Family Health Care

Pediatrics Alternative Healthcare Adult Care

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DATE:_____

REASON FOR BEING SEEN:_____

PATIENT NAME:_____

MAILING ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

HOME #:_____ CELL #:_____ DOB:_____

SS#:_____ SEX: F ☐ M ☐ MARITAL STATUS:_____

DRUG ALLERGIES:_____

MEDICATIONS:_____

_____

EMAIL:_____ PHARMACY:_____

EMERGENCY CONTACT:_____PHONE:_____ RELATION:_____

PERSON(s) WE MAY SPEAK WITH REGARDING YOUR CARE OR BILLS:_____

How did you hear about us? (Please circle all that apply)

Newspaper	Radio	Family Member	Insurance	Building Sign	Friend
Mailer/Postcard	Yellowpages	Superpages	Red Book	Internet	Other:_____

COMMUNICATION: By providing us with your landline or cell phone number(s), you give express authorization to contact you at those numbers. This express authorization also applies to any landline or cell phone number(s) you may acquire in the future. Phone calls to you may be made utilizing automated dialer technology. Providing your phone number(s) is not a condition of receiving our services.

RELEASE OF MEDICAL RECORDS: I authorize the release of any medical/surgical information necessary for determining the extent of third-party coverage and for the processing an insurance claim on my behalf. I permit a copy of this authorization to be valid as the original. Additionally, I hereby authorize Family Health Care to release any or all medical records to other medical providers requesting such only when related to the coordination of my care.

CONSENT TO TREAT: I voluntarily consent to medical treatment and procedures that may be performed on me during this visit. This includes, but is not limited to, medical, therapy, or surgical care, x-rays, tests, medications, laboratory tests, or other services, which may be ordered by the physician participating in my care.

****As a courtesy, Family Health Care will bill my insurance carrier. I agree to pay all charges incurred that are not paid or covered by my insurance carrier within 30 days of visit.***

I, the undersigned, acknowledge that the information I have provided above is accurate to the best of my knowledge. I have read and understand the above mentioned policies. Also, I have been offered a copy and understand the Privacy Practice of Family Health Care as well as the Financial Policy Explanation & Patient Agreement of Family Health Care.

Patient, Responsible party, or Guarantor Signature:

X_____ **DATE:**_____

If person signing this document is not the patient being seen, please complete the following:

Print Name:_____

ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP:**_____

Patient History Form

Today's Date: _____

Patient Name: _____ DOB: _____

Please answer these questions to the best of your knowledge.
** If you have any questions, **please star (*)** it so we can address at your visit.

PAST MEDICAL HISTORY

1. Check off the following diagnoses that you have **now** or have had **in the past.**
2. Please **circle** the diagnosis if this is a **current** problem for you.
3. Indicate **when** (i.e. childhood) you were diagnosed and any **specifics** (eg type of cancer).

	Diagnosis:	Age/Details		Diagnosis:	Age/Details
☐	Chicken Pox		☐	Seizures	
☐	Measles		☐	Stroke	
☐	Mumps		☐	Blood clots in lung or leg	
☐	Rubella		☐	Abnormal bleeding	
☐	Scarlet Fever		☐	Anemia	
☐	Rheumatic Fever		☐	Thyroid disorder	
☐	COPD		☐	Hepatitis/liver disorder	
☐	Asthma		☐	Gall bladder problems	
☐	Allergies		☐	Reflux or ulcers	
☐	Eczema/skin rashes		☐	Colitis	
☐	Bronchitis		☐	Kidney disease	
☐	Pneumonia		☐	Rheumatoid arthritis	
☐	Tuberculosis		☐	Degenerative arthritis	
☐	Diabetes		☐	Gout	
☐	High blood pressure		☐	Glaucoma	
☐	High cholesterol		☐	Cancer:	
☐	Heart disease		☐	Parkinson's disease	
☐	Mitral valve prolapse		☐	Shingles	
☐	Heart murmur		☐	Prostate problems	
☐	Psychiatric disorders		☐	Chronic urinary infection	
☐	Depression/anxiety		☐	Irritable bowel syndrome	
☐	Migraine headaches		☐	Incontinence	

Other problems not listed:

_____

_____

2. SURGICAL HISTORY

	Procedure:	Date:
1.	_____	_____
2.	_____	_____
3.	_____	_____