

PATIENT MEDICAL HISTORY

NAME: _____ DATE: _____ AGE: _____ WEIGHT: _____ HEIGHT: _____

REASON FOR VISIT: _____

PREVIOUS SURGERY				
	YES	NO	DATE	COMMENTS
APPENDIX				
BREAST				
COLON/INTESTINE				
GALLBLADDER				
HERNIA				
STOMACH				
THYROID				
VEIN				
SPLEEN				
LIVER				
HEART/LUNG				
BLADDER/KIDNEY				
HYSTERECTOMY/OVARY				
OTHER				
MEDICAL DISORDERS				
	YES	NO	DATE	COMMENTS
HIGH BLOOD PRESSURE				
CANCER				
DIABETES				
HEART PROBLEMS				
BLEEDING TENDENCY				
BLOOD CLOT				
STROKE				
EPILEPSY/SEIZURE				
HEPATITIS/JAUNDICE				
ULCER				
COLON				
URINARY				
MENTAL ILLNESS				
SERIOUS ACCIDENT				
RESPIRATORY				
ANESTHETIC PROBLEM				
ARTHRITIS				
AIDS/HIV				
OTHER				
FAMILY HISTORY				
	ALIVE	DECEASED	MEDICAL PROBLEMS	CAUSE OF DEATH
FATHER				
MOTHER				
BROTHERS	#	#		
SISTERS	#	#		
CHILDREN	#	#		
SOCIAL HISTORY		MEDICATIONS		ALLERGIES
	DAILY AMOUNT			
TOBACCO USE				
ALCOHOL USE				
CAFFEINE USE				

ALL SECTIONS MUST BE COMPLETED AND RETURNED TO OFFICE

Date: _____

A NEW FORM MUST BE COMPLETED EVERY 12 MONTHS PER INSURANCE REGULATIONS

PATIENT NAME _____ SS# _____

ADDRESS _____ DATE OF BIRTH _____

CITY/STATE _____ ZIP _____ PHONE # _____

CELL PHONE# _____

SEX M F MARITAL STATUS S M W SEP D

IS THIS A WORK RELATED INJURY OR ILLNESS YES _____ NO _____

EMPLOYER _____ PHONE # _____

EMPLOYER STREET ADDRESS _____

CITY/STATE _____ ZIP _____

IMMEDIATE SUPERVISOR _____

GUARANTOR _____

STREET ADDRESS _____ PHONE # _____

CITY/STATE _____ ZIP _____

WHO REFERRED YOU TO THIS OFFICE? _____ WHEN _____

WHO IS YOUR PRIMARY CARE DOCTOR? _____ PHONE # _____

#1 PRIMARY INSURANCE Co. _____ ID# _____ GROUP # _____

SUBSCRIBER _____ RELATIONSHIP _____ SUBSCRIBER'S DATE OF BIRTH _____

SUBSCRIBER'S EMPLOYER _____ INSURANCE EFFECTIVE DATE _____

#2 SECONDARY INSURANCE Co. _____ ID# _____ GROUP # _____

SUBSCRIBER _____ RELATIONSHIP _____ SUBSCRIBER'S EMPLOYER _____

ALL CO PAY'S MUST BE PAID AT TIME OF SERVICE

EMERGENCY CONTACT

NAME _____ RELATIONSHIP _____

STREET ADDRESS _____ CITY/STATE _____ ZIP _____

PHONE NUMBER(S) _____

I authorize the physicians to provide medical treatment.

I authorize release of medical information or information necessary to process my claims.

I authorize payment of medical insurance benefits to the physician.

I authorize government benefits to myself or the party who accepts assignment.

I understand I am responsible for all co-pays, deductibles and balances as determined by my insurance plan.

PATIENT'S SIGNATURE _____

(Guardian, if Minor)

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NOTICE OF PRIVACY PRACTICES AVAILABLE UPON REQUEST

My signature acknowledges that I have provided complete, accurate, information and authorizes the physician to examine and treat me.

- Federal privacy rules permit my personal and medical information to be used and disclosed *without* my permission for billing, medical treatment and health care operations. For other purposes, my information will only be released with my written permission.**

- I authorize release of any medical information necessary to process insurance claims, and I authorize payment of medical benefits directly to the physician.**

- I understand that all lab work is sent to an outside laboratory and I may be billed separately by the lab and I am able to receive copies of those reports from this office.**

- I understand that my insurance company may not cover services due to:**
 - **Lack of Coverage**
 - **Non-Covered Services**
 - **Services not meeting their definition of "medical necessity"**
 - **Too many services within your insurance carrier's definition of 'time period'**

DUE TO HIPPA POLICY WE MUST HAVE THE FOLLOWING INFORMATION IN ORDER TO DISCUSS RESULTS.

WHAT PHONE NUMBERS CAN WE CALL AND LEAVE DETAILED MESSAGES ON ANSWERING MACHINE OR VOICE MAIL?

HOME_____ **WORK**_____ **CELL**_____

WITH WHOM MAY WE DISCUSS YOUR MEDICAL CARE?

NO ONE **SPOUSE** **CHILDREN** **PARENTS**

FRIEND/PARTNER (LIST FULL NAME) _____

OTHER (LIST FULL NAME)_____

SIGNATURE_____ **DATE**_____