PATIENT INFORMATION FORM

PHARMACY # _____ DOCTOR/MIDWIFE _____

PRIMARY CARE DOCTOR _____ PRIMARY CARE DOC. PH# _____ FAX# _____

NAME _____ SEX ☐ M ☐ F

SOCIAL SECURITY# _____ BIRTHDATE_____ MARITAL STATUS ☐ S ☐ M ☐ W ☐ D

RELIGION _____AGE____ HOME PH.# ( ) _____ CELL PH: #_____

STREET ADDRESS _____ APT. _____

CITY _____ STATE _____ ZIP _____

DRIVER'S LICENSE #_____ EMAIL _____

EMPLOYER/SCHOOL_____ TITLE_____PHONE # ( ) _____

STREET ADDRESS _____ CITY _____ STATE_____ ZIP _____

SPOUSE _____ AGE _____ BIRTHDATE _____

SPOUSE EMPLOYER_____ TITLE_____PHONE # ( ) _____

STREET ADDRESS _____ CITY _____ STATE_____ ZIP _____

TRANSLATOR NEEDED ☐ YES ☐ NO PRIMARY LANGUAGE SPOKEN _____ REFERRED BY _____

SOMEONE TO CONTACT LOCALLY IN CASE OF EMERGENCY, OTHER THAN SOMEONE LIVING WITH YOU:

NAME _____ PHONE ( ) _____ RELATIONSHIP _____

STREET ADDRESS _____ CITY _____ STATE_____ ZIP _____

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

FATHER'S NAME_____ MOTHER'S NAME _____

EMPLOYED BY _____ EMPLOYED BY _____

POSITION _____ POSITION _____

PHONE _____ PHONE: _____

PRIMARY INSURANCE INFORMATION

INSURANCE CO. _____

ADDRESS _____

CITY/STATE/ZIP _____

PHONE # _____

ID# _____

GROUP NAME OR # _____

INSURED'S FULL NAME _____

IS THIS AN EMPLOYER PLAN? _____

INSURED'S SOCIAL SEC # _____

INSURED'S D.O.B. _____

RELATIONSHIP TO INSURED _____

(Self —— Husband —— Wife —— Child —— Other)

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GUARANTEE OF PAYMENT

I fully understand that I am directly responsible for payment to the Physicians in this office for all medical services rendered to me. I also understand that all bills are payable and become due at the time services are rendered, unless other arrangements have been made. I agree to pay all collection costs including reasonable attorney's fees and costs in event it becomes necessary to file suit to effect payment. I authorize payments to be made directly to my doctor.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the Physicians in this office to release any information acquired in the course of my examination or treatment to my insurance company for the purpose of processing any insurance claim.

ASSIGNMENT OF INSURANCE BENEFITS

If insurance claims are field by this office on my behalf. I hereby authorize direct payment of any benefits to the Physicians in this office for the medical or surgical treatment received by me. In this circumstance, I understand that I am financially responsible for any charges not covered by insurance. I permit a copy of the authorization to be used in place of the original.

Signature _____ Date _____

Authorization to Discuss Protected Health Information*

I _____, authorize _____

_____

to release or discuss information related to my medical condition (including information related to my treatment plan, medication information and/or billing information) to the following named persons**.

1. _____ 3. _____

2. _____ 4. _____

- * PLEASE BE ADVISED THAT ANY PERSON NOT REFERRED TO ON THIS LIST WILL NOT BE GIVEN ANY INFORMATION RELATED TO YOUR CARE, INCLUDING BILLING INFORMATION. YOU MAY CHANGE, RESTRICT OR EXPAND THIS LISTING AT ANY TIME.

- ** YOU ARE NOT REQUIRED TO LIST ANY NAME IF YOU DO NOT SO CHOOSE.

Please list phone numbers where you would like us to contact you for:

- Results - lab, X-ray, Ultrasounds, Mammograms, etc.
- Reminder notices
- Changes on scheduled appointments

1. _____

2. _____

_____

Patient's name: _____

DOB: _____

SS#: _____

Date: _____

Patient's Signature: _____

ADVANCE DIRECTIVE

DO YOU HAVE AN ADVANCE DIRECTIVE / LIVING WILL? _____ IF YES, PLEASE PROVIDE US WITH A COPY FOR OUR RECORDS.

IF NO, PLEASE LET US KNOW IF YOU REQUIRE INFORMATION.

I hereby authorize the use of and/or disclosures of any telephone number, provided by me or on my behalf, that is assigned to a residential line, cellular telephone service, paging service, facsimile machine, computer, or any other service or device for which the called party is charged for the call for the purpose

Patient:_____ Date:_____

Medications: _____

_____

Allergies: _____

Last Menstrual Period: _____ Cycle Frequency: _____ Duration: _____

Flow: _____

Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No

General

Have you gained or lost weight recently?	Y	N
How many pounds?	___	
Other		

Integumentary

Skin rash	Y	N
Nipple discharge	Y	N
Persistent itch	Y	N

Neurological

Trouble sleeping	Y	N
Headache	Y	N
Seizures	Y	N
Other		

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Frequent urination	Y	N
Other		

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other		

Respiratory

Asthma	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other		

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other		

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N
Anemia	Y	N

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N
Other		

Psychiatric

Are you unhappy with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N
Other		

General Questions

Safe Sex	Y	N
Sexually Active	Y	N
If so, # of partners	_____	
STD History	Y	N
Smoking	Y	N
Alcohol	Y	N
If so, how much	_____	

Self Breast Exam	Y	N
Diet and Exercise	Y	N
Sunscreen	Y	N
Domestic Violence	Y	N
Recreational Drugs	Y	N
Wear Seat Belt	Y	N

Physician Reviewed: _____