FIRST TEAM MEDICAL CLINICS LLC
1654 MARDON DR
BEAVERCREEK, OHIO 45432
Patient Information

Date: ______________Patient Name_____________________ Account Number: ______________
SS #_____________DOB________ □ Male □ Female _____________ Home phone_________
E-Mail ________________________________ Cell Phone _______________________
Check appropriate Box: □Minor □Single □Married □Divorced □Widowed □Separated
Patient's or parent/guardian's employer _______________Work phone _____________________________
Address ______________________________City ____________________ State____ Zip____________
Business Address __________________________________ City _______________ State _____ Zip ______
Spouse or parent/guardian's name____________________________
Employer______________________________ Work phone__________________________
Business Address________________________________ City____________________State_____Zip____
If Patient is a student, name of school/college ______________________City______________ State_____
Whom may we thank for referring you? ____
Person to contact in case of an emergency_______________________Phone________________________
Home email _______________________________ Work Email ___________________________________

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.
Which email address would you like us to use to communicate with you? *(check one)* q Home q Work

Contact Method *(check one)* q Primary Phone q Secondary Phone q Mobile Phone q Home Email

Verification Question *(choose only one question by circling the question, then give the answer to that question)*
q What is the name of your favorite pet? q In what city were you born? q What high school did you attend?
q What is your favorite movie? q What is your mother's maiden name? q On what street did you grow up? q What was the make of your first car? q When is your anniversary?

Verification Answer to the Chosen question:
Answers must be at least 6 characters: ____________________________________

List any known allergies you have had to any medications.
If no allergies are known, check here: q

1) ____3) ____

2) ____4) ____

Race *(check one)*
q White q Black/African American q Hispanic q American Indian/Alaskan Native q Asian q Asian Indian q Chinese q Filipino q Japanese q Korean q Vietnamese q Native Hawaiian or other Pacific Island

qSamoan q Guamanian or Chamorro qOther q I choose not to specify

Multi-Racial *(check one)* qYes qNo q Unknown

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

____ ________________________________

Parent or Guardian Date

Responsible Party

Name of The Person responsible for this account _____________Relationship to Patient _____________

Address ____ Home Phone _____________________

E-Mail ____ Cell Phone ________________________

Driver's License # _______________________Date of Birth: _________________________

Employer _______________________________________Work Phone___________________________

Is the person currently a patient at our office? □ Yes □ No

Do you have any additional insurance? □ Yes □ No if yes, complete the following:

Name of the Insured____

Relationship to patient___________________________

Birth date: _____________________ SS#______________________________

Date employed_________________________________

Name of Employer _____________________________________ Work Phone ______________________

Address of Employer____ State ____________

Zip/P.C____________________________

Insurance Company____________ Group #________ Union or local # _______________

Ins. Co. Address ___________________________City _________________ State _________

Zip___________

How much is your deductible? _________________ how much have you used? _________________

Health History

Patient Name: ____________________________DOB: __________________Date:____________

Chief Complaint:

____

History of Present illness:

Location: ____ (Where is the pain/problem?)

Quality: _________________________ (Example: normal vs abnormal color, activity, etc..)

Severity: _______________________ (How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?)

Duration: ________________________________ (How long have you had this pain/ problem? When did it start?)

Timing: _________________________ (Does the pain/problem occur at a specific time?)

Context: ____ (Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms __________________ _____ **Modifying Factors ____________________**
____

(What other associated problems have you been having?)(What makes the pain/problem worse or better? Have you had previous episodes?)

Past Medical History

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

Low Blood Pressure…….NO YES High Blood Pressure……NO YES
Measles…………NO YES Anemia…………………..NO YES Back Trouble……………….NO YES
Hepatitis……….NO YES Mumps…………… NO YES Bladder Infection…….NO YES
Kidney Disease… NO YES Ulcer………………………NO YES Chicken Pox……… NO YES
Whooping Cough… NO YES Migraine Headaches. NO YES Hemorrhoids……………NO YES
Thyroid Disease…..NO YES Epilepsy……………………NO YES Bleeding Tendency…….NO YES
Scarlet Fever………. NO YES Tuberculosis……………..NO YES Diabetes…………………..NO YES
Diphtheria…………… NO YES Asthma…………………NO YES Small pox……………. NO YES
Cancer……………………….NO YES Hives of Eczema…………..NO YES
Pneumonia…………. NO YES Polio…………………………NO YES AIDS & HIV……………………NO YES
Rheumatic Fever… NO YES Glaucoma…………………NO YES Infectious Mono……………NO YES
Arthritis………………. NO YES Hernia………………………NO YES Bronchitis……………………..NO YES
Venereal Disease… NO YES Mitral Valve Prolapses….NO YES
Blood or Plasma Transfusion……………..NO YES Stroke……………………………NO YES
Date of Last Chest X-ray _____________________
Any Other Disease…….NO YES (Please List) ______________________
____
____
____

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State
____	______	________________
____	______	________________
____	______	________________
____	______	________________
____	______	________________

Patient Social History:

Marital Status Single: ______Married: ______ Separated: ______ Divorced:_____ Widowed: _____
Use of Alcohol Never: ______ Rarely: _______Moderate: _______ Daily: ____
Use of Tobacco Never: ______ Rarely: _______Moderate: _______ Daily: _____
Use of Drugs Never: ______ Type/Frequency: _______________
Excessive Exposure at home or at work to: Fumes: ______ Dust: ______ Solvents: _____
Airborne Particles: ________ Noise: ________
Have you ever taken Fen-Phen/Redux? NO YES
Are you taking any medications (prescription or over the counter) for acid indigestion?
NO YES if YES what type: ____

CLINICIAN SIGNATURE: ____________________ DATE REVIEWED:________________________________
PATIENT NAME: _____________________________ DATE:____

Name:____________________________________ __________________ **Date:**___________________

Family Medical History

	Age	Disease History	If Deceased, Cause Of Death
Father	______	______________________________________	___________________
Mother	______	______________________________________	___________________
Siblings	______	______________________________________	___________________
	______	______________________________________	___________________
	______	______________________________________	___________________
	______	______________________________________	___________________
Spouse:	______	______________________________________	___________________
Children:	______	______________________________________	___________________
	______	______________________________________	___________________

Indicate which of the below you have experienced in the last 1-2 months

1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory

Asthma	1 2 3 4 5
Stuffy Nose	1 2 3 4 5
Hay Fever	1 2 3 4 5
Sore throat	1 2 3 4 5
Chronic Cough	1 2 3 4 5
Chest Congestion	1 2 3 4 5
Frequent Sneezing	1 2 3 4 5
Itchy/Watery Eyes	1 2 3 4 5
Drainage	1 2 3 4 5
Earache or Ear Infection	1 2 3 4 5
Itching	1 2 3 4 5
Hoarseness	1 2 3 4 5
Shortness of Breath	1 2 3 4 5
Wheezing	1 2 3 4 5

Neurological

Headaches	1 2 3 4 5
Migraines	1 2 3 4 5
Dizziness	1 2 3 4 5
Numbness	1 2 3 4 5
Tingling	1 2 3 4 5
Pins/needles in hands or feet	1 2 3 4 5

Muscular/Skeletal

Muscle Aches	1 2 3 4 5
Fibromyalgia	1 2 3 4 5
Arthritis	1 2 3 4 5
Joint Pain	1 2 3 4 5
Low Back Pain	1 2 3 4 5
Neck Pain	1 2 3 4 5
Wrist/Hand Pain	1 2 3 4 5
Elbow Pain	1 2 3 4 5
Shoulder Pain	1 2 3 4 5
Hip Pain	1 2 3 4 5
Knee Pain	1 2 3 4 5
Ankle/Foot Pain	1 2 3 4 5
Pain b/t shoulder blades	1 2 3 4 5

General

Fatigue	1 2 3 4 5
Malaise	1 2 3 4 5
Weakness, tiredness	1 2 3 4 5
Lightheadedness	1 2 3 4 5
Irritability	1 2 3 4 5
Constipation	1 2 3 4 5
Diarrhea	1 2 3 4 5
Feeling foggy	1 2 3 4 5

Forgetfulness 1 2 3 4 5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

______________________________________ ____________________

Signature of the Patient, Parent or Guardian Date

Doctor's Review

____________________________ ______________________

Signature of Doctor Date

Assignment and Release

I understand and agree that (regardless of whatever health insurance or medical benefit I have). I am ultimately responsible to pay FIRST TEAM MEDICAL CLINICS LLC., any balance due on my account, for any professional services rendered and for any supplies, test, or medications provided. I hereby authorize payment of any health insurance or medical plan benefits directly to FIRST TEAM MEDICAL CLINICS LLC., for medical services rendered and for any supplies, test, or medications provided. I hereby authorize the release of any health status, conditions, symptoms, or treatment information contained in your records that are needed to file and process insurance or medical plan claims to pursue appeals on any denied or partially denied claims. For legal pursuit as to any unpaid or partially paid claims or to pursue any other remedies necessary in connection with same, I hereby assign directly to FIRST TEAM MEDICAL CLINICS LLC., all rights to payments and benefits and all legal and other health plan that I (or my child, spouse, or minor dependent) may have under my/our applicable health plan(s) or health insurance policy/policies. This assignment includes, but is not limited to, a designation that FIRST TEAM MEDICAL CLINICS LLC., can act on my behalf, as our representative or ERISA representative, as to any initial claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to FIRST TEAM MEDICAL CLINICS LLC., and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer. This assignment and designation remains in effect unless revoked in writing, and photocopy is to be considered as valid enforceable as the original.

I authorize release of any information concerning my (or my child's) health care, advise and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X______________________________________ ________________________

Signature of Patient or parent/guardian of minor Date