



PATIENT INFORMATION

Patient Name: Last: _____ First: _____ Middle: _____
Address: _____ City: _____
State: _____ Zip: _____ Home Ph: _____ Work Ph: _____ Cell: _____
Race: _____ Marital Status: _____ Birthdate: _____ Social Security #: _____
Employer: _____ Employer Phone: _____
If married, spouse's name: _____ Spouse's Employer: _____
Person to notify in case of emergency: _____ Phone: _____
Relatives/friends who are patients here?: _____ Who referred you to us: _____

INSURANCE POLICY INFORMATION

Please give your insurance card and driver's license to the receptionist

Insurance Company (Primary): _____
Policy holder's name: _____ Birthdate: ____/____/____
Contract Number: _____ Group Number: _____

CONSENT FOR TREATMENT

I consent to necessary treatment, including drugs, medicine, performance and operation of X-ray, or other studies that may be used by the attending physician, his nurse or staff.

AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

____ I **DO NOT** wish to have test results or other medical information released to any person other than myself.
____ I **DO** wish to have test results or other medical information released to the following person:

| | | | |
|---------------|-----------------------|---------------|-----------------------|
| _____ Name | _____ Relationship | _____ Name | _____ Relationship |
|---------------|-----------------------|---------------|-----------------------|

You may contact me at the following locations (circle those that apply): Home phone cell phone work phone
You may leave a voicemail message: yes no

It is the responsibility of the patient to notify this office of any changes in the above information. If changes do occur, the patient must file another Authorization for Release of Patient Information with this clinic.

Please understand that it may be necessary for us to disclose some or all of the Information contained in your medical records to other physicians, nurses, and/or healthcare providers (collectively referred to as "providers"). At times, other providers assist using assessing a patient's condition, screening for potential problems, or providing consultation under certain circumstances. All healthcare providers are required by law to maintain your patient confidentiality. Also, due to the increased awareness of quality care and outcome measurements, it may be necessary to disclose information regarding your care to healthcare agencies (both private and governmental), your insurance company and/or your self-insured employer. Regarding the information going to your employer, other than information needed to verify your insurance coverage, the data released will consist of statistical information only.

NON-COVERED SERVICE AGREEMENT

As your physician, I want to provide you with the best care possible. There may be certain routine services performed during your visit(s), such as: Dexa Scans, Pap Smears, Biopsies, Ultrasounds or X-rays, Lab Work, Injections and/or other testing that I feel necessary for the maintenance of your good health and that may NOT be covered by your insurance contract. By signing below, you agree that you will be responsible for costs not covered by your insurance.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I received a copy of the Notice of Privacy Practices.

SIGNATURE: _____ **DATE:** _____



Patient Name: _____ DOB: _____ Today's Date: _____

Reason for Visit: Annual Exam Problem I would like to discuss

Describe Problem: _____

Medications you are currently taking: _____

Medication allergies: _____

Medical problems or surgery in the past year: _____

Do you currently smoke? No Yes – how much? _____

Do you currently drink? No Yes – how much? _____

Date of last menstrual period: _____ Frequency of Periods: Every _____ Days Avg # of Days of Period: _____

Are your periods: Light Moderate Heavy

Do you have painful periods? No Yes

Are you currently sexually active? No Yes

What are you using to prevent pregnancy? _____

Do you have problems with urinary leakage? No Yes

Please circle any recent symptoms that you may be experiencing or may have experienced in the past year:

CONST Weight gain
Fever
Fatigue

EYES Dry eyes
Vision Changes

ENT Mouth Sores
Sore throat
Ringing in ears

RESP Persistent cough
Wheezing

CV Shortness of breath
Difficulty breathing
Chest pain
Rapid heartbeat
Swollen hands and feet
Painful breasts
Breast lumps
Nipple discharge

GI Persistent diarrhea
Bloody stools
Nausea and vomiting
Constipation
Bloating/gas
Abdominal pain

ALL Hives, blisters
Red itchy eyes

RENAL Pain or burning w/urination
Strain to urinate
Bladder infection

PSYCH Depression
Mood swings
Anxiety

MSK Joint or muscle pain
Muscle weakness

Lymph Swollen lymph nodes

NEURO Seizures
Frequent headaches
Dizziness
Numbness

HEME Easy bleeding
Easy bruising

ENDO Night sweats
Hot/cold intolerance

SKIN Rash

OTHER _____

SIGNATURE: _____ **DATE:** _____



PATIENT HISTORY INTAKE FORM

PREVIOUS PREGNANCIES:

Total # of pregnancies: Total # of living children: # Miscarriages: #Abortions:

Table with 6 columns: Baby's Birth Date, Birth Weight, Baby's Name, Weeks of pregnancy, Complications, Vaginal or C-Section. Rows 1-5.

FEMALE GENITOURINARY HISTORY:

Have you ever had the following?:

Abnormal Pap, Herpes, Gonorrhea, Trichomonas, Genital Warts, Chlamydia, Did you breastfeed, Age periods began, Menopausal patients only age periods stopped, ever used hormones, type

PAST MEDICAL HISTORY:

Please circle any of the following you have been diagnosed with:

High blood pressure, Diabetes, Hepatitis, Heart disease, Heart attack, Mitral valve prolapse, Gastric ulcers, Glaucoma, Asthma, Blood clots in legs/lungs, Thyroid disease, Lupus, Seizure disorder, Sleep apnea, Osteoporosis, Stroke, HIV/AIDS, Elevated cholesterol/lipids, Cancer -type, Anemia, Tuberculosis, COPD, Eating disorder, Arthritis

PAST SURGICAL HISTORY:

Have you ever had the following?:

Hysterectomy, Surgery for Ovarian cysts, Surgery for endometriosis, Other, Bladder surgery, Appendectomy, Mastectomy, Gallbladder removed, Breast Biopsy, Tubes tied

FAMILY HISTORY:

Has any blood relative ever had any of the following? Which family member?

Breast cancer, Ovarian cancer, Colon cancer, Uterine cancer, Stroke, High blood pressure, Blood clots in legs/lungs, Thyroid disease, Heart disease, Diabetes, Osteoporosis, Birth defects, Other

SOCIAL HISTORY:

Marital Status S M W D Sexual Orientation: Heterosexual Homosexual Bisexual

Occupation: Do you exercise:

Have you ever been physically abused?: Have you ever been mentally abused?: Have you ever been sexually abused?:

SIGNATURE: DATE: