

NALLY FAMILY PRACTICE

Welcome. Why choose Nally Family Practice?

We would like to be your nearby Surprise, Arizona family physician office. Our office is made up of two practitioners: Dr. Adam Nally and physician assistant, Brant Morrow PA-C. They work closely together to provide the best care for you and your family.

We are proud to inform you that our practice now offers the opportunity to use the power of the web to track the most important aspects of your healthcare through our office. The Patient Portal enables our patients to communicate with our doctors, nurses, and staff members easily, safely, and securely *via* the Internet.

Participating patients are given secure User IDs and passwords, enabling them to access the Portal to view their personal and private documents, including lab and diagnostic test results, educational information, billing statements, and other health information.

Through the Patient Portal, you are able to:

- ask questions of doctors, nurses, and staff members
- request prescription refills and referrals
- set up appointments
- view your personal health record
- examine your current and past statements

You must fill out all of the enclosed forms completely prior to your first appointment. Incomplete paperwork will cause your visit to be rescheduled. As a patient of our practice it will be **required** for you to provide your SSN for identification purposes and prescriptions, please talk to our office staff with any questions or concerns. Completed packet should be returned at least 24 hours prior to your appointment. Packets can be dropped off in the office or emailed to shery@nallyfamilypractice.com. Please check that you have received, filled out, and signed these forms included in this packet:

- | | |
|--|---|
| <input type="checkbox"/> Demographics form page 2 | <input type="checkbox"/> ERISA Authorization page 5 |
| <input type="checkbox"/> Insurance form page 3 | <input type="checkbox"/> ABN (Advanced Beneficiary Notice) page 5 |
| <input type="checkbox"/> Disclosure of health page 4 | <input type="checkbox"/> Explanation of Physical page 6 |
| <input type="checkbox"/> Email Authorization page 4 | <input type="checkbox"/> Health History assessmentpages 8-10 |

Print Name: _____ Date: _____



NALLY FAMILY PRACTICE

Patient: _____ D.O.B: _____

Demographics

Please Complete prior to your first office visit, so we can better assist you with your health during that visit.
Please print all written information.

Patient Information

First: _____ MI: _____ Last: _____ Suffix: _____ Sex: Female Male

Preferred name: _____ DOB: _____ Age: _____ SSN: _____

Marital Status: Married Divorced Single Widowed Primary Language: English Spanish Other: _____

Ethnicity: Caucasian Black Hispanic Asian Other: _____

Primary Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Primary Telephone: _____ Leave VM? Yes No Secondary Telephone: _____

Occupation: _____ Employer: _____ Employer phone: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Preferred Pharmacy (name & cross streets) _____

E-mail: _____

**E-mail authorization is a separate form that specifies what we can send you, for example: electronic statements, forms to update your chart, and login information about your portal account.*

Family Information

Spouse's name: _____ Telephone: _____ Leave VM? Yes No

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____ Employer phone: _____

Number of Child 1: _____ Child 2: _____ Child 3: _____

children: _____ Child 4: _____ Child 5: _____ Child 6: _____

Other children: _____

Are your children covered under your insurance Policy? Yes No Spouse's? Yes No

Emergency Contacts

Name: _____ Relationship: _____ Phone: _____

Primary Address: _____ City: _____ State: _____ Zip: _____

Name: _____ Relationship: _____ Phone: _____

Primary Address: _____ City: _____ State: _____ Zip: _____

Name: _____ Relationship: _____ Phone: _____

Primary Address: _____ City: _____ State: _____ Zip: _____



NALLY FAMILY PRACTICE

Patient: _____ D.O.B: _____

Insurance information

Please Complete prior to your first office visit, so we can better assist you with your health during that visit.
*Please make sure to inform the office whenever any of your insurances change.

Primary Insurance

Insurance Name: _____ Effective Date start: _____ End: _____
ID-Policy-Subscriber Number: _____ Group Number: _____
Insurance Address to submit Claims: _____
City: _____ State: _____ Zip Code: _____
Policy Holder's Full Name: _____ *Same as on insurance Card*
Policy Holder's SSN: _____ Policy Holder's Date of Birth: _____
Relationship to patient: Self Other: _____
Employer of Policy Holder: _____ Telephone: _____

Secondary Insurance

Insurance Name: _____ Effective Date start: _____ End: _____
ID-Policy-Subscriber Number: _____ Group Number: _____
Insurance Address to submit Claims: _____
City: _____ State: _____ Zip Code: _____
Policy Holder's Full Name: _____ *Same as on insurance Card*
Policy Holder's SSN: _____ Policy Holder's Date of Birth: _____
Relationship to patient: Self Other: _____
Employer of Policy Holder: _____ Telephone: _____

Tertiary Insurance

Insurance Name: _____ Effective Date start: _____ End: _____
ID-Policy-Subscriber Number: _____ Group Number: _____
Insurance Address to submit Claims: _____
City: _____ State: _____ Zip Code: _____
Policy Holder's Full Name: _____ *Same as on insurance Card*
Policy Holder's SSN: _____ Policy Holder's Date of Birth: _____
Relationship to patient: Self Other: _____
Employer of Policy Holder: _____ Telephone: _____

(The above information must be filled out completely or patient will be considered a cash pay and be billed for services rendered)

I _____ hereby authorize Adam S. Nally, DO. Office to release any information acquired in the course of my examination or treatment to the referring physician or insurance carriers listed above.

Signature: _____ Date: _____



NALLY FAMILY PRACTICE

Patient: _____ D.O.B.: _____

Disclosure of Health Information to Family, Friends or Others

The HIPAA Privacy Rule prohibits the disclosure of Protected Health Information (PHI) without the authorization of the patient. Examples of PHI would be test results, medication information, payment information, or anything considered patient condition, treatment, or payment related. Please choose one of the following disclosure options:

- No, do not** allow disclosure of my PHI to anyone, including family members, other relatives, close personal friends, etc.
- Yes, please allow** disclosure of my PHI (including detailed messages by phone, fax, e-mail, voice mail, or any other means) to my contact info and to the following person(s):

Full Name: _____

Relationship: _____ Phone#: _____

Full Name: _____

Relationship: _____ Phone#: _____

Full Name: _____

Relationship: _____ Phone#: _____

Signature: _____ Date: _____

I understand my HIPAA rights and I request that this office leave messages, including those containing PHI, to my personal contact information or with the above-named persons. I understand that it is my responsibility to keep the office informed of any changes to this information and agree to hold the office harmless if my PHI is disclosed due to my failure to notify the office of changes or updates.

E-mail Authorization

Our office offers a patient portal for electronic access to your laboratory, radiological or other diagnostic data.

The portal allows for secure communication with providers and office staff, and access to your complete medical record, including labs, imaging, and billing statements.

Our office also offers an E-statement option. You have the choice of receiving your billing statements via e-mail, regular mail, or both. It is a secure 256 bit encryption and SSL protected way to receive your statements.

By checking yes and signing this form, you are giving Nally Family Practice (Adam S. Nally, D.O., P.C.) permission to send protected health information for your review to the e-mail address below. It is your responsibility to ensure that the address below is secure and protected. It is also your responsibility to immediately notify our office when changes to your e-mail address occur. It is our intent to help you receive information about your medical care in a more efficient manner.

Electronic Diagnostic Results

- Yes – I would like to receive my results via e-mail
- No – I do not want my results via e-mail

Electronic Billing Statements

- Yes – I would like to receive e-statements.
- Yes – I would like to receive both mailed and electronic statements.
- No – I do not want my billing statements via e-mail

Patient Full Name: _____

E-mail Address (please print): _____

Signature: _____ Date: _____

We do not create individual profiles with the information you provide. If information is collected, it will be used solely in connection with Nally Family Practice. We do not give, sell, or transfer any personal information to a third party. All information is securely stored with 256-bit encryption and SSL protection.

NALLY FAMILY PRACTICE

Patient: _____ D.O.B.: _____

ERISA Authorization (This allows us to bill your insurance)

For good and valuable consideration, I _____, do hereby designate, authorize, and convey to Dr. Adam S. Nally, D.O. to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan:

- a) the right and ability to act on my behalf in connection with any claim, right or chose in action that I may have under such insurance policy and/or any employee Health care benefit plan; and
- b) The right and ability to act on my behalf to pursue such claim, right or choice in action in connection with said insurance policy and/or employee health care benefit plan (including but not limited to, the right to act in my behalf in respect to an employee health care benefit plan governed by the provisions of the Employee Retirement Income Security Act of 1974 as provided in 29 CFR §2560.503-1(b)(4)) with respect to any medical or other health care expense incurred as a result of the service I received from the above-named doctor and, to the extent permissible under law, to claim on my behalf, such medical or other health care service benefits, insurance or health care benefit plan reimbursement and any other applicable remedy.

I acknowledge full responsibility for all charges incurred, regardless of possible insurance coverage. I hereby authorize the office of Adam S. Nally, D.O. to obtain, on my behalf, any insurance information covered by "The Privacy Act" from my insurance company(s) files. I further agree to abide by all provisions of the office financial policy. A copy of the office financial policy is available upon request. I authorize payment of medical benefits to the provider for services of these insurance companies listed on Insurance Information form.

Signature: _____ Date: _____

NOTICE OF COVERAGE –

This notice is to inform you that periodically your doctor may order testing or perform an examination that is not a covered item or service under your insurance plan. Your insurance only pays for covered items and services when certain rules are met. The fact that your insurance may not pay for a particular item or service does not mean that you should not receive it. There are legitimate reasons your doctor may recommend particular items or services that are not covered. It is ultimately your responsibility, as the insured, to know what your individual insurance plan will and will not cover. By signing this form, you are agreeing to pay for services rendered that are not covered by your insurance company.

Any patient requesting to schedule a preventive service such as a physical that wishes to discuss any other health problems with the doctor needs to ask their insurance carrier if they bundle a problem-oriented visit with preventive service. It is our recommendation to schedule the problem-oriented visit first and the preventive service another day. If you choose to discuss any acute issue during a preventative visit, you may have a financial responsibility.

Please contact your insurance company to verify coverage. Our office does not verify your insurance coverage and we do not know what your insurance policy covers. Coverage is determined by your insurance company once the claim is filed.

Most insurances do not cover the following services: complete physical, preventative or screening EKG, hepatitis A injection, tetanus vaccine, TDap vaccine, and dietary counseling. You may be presented with an Advanced Beneficiary Notice (ABN) if you request a service or procedure that is not covered by your insurance. You have the right to refuse or delay service if you would like to check on insurance coverage.

Any labs or imaging performed in our office will be billed by the relevant third-party company and any billing issues would need to be addressed with that company.

By signing this form, I understand that my insurance may not cover the above items or services and that I may have to pay the bill while my insurance makes its decision. If my insurance does pay, I will be refunded any payment that is due to me. If my insurance denies payment, I agree to personal and full responsibility for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand that I can appeal my insurance's decision.

Refusal to sign this form is grounds for refusal of service and will result in discharge from our practice.

Signature: _____ Date: _____



NALLY FAMILY PRACTICE

Patient: _____ D.O.B: _____

Explanation of Physical Exam versus Problem Focused Visit

Terms you should know when scheduling your appointment:

- Physical (Complete physical)
- IPPE (Welcome to Medicare physical)
- AWV (Annual wellness visit) for those 65 and older

We want you to receive wellness care – health care that may lower your risk of illness or injury. Most commercial plans cover wellness care. For those that qualify for Medicare or Medicare advantage insurance plans, it is important to note that your plan pays for some wellness care, but it does not pay for all the wellness care you might need. We want you to know about your Medical benefits and how we can help you get the most from them.

The term “physical” is often used to describe wellness care. But Medicare and Medicare advantage plans do not pay for a traditional, head-to-toe physical. Some secondary and tertiary payers will cover the cost of your “physical”, so it is important for you to contact your insurance providers and know your coverage benefits prior to your visit. Medicare does pay for a wellness visit once a year to identify health risks and help you to reduce them. At your wellness visit, our health care team will take a complete health history and provide several other services:

- Screenings to detect depression, risk for falling and other problems,
- A limited physical exam to check your blood pressure, weight, vision and other things depending on your age, gender and level of activity,
- Recommendations for other wellness services and healthy lifestyle changes.

Before your appointment and during, our staff will ask you some questions about your health and may ask you to fill out a form. A physical, IPPE, and AWV **DOES NOT** include addressing specific new or existing health problems or refilling medication. That would be a separate service and may require a longer appointment.

Please let our scheduling staff know if you need the doctor's help with a health problem, a refill or something else. A separate charge applies to these services, whether provided on the same date or a different date than the physical, IPPE, or Annual Wellness Visit.

We hope to help you get the most from your wellness benefits. Please contact us with any questions.

Sincerely,

Nally Family Practice

Office Financial Policy

- ✓ Any outstanding balance of \$30 or more will go to pre-collections 30 days after the due date on the statement. If an account is sent to pre-collections, a fee of up to \$20 will be applied.
- ✓ Any patient account that goes to final collections will be subject to a \$45 fee.
- ✓ Any declined financial transaction (returned check, rejected electronic draft, etc.) will be subject to a \$45 fee.
- ✓ Patient accounts that are sent to final collections or file bankruptcy will be discharged from our practice.
- ✓ Patients with large outstanding balances may need to make payment arrangements or pay in full before being seen. Seeing patients with large outstanding balances is at the discretion of the medical provider.
- ✓ Copays are the responsibility of the patient. Any questions about copays should be directed to the patient's insurance company.
- ✓ Patients with large deductible plans, no insurance (self-pay), or out-of-network plans will be required to pay at time of service.

I acknowledge my understanding and acceptance of this policy and agree to abide by all terms of this office financial policy.

Name _____ Date _____

This financial policy is available to all patients by request.

February 7, 2018



NALLY FAMILY PRACTICE

Patient: _____ D.O.B: _____

Health History

Please Check those conditions you have been diagnosed with and write any that are not listed below.

Vision: Cataracts Glaucoma Macular Degeneration

Hearing: Hearing loss Dizziness Vertigo
 Tinnitus (ringing in ears)

Allergies : (Environmental) Chronic (sinus infection) Allergic rhinitis (runny nose)

Lungs: Asthma Emphysema Valley fever COPD
 Pulmonary Embolism

Cardiovascular: Hypertension (Elevated blood Pressure) Dyslipidemia (High cholesterol)
 Myocardial Infarction (Heart Attack) Dysrhythmia (Abnormal heart rhythm)
 Atrial fibrillation Heart murmur
 CHF (heart Failure) CAD (heart disease)

Vascular Disease: Use of Anti-Coagulant (Blood thinner daily) DVT (blood clot in extremity)
 Hemophilia (bleeding Disorder) Coagulopathy (clotting disorder)
 CVA (Stroke) TIA (mini-stroke) Peripheral Vascular Disease (PVD)

Endocrine: Hashimoto's disease Graves' disease Anemia Thyroid cancer
 Hyperthyroidism Hypothyroidism CKD (chronic kidney Disease)
 Iron deficiency Vitamin D deficiency Vitamin B12 deficiency
 Diabetes Mellitus (DM) *Type I* (insulin use) Diabetes Mellitus (DM) *Type II*

Cancer: Previous Type: Current Type:

Neurologic: Encephalopathy: Neuropathy:
 Concussion/head trauma (date): Sciatica Location:
 Parkinson's disease Tremor Alzheimer's disease Neuritis
 Seizure disorder

Rheumatologic: Rheumatoid arthritis Osteopenia Herniated Disk Lupus
 Fibromyalgia Osteoporosis Chronic Fatigue syndrome
 Connective tissue disorder
 Osteoarthritis: Spine Hips Knees Ankles/Feet Shoulders Hands
 Chronic back problems: Neck Mid-Back Low-Back

Gastrointestinal Hemorrhoids Hiatal hernia Diverticulosis
 GERD (acid reflux) Diverticulitis PUD (Peptic Ulcer Disease)
 Cholecystitis (Gallstones/Gall bladder)
 Irritable or Inflammatory bowel disease (IBS, Crohn's Disease, Colitis)

Genitourinary: Overactive bladder Kidney stones Recurrent UTI
 Incontinence: Stress or Urge Chronic Hematuria (blood in urine)
 Sexually Transmitted Disease (STD): Herpes Gonorrhea Trichomonas HPV

Male: Erectile dysfunction Prostate Cancer BPH (prostate enlargement)

Female: Uterine fibroid Ovarian Cysts Abnormal menses
 Fibrocystic breast disease

Skin: Psoriasis Eczema Fungal skin infection
 Actinic Keratosis (pre-cancers)

Psychiatric: Depression Anxiety Mood disorder Alcoholism
 Drug abuse

Previous Fractures: _____

Other: _____

§ NALLY FAMILY PRACTICE

Patient: _____ D.O.B: _____

Health History: Surgical History
Please check all that apply and year done (approximate) and write in any that are not listed below.

| | | | | |
|--------------------------------------|--|---|---|--|
| ENT: | <input type="checkbox"/> Cataract | <input type="checkbox"/> Retina | <input type="checkbox"/> Sinus surgery | <input type="checkbox"/> Tonsillectomy |
| GI: | <input type="checkbox"/> Colostomy | <input type="checkbox"/> Bowel surgery | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Laparoscopy |
| | <input type="checkbox"/> Cholecystectomy (Gall bladder) | | <input type="checkbox"/> Hernia Repair: <input type="checkbox"/> L <input type="checkbox"/> R (location): | |
| Cardio: | <input type="checkbox"/> CABG (heart bypass) | <input type="checkbox"/> Heart transplant | <input type="checkbox"/> PTCA (Cardiac Stent) | <input type="checkbox"/> Valve replacement |
| | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Cardiac Ablation | | |
| GU: | <input type="checkbox"/> C-section#: _____ | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Bladder surgery | |
| | L R | | L R | |
| Extremities: | <input type="checkbox"/> <input type="checkbox"/> TKA (Total Knee Replacement) | | <input type="checkbox"/> <input type="checkbox"/> THA (Total Hip Replacement) | |
| | <input type="checkbox"/> <input type="checkbox"/> Shoulder Surgery | | <input type="checkbox"/> <input type="checkbox"/> Joint Arthroscopy (location): | |
| Pregnancy/ Menstrual History: | #Pregnancies: _____ | #Birth(s): _____ | #Still birth(s): _____ | #Miscarriage(s): _____ |
| | #Elective abortion(s): _____ | | Abnormal PAP History: <input type="checkbox"/> yes <input type="checkbox"/> no | |
| | Menstruation regularity: <input type="checkbox"/> Monthly <input type="checkbox"/> Irregular <input type="checkbox"/> Menopausal | | | |
| | Date of last menstrual period: _____ | | Date of last PAP: _____ | |
| | Date of last Mammogram: _____ | | Date of last DEXA (bone density) Scan: _____ | |
| Other screening exams: | (year) EKG: _____ | EGD: _____ | Chest X-ray (CXR): _____ | Colonoscopy: _____ |

Drug allergies/ intolerances
Please list all medications that you have had an allergy to or side effects from plus the type of reaction.

Medications/vitamins/supplements *Please list all medications including herbal products and supplements.*

| Medication & Strength | i.e. Lisinopril 10mg | Dosing | i.e. 1 tablet/capsule | Frequency | i.e. once a day |
|-----------------------|----------------------|--------|-----------------------|-----------|-----------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

IMMUNIZATIONS *Please give the last date of the immunizations below.*

Hepatitis A: _____ Hepatitis B: _____ Pneumonia: _____ Typhoid: _____
 Yellow Fever: _____ Small Pox: _____ Tetanus: _____ Influenza: _____
 TB Skin Test: _____ Positive Negative

Family History
Please check for which side (Maternal, Paternal) all those that apply and write in any that are not listed.

| | | | |
|--------------------------|--|--|---|
| YOUR father: | <input type="checkbox"/> Adopted / <input type="checkbox"/> Unknown | YOUR mother: | <input type="checkbox"/> Adopted / <input type="checkbox"/> Unknown |
| | M P | | M P |
| Cardiovascular | <input type="checkbox"/> <input type="checkbox"/> Hypertension (Elevated blood pressure) | <input type="checkbox"/> <input type="checkbox"/> Atrial fibrillation | |
| | <input type="checkbox"/> <input type="checkbox"/> Dyslipidemia (High cholesterol) | <input type="checkbox"/> <input type="checkbox"/> Heart murmur | |
| | <input type="checkbox"/> <input type="checkbox"/> Myocardial Infarction (Heart Attack) | <input type="checkbox"/> <input type="checkbox"/> CAD (Heart disease) | |
| | <input type="checkbox"/> <input type="checkbox"/> Dysrhythmia (Abnormal heart rhythm) | <input type="checkbox"/> <input type="checkbox"/> CHF (heart failure) | |
| Lungs: | <input type="checkbox"/> <input type="checkbox"/> Pulmonary embolism | <input type="checkbox"/> <input type="checkbox"/> Emphysema | |
| | <input type="checkbox"/> <input type="checkbox"/> COPD | <input type="checkbox"/> <input type="checkbox"/> Asthma | |
| | <input type="checkbox"/> <input type="checkbox"/> Valley Fever | <input type="checkbox"/> <input type="checkbox"/> Other: | |
| Vascular disease: | <input type="checkbox"/> <input type="checkbox"/> DVT (blood clot in extremity) | <input type="checkbox"/> <input type="checkbox"/> Hemophilia (bleeding Disorder) | |
| | <input type="checkbox"/> <input type="checkbox"/> CVA (Stroke) | <input type="checkbox"/> <input type="checkbox"/> Coagulopathy (clotting disorder) | |
| | <input type="checkbox"/> <input type="checkbox"/> Peripheral Vascular Disease (PVD) | <input type="checkbox"/> <input type="checkbox"/> other: | |

§ NALLY FAMILY PRACTICE

Patient: _____ D.O.B: _____

Health History: Family History continued

Please check for which side (Maternal, Paternal) all those that apply and write in any that are not listed.

| | MP | M P |
|-------------------------|---|--|
| Neurologic: | <input type="checkbox"/> Encephalopathy: _____ <input type="checkbox"/> Sciatica Location: _____ <input type="checkbox"/> Neuropathy: _____ <input type="checkbox"/> Neuritis: _____ | <input type="checkbox"/> Alzheimer's disease <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Tremor <input type="checkbox"/> Parkinson's disease |
| Endocrine: | <input type="checkbox"/> Hashimoto's Disease <input type="checkbox"/> Thyroid cancer <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> CKD (chronic kidney Disease) <input type="checkbox"/> Iron deficiency <input type="checkbox"/> Diabetes Mellitus(DM); <i>Type I</i> (insulin use) | <input type="checkbox"/> Graves' disease <input type="checkbox"/> Anemia <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Vitamin B12 deficiency <input type="checkbox"/> Vitamin D deficiency <input type="checkbox"/> Diabetes Mellitus(DM); <i>Type II</i> |
| Gastrointestinal | <input type="checkbox"/> GERD (acid reflux) <input type="checkbox"/> Hiatal hernia <input type="checkbox"/> Irritable or Inflammatory bowel disease (IBS, Crohn's Disease, Colitis) | <input type="checkbox"/> Cholecystitis (Gallstones/Gall bladder) <input type="checkbox"/> PUD (Peptic Ulcer Disease) |
| Rheumatologic | <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Osteopenia <input type="checkbox"/> Herniated Disk <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Connective tissue disorder | <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Chronic Fatigue syndrome <input type="checkbox"/> Other: _____ |
| Psychiatric: | <input type="checkbox"/> Depression <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anxiety Mood disorder |
| Cancer: | <input type="checkbox"/> Colon <input type="checkbox"/> Prostate <input type="checkbox"/> Leukemia <input type="checkbox"/> Gastric | <input type="checkbox"/> Pancreatic <input type="checkbox"/> Bone <input type="checkbox"/> Lung <input type="checkbox"/> Other: _____ |

YOUR Siblings: _____ Paternal family: _____ Maternal Family: _____

Social history

Circle or check all those that apply.

Marital Status: Single Married Divorced Remarried Widowed
 Who do you live with? _____ Number of Children: _____
 Occupation: _____ Religious Preference: _____
 Sexual Activity: Inactive Active-Single Partner Active-Multiple partners Active-Same gender partner
 Tobacco Use: Never Quit (year____) Current:(Cigarette Cigar Chew)Packs per day:____ for____ years
 Alcohol Use: None Number of beers/ glasses of wine #____, per day / week/ month: _____
 Illicit Drug Use: Never Quit Current:(Marijuana Methamphetamines Cocaine Heroin Ecstasy)

Advanced directives

If you have any of the below documents, please bring a copy in for your medical record.

Do you have an Advanced Medical Directive? Yes No Do you have a Living Will? Yes No

Do you have a medical Power of Attorney? Yes No

What are we seeing you for today? _____

What are your main symptoms? _____

Please list any other concerns: _____

How did you find us? _____

Thank you and Welcome to the practice.