Single ___

Married ___

Widowed___

Divorced___

Date____________________

Name:____**Sex:** _____**Age**:_____ **Birth date**:____________

(LAST) (FIRST) (MIDDLE)

Address: ____

(NUMBER) (STREEET) (CITY) (STATE) (ZIP CODE)

Home Phone:______________________ **Cell Phone:** ______________________**E-Mail**______________

Social Security Number:_ ______________________**Insurance**:__________________ Referred **to Doctor by:**______________

Patient's Occupation: ________________**If employed by whom**:__________________ **Business Phone Number**:______________

Spouse's Full Name: ________________________________**Phone:** ________________________________

Emergency Contact:________________________________**Relation**:______________ **Phone**______________

I certify that I, and/or my dependents, have insurance coverage with ______________________ and assign directly to Dr.________________ all insurance benefits, if any, otherwise payable to me for services render. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above- named physician may use my health care information and may disclose such information to the above-named insurance copay (ies) and their agents for the of purpose of obtaining payment for services and determining insurance benefit payable for related services.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the centers for Medicare and Medicaid services, my Meidigap insure and their agents any information needed to determine these benefits or benefit.

Patient Signature:____Date:____________

Parent or Guardian Signature: ________________________ ____________________Date____________

Patient Care Assessment/History Form

Date____________________

Name____ Sex: M/F D.O.B.______________

Drug Allergies____

Reason for Visit____

Medical History

Illness	Patient		Family		Illness	Patient		Family	
	Yes	No	Yes	No		Yes	No	Yes	No
Heart Disease					Lung Disease				
Diabetes					Gastrointestinal				
High Blood Pressure					Seizures				
Kidney Problems					Mental Illness				
Cancer (specify below)					Stroke				
PPD					Blood Transfusion				

Specifics and Dates____

____

Other Health Issues not listed above

____

____

	Yes / No	
Tobacco	___ ___	Daily Amount ____________________x ____________________years
Drugs	___ ___	Type______________________________ Daily Amount____________
Alcohol	___ ___	Type______________________________ Daily Amount ____________

Hospitalizations/ER Visits/Surgeries/Procedures

When	Where	Why

Medications(including over the counter meds)

Name	Dosage	Instructions	Reason

Have you ever been rejected for health reasons by the military, an employer, or insurance company? ___Yes ___No

Were you sick, but failed to get medical care within the last year? ____Yes ____No

Did you miss more than ten days of usual activity last year due to illness? ____Yes ____No

General
__Weakness
__Fatigue
__ Chills
__Night Sweats
__Change in weight, appetite
Or sleeping habits

Skin
__Itching
__Rash
__Change in color
__Easy bruising

Nervous System
__Headaches
__Dizziness
__Double vision
__Muscle weakness
__Numbness
__Loss of coordination

Lungs
__Cough
__Wheezing
__Shortness of breath
__Spitting blood
__Positive TB test
__Last chest z-ray____________

Heart
__Chest Pain
__Palpitations (heart pounding)
__Trouble breathing at night
__Trouble climbing stairs
__Ankle swelling
__Heaviness in chest

Gastrointestinal
__Stomach/Abdominal pain
__Indigestion/Heartburn
__Ulcers
__Difficulty swallowing
__Vomiting
__Changes in bowel habits
__Hemorrhoids

Urinary
__Pain with urination
__Blood in urine
__Frequent urination
__Previous infections
__Kidney stones

Eyes
__Glasses/Contacts
__Eye Pain
__Excessive tearing
Date of last eye exam_________

Nose/Throat/Sinuses
__Nosebleeds
__Sore throat
__Hoarseness
__Post nasal drip
__Swelling

Joints & Back
__Pain
__Swelling
__Stiffness
__Deformity

Muscles
__Pain
__Weakness
__Twitching
__Cramps

Psychological
__Nervousness
__ Depression
__Unable to sleep
__Nightmares

Ears
__ Loss of hearing
__Ringing
__Drainage
__Hearing voices

Mouth
__Dentures
__Bleeding gums
__Toothache

Male
__ Hernia
__Discharge from penis
__Pain in testicles
__Varicose
__Erectile dysfunction

Female
__ vaginal itching/burning
__Vaginal discharge
__Problem w/ menstruation
Last Period_______________
Last Pap smear__________
__methods of contraception
__Sexual difficulties
__ Pregnancy, #___________
__Miscarriages/Abortions,______
__Difficulty during pregnancy
__ Lumps in breast
__Discharge from nipple(s)

Patient Signature____ Date____________________

Physician Signature____ Date____________________