FAMILY LIFE MEDICAL

NEW PATIENT REGISTRATION

Date: _____

Patient Name: _____

SS#: _____ DOB: _____ Sex: _____

Address: _____ Apt # _____ City, State, Zip _____

Phone: _____ Cell: _____ Work: _____

Email (required for patient portal access): _____

Pharmacy Name: _____ Pharmacy Tel: _____

Referral Source

☐ ☐ ☐ ☐ ☐

Friend/Family Insurance Company Newspaper _____ Web Other: _____

Financially Responsible Party/Policy Holder

☐ Same as Patient Information (If different, please complete section below)

Name: First _____ MI ___ Last _____ DOB: _____

Relationship to patient: _____ SSN# _____

Address: _____ Apt # _____ City _____ State _____ Zip _____

Phone: Home _____ Cell _____

Emergency Notification

Name: _____ Relationship to Patient: _____

Phone: Home _____ Cell _____ Work _____

You may release the following information to the person named above: ☐ Appointments ☐ Billing Information ☐ Medical Care ☐ Leave message ☐ Do not release information.

OPTIONAL AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO OTHERS

I authorize Family Life Medical and its representatives to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, billing information, and/or medical care. This authorization will remain in effect until I provide written notification to Family Life Medical of changes or updates. I authorize Family Life Medical to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, billing information, test results, and/or medical care.

Print Patient's Name: _____

Authorization to Treat a Minor (Ages 0-18) ☐ ***Not Applicable (patient is an adult)***

If there are circumstances when I am unable to bring my child to the officer for their evaluation and treatment, I give my permission and authorization for the following person(s) (over the age of 18) to obtain medical care for my child. I also authorize the providers of Family Life Medical to discuss or disclose Information regarding any matters relating to my child's appointment, insurance, test results or medical care to those listed below. This authorization will remain in effect until I provide written notification to Family Life Medical of changes or updates. I authorize Family Life Medical to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, insurance, billing information, test results and/or medical care.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

CONSENT FOR TREATMENT, RELEASE OF INFORMATION, AUTHORIZATION & ASSIGNMENT OF BENEFITS

- I consent to treatment necessary to the care which has been discussed and directed by the provider.
- I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, its intermediaries, its carriers, or any other insurance carrier any information needed for this or any other related claim to be processed. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to me or to the party who accepts assignment.
- I understand it is mandatory to notify the health care provider of any party who may be responsible for paying for my treatment.
- I further authorize and request that insurance payments be directed to Family Life Medical.

Health Information Exchange Authorization

I authorize release of my medical information to the HIE in which FLM participates: ☐ Yes ☐ No

I have read, fully understand, and agree to the above medication refill guidelines, financial responsibility statement, payment guidelines, consent for treatment and release of medical information, privacy practices, & insurance authorization. I also certify that all the information provided is complete and accurate.

Signature: _____ Date: _____

Relationship to Patient: _____

Patient Medical History

Confidential

Patient Name_____ Today's Date_____

Date of Birth_____Age_____SSN_____

Height_____ Weight_____ Emergency Contact _____

Referring Doctor_____ Family Physician _____

Chief Complaint _____
(Reason for today's visit)

Current Medications **Dose** **Frequency**

_____
_____
_____
_____
_____
_____
_____
_____

Have you taken any aspirin, ibuprofen or arthritis medicine in the last two weeks?_____
If so when?_____ Do you bruise easily? _____

DRUG ALLERGIES:_____

Immunizations: Enter date (if known) of any vaccinations you have had. Tetanus (tdap) _____ Varicella (Chicken Pox) shot or illness _____ Pneumovax (pneumonia) _____ Influenza (flu shot) _____ Hepatitis A _____ Hepatitis B _____ MMR _____ Meningitis _____ Zostavax (Shingles) _____ HPV _____

Health Maintenance Screenings:
Colonoscopy Date _____ Performed by _____ Normal? ☐No ☐Yes Polyp? ☐No ☐Yes
Vision Screening Date _____ Performed by _____ Normal? ☐No ☐Yes
Hearing Screening Date _____ Performed by _____ Normal? ☐No ☐Yes

Women only:
Mammogram Most recent date/where _____ Abnormal? ☐No ☐Yes
Pap Smear Most recent date/where _____ Abnormal? ☐No ☐Yes
Bone density test Most recent date/where _____ Abnormal? ☐No ☐Yes
Women's Health History: Total number of pregnancies: ___ Number of births: ___ Number of Miscarriages: ___ Number of abortions: ___ Age at beginning of periods (menstruation): ___ Age at end of periods (menopause/hysterectomy): _____ / ☐not applicable

Medical Illnesses:
_____
_____
_____
_____
_____

Hospitalizations **Date**

_____
_____
_____
_____
_____

Surgical Procedures **Date**

_____
_____
_____
_____
_____
_____

Have you ever had problems with anesthesia? ☐ Yes ☐ No
If yes, describe: _____

Release of Records

Who may have access to your medical records?

Name	**Relation**	**Contact Information**

Family History

Family Member	**Medical Illnesses**
Mother	
Grandparents (maternal)	
Father	
Grandparents (paternal)	
Sister(s) / Brother (s)	

Social History

Feeling tired or having little energy? ☐ No ☐ Yes / if yes, ☐ several days, ☐ more than half the days, ☐ nearly everyday

Poor appetite or overeating? ☐ No ☐ Yes / if yes, ☐ several days, ☐ more than half the days, ☐ nearly everyday

Feeling bad about yourself or that you are a failure, or have let yourself or your family down? ☐ No ☐ Yes / if yes, ☐ several days, ☐ more than half the days, ☐ nearly everyday

Trouble concentrating on things such as reading the newspaper or watching tv? ☐ No ☐ Yes / if yes, ☐ several days, ☐ more than half the days, ☐ nearly everyday

Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual? ☐ No ☐ Yes / if yes, ☐ several days, ☐ more than half the days, ☐ nearly everyday

Thoughts that you would be better off dead or of hurting yourself in some way? ☐ No ☐ Yes / if yes, ☐ several days, ☐ more than half the days, ☐ nearly everyday

Socioeconomic:
Are you presently working or going to school full or part time? _____

If you are not currently working, you are: ☐retired ☐unemployed ☐disabled ☐other_____

Occupation (or prior occupation): _____

Employer / School: _____

Marital Status:_____ Do you live alone? _____ Who lives with you?_____

Spouse/partner's name: _____

Do you have children?_____ If yes, how many?_____

Education: ☐high school or GED ☐college ☐other _____

Who lives with you? _____

Do you manage your own responsibilities? ☐finances/shopping, ☐medications, ☐yard care

Tobacco Use:
Smoke or smoked ☐cigarettes ☐pipe ☐cigars?☐never☐yes Exposure to secondhand smoke?☐No☐Yes
(if never used any tobacco can skip to Alcohol Use section below) Current smoker: Packs per day: _____
# of years: _____ Former smoker: Quit date _____ Approximately how many packs/day did you smoke? _____ How many years did you smoke? ____ Other tobacco? ☐Snuff/Chew Quit Date: _____
Are you ready to quit?☐No☐Yes

Alcohol Use:
Do you drink alcohol? ☐Yes ☐ No # of drinks/week: _____ ☐Beer☐Wine☐Liquor
How many times in a year have you had >3 drinks (for women) >4 drinks (for men) in a day? _____
☐Prior addiction?

Drug Use:
Do you take or have you taken recreational drugs? ☐Yes ☐No ☐Prior addiction
If yes, which ones? _____
Quit which ones? ☐All _____ Any used currently? _____

Exercise:
Do you exercise regularly? ☐No ☐Yes If yes, what kind of exercise? _____
How long (minutes)? _____ How often? _____

Safety:
Do you use seatbelts consistently? ☐No ☐Yes
Do you feel anxious? ☐No ☐Yes Stressed? ☐No ☐Yes if yes, how often? _____
Do you experience pain? ☐No ☐Yes If yes, how often? _____
Do you experience pain with ☐walking, ☐certain activities, ☐everything?
Have you ever fallen at home? ☐No ☐Yes If yes, how many times?
Do you feel safe at home? ☐No ☐Yes
Do you have a loss of bladder control? ☐No ☐Yes If yes, how often?
Do you drive a vehicle? ☐No ☐Yes

In the past two weeks:
Do you have little interest or pleasure in doing things? ☐No ☐Yes If yes, ☐Several days, ☐More than half the days, ☐Nearly everyday
Have you been feeling down, depressed, or hopeless? ☐No ☐Yes If yes, ☐Several days, ☐More than half the days, ☐Nearly everyday
Trouble falling or staying asleep? ☐No ☐Yes If yes, ☐Several days, ☐More than half the days, ☐Nearly everyday

Does anyone complain that you snore? ☐Yes ☐ No

Do you stop breathing at night? ☐Yes ☐No

Do you wake up tired in the morning? ☐Yes ☐No

Do you fall asleep in the daytime? ☐Yes ☐No

Caffeine intake: _____ per day

Are you at risk for AIDS (e.g. sexual orientation, drug abuse, previous blood transfusion)? _____
If yes, explain: _____

Medical Forms: Please check any of the following forms you have completed:
☐Advance Directive for Health Care (ADHC) ☐Durable Power of Attorney (DPA) for healthcare decisions
☐Living Will ☐Do not know what these are

Review of Systems

Are you currently having, or have you had problems with: (check all that apply)

General well-being
- ☐ Fever
- ☐ Weight loss (>10#)
- ☐ Excess fatigue
- ☐ Recurrent Nausea / vomit
- ☐ Night sweats

Eyes
- ☐ Wear glasses
  Date of last exam _____
- ☐ Infections
- ☐ Injuries
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Blurred vision
- ☐ Trouble focusing
- ☐ Recent change in vision

Ears, Nose, Mouth and Throat
- ☐ Wear hearing aids
  Date of last exam_____
- ☐ Hearing loss
- ☐ Ear infection
- ☐ Pressure in ears
- ☐ Ringing in ears
- ☐ Pain in ears
- ☐ Balance disturbance
- ☐ Itching in ears
- ☐ Dizziness
- ☐ Nasal congestion
- ☐ Nasal drainage
- ☐ Nosebleeds
- ☐ Sinus problems
- ☐ Sinus infections
- ☐ Sinus headaches
- ☐ Throat infections
- ☐ Difficulty swallowing
- ☐ Lip or mouth sores
- ☐ Sore throats

Respiratory
- ☐ Chronic cough
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Asthma
- ☐ Chronic obstruction
- ☐ Pulmonary disease
- ☐ Shortness of breath
- ☐ Oxygen use at home
- ☐ Pneumonia
- ☐ Lung cancer
- ☐ Tuberculosis
- ☐ Blood in saliva
  Date of last chest X-ray_____

Cardiovascular
- ☐ Chest pain
  Date of last EKG _____
- ☐ Heart attack
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Irregular heartbeat
- ☐ Heart murmur
- ☐ Arm and leg swelling
- ☐ High cholesterol

Gastrointestinal
- ☐ Blood in vomit
- ☐ Indigestion
- ☐ Nausea / vomiting
- ☐ Jaundice
- ☐ Abdominal pain
- ☐ Change in bowel habits
- ☐ Ulcers or Gastritis
- ☐ Colon, liver, stomach cancer
- ☐ Hepatitis

Hematologic
- ☐ Anemia
- ☐ Hemophilia
- ☐ Easy bleeding / bruising
- ☐ Swollen glands

Genitourinary
- ☐ Urinary tract infection
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Difficulty urinating
- ☐ Incontinence
- ☐ Kidney stones
- ☐ Prostate cancer
- ☐ Endometriosis
- ☐ Uterine, ovarian or cervical cancer

Neurological
- ☐ Disorientation
- ☐ Fainting / blacking out
- ☐ Light headedness
- ☐ Seizures
- ☐ Stroke
- ☐ Mini-stroke
- ☐ Memory problems
- ☐ Concentration problems
- ☐ Speech problems
- ☐ Facial weakness/ spasms
- ☐ Muscle weakness
- ☐ Coordination problems
- ☐ Uncontrolled shaking
- ☐ Headache
- ☐ Migraine

Endocrine
- ☐ Diabetes
- ☐ Hormone problems
- ☐ Low blood sugar
- ☐ Thyroid disease
- ☐ Increased appetite
- ☐ Excessive thirst
- ☐ Excessive urination
- ☐ Temperature intolerance
- ☐ Pituitary gland problems
- ☐ Bleeding tendencies

Immunologic
- ☐ Environmental allergies
- ☐ Hay fever
- ☐ Food allergies
- ☐ Immune system problems
- ☐ Connective tissue disease
- ☐ Frequent colds / infections

Skin
- ☐ Eczema or psoriasis
- ☐ Dermatitis
- ☐ Dry or scaling skin
- ☐ Rashes
- ☐ Changes in skin color
- ☐ Changes in moles
- ☐ Skin cancer
- ☐ Breast pain or swelling
  Date of last Mammogram
  _____

Musculoskeletal
- ☐ Broken bones
  list:_____
- ☐ Arm or leg weakness
- ☐ Joint pain or swelling
- ☐ Back pain
- ☐ Arthritis

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Manic/Depression
- ☐ Schizophrenia
- ☐ Considering suicide / homicide
- ☐ Panic attacks
- ☐ Sudden mood swings
- ☐ Emotional difficulties
- ☐ Insomnia
- ☐ Other psychiatric problems
- ☐ Under psychiatric care
- ☐ Desiring psychiatric care

The above information is accurate to the best of my knowledge.

_____ _____

Patient Signature *Date*

I have reviewed the above information with the patient.

____ _________________________

Kyle Scarborough MD *Date*