

Patient name \_\_\_\_\_

DOB \_\_\_\_\_

**The purpose of today's visit- please choose only 1** **This is an annual physical (no concerns/symptoms):**

An appointment intended to prevent illnesses and detect health concerns early, before symptoms are noticeable. Preventive visits could be an annual physical, well-child exam, Medicare wellness exam or welcome to Medicare visit. Insurance companies are required to cover preventive care services at no cost to patients. During your appointment, your provider will review your overall health and well-being.

Depending on your age, services may include:

- Complete physical exam
- Routine bloodwork
- Pelvic exams, Pap smear
- Sexually-transmitted disease testing
- Alcohol, depression, obesity and tobacco counseling
- Select Immunizations

I am being seen today for an annual physical and **I do not have any complaints or concerns I wish to discuss.**

\_\_\_\_\_  
Patient signature\_\_\_\_\_  
Today's date **This is an office visit(concerns/symptoms):**

An appointment designed to discuss new or existing health problems or symptoms. To address these specific health concerns, your provider may order tests, prescribe medication, refer you to a specialist or provide advice and education. Office visits are billed to insurance and patient is generally responsible for a standard insurance co-pay or deductible.

I am being seen today for an office visit due to concerns/symptoms I am having and would like to discuss with the doctor. **I understand that this is considered an ordinary office visit and I will be responsible for any copay or deductible.**

\_\_\_\_\_  
Patient signature\_\_\_\_\_  
Today's date

Today's Date: \_\_\_\_\_

PLEASE PRINT AND COMPLETE ALL SECTIONS			
PATIENT NAME (LAST - FIRST - MIDDLE INITIAL)		NICKNAME (if applicable)	PATIENT DATE OF BIRTH
PATIENT ADDRESS		CITY, STATE	ZIP
HOME PHONE	CELL PHONE	PATIENT SSN	PATIENT MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Other _____
PATIENT RACE <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Chinese <input type="checkbox"/> Other Race <input type="checkbox"/> Decline to Specify		PATIENT ETHNICITY <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Decline to Specify	PATIENT SEX <input type="checkbox"/> Male <input type="checkbox"/> Female
PATIENT EMAIL ADDRESS		PREFERRED PHARMACY & LOCATION	
EMERGENCY CONTACT NAME		RELATIONSHIP TO PATIENT	EMERGENCY CONTACT PHONE NUMBER
<b>PRIMARY INSURANCE POLICY HOLDER</b>		Relationship to patient: <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> parent <input type="checkbox"/> guardian <input type="checkbox"/> other	
NAME (LAST - FIRST - MIDDLE INITIAL)		ADDRESS (if different from patient)	
HOME PHONE	CELL PHONE	DATE OF BIRTH	SSN
<b>SECONDARY INSURANCE POLICY HOLDER</b>		Relationship to patient: <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> parent <input type="checkbox"/> guardian <input type="checkbox"/> other	
NAME (LAST - FIRST - MIDDLE INITIAL)		ADDRESS (if different from patient)	
HOME PHONE	CELL PHONE	DATE OF BIRTH	SSN
<b>FINANCIALLY RESPONSIBLE PARTY</b>		Relationship to patient: <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> parent <input type="checkbox"/> guardian <input type="checkbox"/> other	
NAME (LAST - FIRST - MIDDLE INITIAL)		ADDRESS (if different from patient)	
HOME PHONE	CELL PHONE	DATE OF BIRTH	SSN

RELEASE OF INFORMATION	
I understand that: <ul style="list-style-type: none"> <li>once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.</li> <li>I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).</li> <li>my records are protected and cannot be disclosed without written permission</li> <li>this Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.</li> </ul>	
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE

INSURANCE ASSIGNMENT OF BENEFITS	
I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.	
SIGNATURE (Patient or, if minor Signature of parent or guardian)	DATE

# Patient Information Sheet

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Today's date:** \_\_\_\_\_

**Purpose of today's visit:**

- This is a routine annual physical, I currently have no complaints that I would like to discuss
- I would like to discuss the following complaints with the doctor:
  - 1- \_\_\_\_\_
  - 2- \_\_\_\_\_

**Current Prescription Medications:**

Name of Medication	Dosage	How often? (daily, weekly, etc)

**Personal Medical History:** (Please circle all that apply)

- |            |                   |                     |                  |                 |
|------------|-------------------|---------------------|------------------|-----------------|
| ADHD       | Bladder problems  | Emphysema/COPD      | High cholesterol | Thyroid disease |
| Alcoholism | Irregular heart   | Epilepsy            | HIV/AIDS         | Ulcers          |
| Allergies  | beat              | Heart attack        | Kidney disease   | _____           |
| Asthma     | Glaucoma          | Heart disease       | Migraines        | _____           |
| Anxiety    | Cancer: _____     | Heart murmur        | Neuropathy       | _____           |
| Anemia     | Clotting Disorder | Hepatitis: _____    | Seizures         |                 |
| Arthritis  | Diabetes          | High blood pressure | Stroke           |                 |

**Family Medical History:** (Please circle all that apply)

- |            |                   |                     |                  |                 |
|------------|-------------------|---------------------|------------------|-----------------|
| ADHD       | Bladder problems  | Emphysema/COPD      | High cholesterol | Thyroid disease |
| Alcoholism | Irregular heart   | Epilepsy            | HIV/AIDS         | Ulcers          |
| Allergies  | beat              | Heart attack        | Kidney disease   | _____           |
| Asthma     | Glaucoma          | Heart disease       | Migraines        | _____           |
| Anxiety    | Cancer: _____     | Heart murmur        | Neuropathy       | _____           |
| Anemia     | Clotting Disorder | Hepatitis: _____    | Seizures         |                 |
| Arthritis  | Diabetes          | High blood pressure | Stroke           |                 |

## Patient Information Sheet

Allergies to Medications:

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Other medical problems not listed above:

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Surgical History: (Please list all prior surgeries and approximate dates performed)

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Hospitalization History:

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### **Social/Cultural History:**

Smoking/Tobacco use: Current: \_\_\_\_\_ Past: \_\_\_\_\_ Never: \_\_\_\_\_

Alcohol use: Current: \_\_\_\_\_ Past: \_\_\_\_\_ Never: \_\_\_\_\_

Current occupation: \_\_\_\_\_

Marital Status \_\_\_\_\_

**Women:** How many pregnancies/living children \_\_\_\_\_

**Men:** How many children \_\_\_\_\_