FAMILY HEALTH CARE
Patient Information

Please complete *ENTIRE* page with current information. Filing your insurance claims is a courtesy that we offer you. Your insurance company requires us to update your information each time you are in, in order to file your claims. If you would rather pay in full for today's visit you need only complete the top half of this form. Thank You.

Patient's Name: _____ **SS#:** _____
First Name MI Last Name

Date of Birth: _____ □ Male □ Female □ Single □ Married □ Widowed □ Divorced

Address: _____
Street Address City State Zip Code

Phone Numbers: _____
Cell Phone Home Phone Work Phone

Patient's Employer: _____ Years w/ Firm: _____ Occupation: _____

Spouse's Name: _____ **SS#:** _____

Spouse's Date of Birth: _____ Employer: _____ Phone: _____

Responsible Party: _____ **Relationship:** □Self □Spouse □Parent □Other_____

Emergency Contact: Who may we contact in case of emergency? _____ Phone: _____

Nearest Relative Not Living With You: _____ Relationship: _____

Relatives Address: _____ Phone: _____
Street Address City State Zip Code

Closest Friend: _____Phone: _____ Address: _____
Street Address City State Zip Code

Referred By: _____

If Patient is a Minor, are parents □Married □ Divorced Custodial Parent: _____

Father's Name: _____ Employer: _____ Phone: _____

Father's SS#: _____ Occupation: _____

Mother's Name: _____ Employer: _____ Phone: _____

Mother's SS#: _____ Occupation: _____

INSURANCE INFORMATION

Please notify the front desk immediately if this is a Worker's Compensation claim.

Primary Insurance: _____ Phone Number: _____

Insured Party's Name: _____ Date of Birth: _____

Policy #: _____ Group #: _____ Relationship to Patient: _____

Secondary Insurance: _____ Phone Number: _____

Insured Party's Name: _____ Date of Birth: _____

Policy #: _____ Group #: _____ Relationship to Patient: _____

Does your Insurance Company Require Referrals: □ Yes □ No

Does your Insurance Company require Prior Authorizations for surgery, admissions, tests, etc? □ Yes □ No

Please read & sign below:

I hereby authorize the providers of Family Health Care to furnish my insurance company all information requested. I hereby assign to Family Health Care all money to which I am entitled for medical expenses relating to the services provided. I release the providers and Family Health Care from all legal responsibility or liability that may arise from this authorization.

I willingly consent to the care I receive from the providers at Family Health Care.

I understand that any credit balance on my account will remain unless specifically requested in writing.

I further understand that interest will be assessed at the rate of 1.5% per month (18% per annum) on all balances carried beyond 90 days.

I hereby authorize Family Health Care to charge any balances over 90 days to my □Visa □ MasterCard

Account Number: _____ Exp. Date: _____ Security Code: _____

Signature: _____ Date: _____

FAMILY HEALTH CARE
a balanced approach to family health and well being

Name: _____ Date of Birth: _____ Age: _____ Date: _____

Occupation: _____ PT/FT Marital Status: _____ Number & Age of Children: _____

Chief Concern for Today's Visit: _____

ONGOING HEALTH CONCERNS (Include all you take medication for.)

	Yes	No	Medication		Yes	No	Medication
Diabetes	☐	☐		Cancer	☐	☐	
Heart Disease	☐	☐		High BP	☐	☐	
Stroke	☐	☐		Kidney Disease	☐	☐	
Asthma	☐	☐		Emphysema	☐	☐	
Other	☐	☐		Please Describe:			

ALLERGIES

SURGERIES/HOSPITALIZATIONS (and dates):

HABITS

Alcoholic Drinks/Week: _____ Coffee/Caffeine/Day: _____ Water/Day: _____
Exercise Routine: _____ Hours Sleep/Night: _____ Mg Calcium/Day: _____
Tobacco Products/Day: _____ Interested in Stopping: _____ BM/Day: _____

MEDICATIONS (Please Include vitamins, supplements & over-the-counter products.)

Name	Dose	Frequency	Name	Dose	Frequency

HEALTH MAINTENANCE HISTORY

	Date	Normal	Abnormal		Date	Normal	Abnormal
Last Complete Physical		☐	☐	Last Bone Density Study		☐	☐
Last Blood Work		☐	☐	Last Colonoscopy		☐	☐
Last Cholesterol Check		☐	☐	Last Flu Vaccine		☐	☐
Last Pap Smear		☐	☐	Last Tetanus Injection		☐	☐
Last Mammogram		☐	☐	Other:		☐	☐

HISTORY

Constitutional	Currently	In the past	No
Weight Stable	☐	☐	☐
Fatigue	☐	☐	☐
Hair Loss	☐	☐	☐
Appetite Changes	☐	☐	☐
Memory Changes	☐	☐	☐
Sleeping Problems	☐	☐	☐
Eyes			
Vision Changes	☐	☐	☐
Eye Infections	☐	☐	☐
Eye Pain	☐	☐	☐
Ear/Nose/Throat			
Ear Infections	☐	☐	☐
Nose Bleeds	☐	☐	☐
Hearing Problems	☐	☐	☐
Ear Pain	☐	☐	☐
Ringing in Ears	☐	☐	☐
Sore Throat	☐	☐	☐
Swallowing Problems	☐	☐	☐

Cardiovascular	Currently	In the past	No
Chest Pain	☐	☐	☐
Murmur	☐	☐	☐
Palpitations	☐	☐	☐
Swelling in Legs	☐	☐	☐
Respiratory			
Short of Breath	☐	☐	☐
Cough	☐	☐	☐
Wheezing	☐	☐	☐
GI			
Abdominal Pain	☐	☐	☐
BM Habit Changes	☐	☐	☐
Constipation	☐	☐	☐
Hemorrhoids	☐	☐	☐
Heartburn	☐	☐	☐
Hepatitis	☐	☐	☐
Diarrhea	☐	☐	☐

GU	Currently	In the past	No
Urinary Leaking	☐	☐	☐
Decrease force/flow	☐	☐	☐
Vaginal Discharge	☐	☐	☐
Irregular Periods	☐	☐	☐
1st day of last period:		_____	
# days between periods:		_____	
# days of flow:		_____	
Number of Pregnancies:		_____	
Painful Intercourse	☐	☐	☐
Testicular Pain	☐	☐	☐
Breasts			
Lumps of Concern	☐	☐	☐
Tenderness	☐	☐	☐
Skin			
Rashes	☐	☐	☐
Psoriasis	☐	☐	☐
Eczema	☐	☐	☐
Acne	☐	☐	☐

HISTORY (cont.)

Musculoskeletal	Currently	In the past	No
Joint Pain	☐	☐	☐
Arthritis	☐	☐	☐
Recurrent Back Pain	☐	☐	☐
Foot Pain	☐	☐	☐
Gout	☐	☐	☐
Osteoporosis	☐	☐	☐
Muscle Weakness	☐	☐	☐

Neurologic	Currently	In the past	No
Fainting	☐	☐	☐
Frequent Headaches	☐	☐	☐
Seizures	☐	☐	☐
Tremors	☐	☐	☐
Numbness/tingling	☐	☐	☐
Endocrine	☐	☐	☐
Diabetes			
Thyroid Problems	☐	☐	☐

Hematologic/Lymphatic	Currently	In the past	No
Anemia	☐	☐	☐
Enlarged Lymph Nodes	☐	☐	☐
Psychiatric			
Mental Illness	☐	☐	☐
Depression	☐	☐	☐
Anxiety	☐	☐	☐
Allergies			
Hay Fever	☐	☐	☐
Immune Problems	☐	☐	☐

FAMILY HISTORY

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
Alcoholism	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
High BP	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Thyroid Disorder	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐

ADDITIONAL PROVIDERS

Provider Name	Specialty/What they treat you for	Date of Last Visit	Phone Number
______________________	____________________________	________________	______________
______________________	____________________________	________________	______________
______________________	____________________________	________________	______________
______________________	____________________________	________________	______________
______________________	____________________________	________________	______________

FOR OFFICE USE ONLY

Date/Initial____________	Date/Initial____________	Date/Initial____________	Date/Initial____________
Date/Initial____________	Date/Initial____________	Date/Initial____________	Date/Initial____________
Date/Initial____________	Date/Initial____________	Date/Initial____________	Date/Initial____________
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Date/Initial____________	Date/Initial____________	Date/Initial____________	Date/Initial____________
Date/Initial____________	Date/Initial____________	Date/Initial____________	Date/Initial____________

Disclosure Form

Your Name: _____ Date of Birth: _____
Please print

Of the persons living in your household or with whom you are associated, to whom may Family Health Care employees disclose your health information (such as appointment times, lab results, test results, or financial matters) if you are not available?

1. Please PRINT their name _____ Relationship to you _____

2. Please PRINT their name _____ Relationship to you _____

3. Please PRINT their name _____ Relationship to you _____

4. Please PRINT their name _____ Relationship to you _____

How would you prefer we contact you?

- ❑ Home Phone # _____
- ❑ Work Phone # _____
- ❑ Telephone only
- ❑ Telephone or mail (envelope with our return address)
- ❑ Mail only (envelope with our return address)

  Address _____

  _____

- ❑ E-mail Address _____

Signature _____ Date _____

Please date and initial in this column if the information on this form is correct.
Date: _____ Initial: _____
Date: _____ Initial: _____
Date: _____ Initial: _____
Date: _____ Initial: _____
Date: _____ Initial: _____
Date: _____ Initial: _____
Date: _____ Initial: _____
Date: _____ Initial: _____
Date: _____ Initial: _____
Date: _____ Initial: _____