ ]Leak of Urine w/ cough/sneeze	625.6	[ ]Low Back Pain	724.5
[ ]Arthritic or Degenerative Joints	715.09	[ ]Varicose Veins	459.32
[ ]Low Thyroid Function	244.8	[ ]High Thyroid Function	240.9
[ ]Fibromyalgia	729.1	[ ]Chronic Fatigue Syndrome	780.71
[ ]Depression	311	[ ]Anxiety Disorder	300.00
[ ]BiPolar Disorder	296.80	[ ]Personal History of Breast Cancer	V10.3
[ ]Personal History of Colon Cancer	V10.05	[ ]Hepatitis	573.3
[ ] Irritable Bowel Disease	564.1	[ ] Kidney Stones	592.0
[ ] Gout	274.0		

Surgical History Please list any and all operations you have had in your entire life, **including Cosmetic or Plastic Surgery.** Please add any not specifically requested.

Operation	Year(s)	Operation	Year(s)
[ ] Tonsillectomy/Adenoidectomy		[ ] Appendectomy	
[ ] Laparoscopic Gallbladder		[ ] Open Incision Gallbladder	
[ ] Total Abdominal Hysterectomy		[ ] Vaginal Hysterectomy	
[ ] Coronary Bypass (CABG)		[ ] Carotid Endarterectomy	
[ ] Colon / Large Intestine Surgery		[ ] Prostate Surgery / Radiation	
[ ] Breast Biopsy L R Both		[ ] Mastectomy L R Both	
[ ] Breast Enlargement		[ ] Breast Reduction	
[ ] Liposuction		[ ] "Tummy Tuck"	
[ ] Hernia Repair		[ ] Spleen Removal	
[ ] Hip Replacement L R Both		[ ] Knee Replacement L R Both	
[ ] Heart Valve Replacement			
[ ] Coronary Artery Stenting			

Allergies [ ] I have no known drug allergies • OR • [ ]I am allergic to the following DRUGS:

	Latex Allergy? Yes No

Patient Name: _____

Medications AND Supplements AND Over The Counter Drugs

Medication	Dose and Frequency

Social History

Marital Status: M D S W Occupation:_____
If you are Disabled, why?_____

Who Lives at home with you?: Alone • Spouse • Family • Domestic Partner • Roommate

Do you exercise? No. Yes If so, What type and how often?

Do you use any of the following?

Substance	Amount	How Often	How Many Years
Alcohol			
Tobacco			
Street Drugs/Type			
Caffeine			

Personal Physicians If you would like for us to communicate your progress with your other physicians, **please provide their names.**

Specialty	Physician Name	Fax Number
Primary Care		
Cardiologist		

Pulmonologist		
Mental Health		
Other		

Patient Name: _____

Family Medical History Which of the following diseases "run in your family".

Disease	Family Member	Disease	Family Member
[ ] Heart Disease		[ ] High Blood Pressure	
[ ] High Cholesterol		[ ] Obesity	
[ ] Diabetes		[ ] Lung Disease	
[ ] Anesthesia Problems		[ ] Kidney Disease	
[ ] Breast Cancer		[ ] Colon Cancer	
[ ] Bleeding Problems			

Review of Systems Please circle all symptoms that you frequently experience

1. General: Fever Chills Malaise Weight Gain Weight Loss Decreased Appetite Increased Appetite Weakness

2. Eyes: Visual Changes Eye Pain

3. Ears/Nose/Throat: Sore Throat Ear pain Ringing in the Ears Hoarseness

4. Cardiovascular: Palpitations Chest pain

5. Respiratory: Shortness of Breath Cough Blood in Sputum

6. Gastrointestinal: Nausea Vomiting Constipation Diarrhea Bowel Changes Rectal Pain Rectal Bleeding Cirrhosis Hiatal Hernia Ulcer Disease Abdominal Pain Bloating

7. GenitoUrinary: Painful Urination Flank Pain Frequency Loss of Libido Erectile Dysfunction Painful Intercourse Incontinence Vaginal Discharge Bloody Urine Getting up at Night to Urinate Heavy Periods Frequent periods Menopause Hot Flashes

8. Musculoskeletal: Back Pain Joint Pain Muscle Pain Unable to walk without Assistance

9. Skin: Rash Itching Easy Bruising

10. Neurological: Numbness Confusion Headache Dizziness

11. Psychiatric: Hallucinations Anxiety Depression Suicidal Homicidal

12. Endocrine: Heat Intolerance Frequent Urination Frequent Thirst

13. Hematology / Lymphatic: Anemia Easy Bruising Bleeding Gums Swollen Nodes