Fred A. Williams, M.D.

www.DrFredWilliams.com

Tel: 903 784 3200 Fax: 903-784-7405

Date: _____

Patient's Name :_____
First Middle Last

Age:_____ Birth date:_____Social Security # :_____

Address:_____

Preferred Telephone number: _____(cell/home) Secondary number: _____(cell/home)

Email Address:_____

Name you would like to be called:_____

Preferred Pharmacy:_____

Your occupation:_____Employed by: _____For how long:_____

Employer's address:_____ Telephone Number:_____

Spouse/significant other/parent/responsible party: _____

Age:_____ Birth date:_____ Social Security number:_____

Employer:_____ Telephone number:_____

Do you have any personal, moral, or religious objection to any of the usual forms of medical treatment including blood transfusion?
Yes____ No_____

If you are covered by insurance, Medicare and/or Medicaid, please present your card when you arrive at each office visit. It is your responsibility to present a valid insurance card at each visit. If we do not have a valid insurance card, you are responsible for all charges. Payment for your portion is due at each office visit.

Insurance Company: _____
Group number:_____Certificate or policy number:_____

Secondary Insurance: _____
Group number:_____Certificate or policy number:_____

I authorize Dr Williams to release any medical information about me to my insurance company/Health care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.
I request payment of authorized Medicare benefits and / or personal insurance to be made on my behalf to Dr Fred Williams for any services furnished me by Dr Williams.

_____ Date:_____
Patient or Guardian Signature

Referred by:_____
Name of person or doctor

Person to Contact in case of Emergency other than spouse: _____Relationship_____

Telephone number: _____

New Patient History

Name:_____D.O.B._____ Date:_____

What is the reason for today's visit? _____

Primary Care Physician: _____

History: (Number of) Total pregnancies:_____ Deliveries:_____ Living children:_____
Miscarriages: _____ Abortions:_____

Last Menstrual Period: _____ Age of first period:_____ Age at menopause:_____
How many days between periods? _____
How many days does your period last? _____
Any problems with your periods? _____
_____

Present type of contraception: Tubal ligation vasectomy birth control pills IUD Implant none Trying for pregnancy
Date of last pap smear:_____ normal / abnormal? Any treatment: _____
Date of last mammogram: _____ normal / abnormal? Any treatment: _____
Are you; sexually active?: yes/no Pregnant? yes/no

Have you ever had? (circle all that apply)

Abnormal menstrual bleeding
Tumor of the uterus or ovaries
Uterine Fibroids
Pelvic or Uterine or Tubal infection
Tubal (Ectopic) Pregnancy
Herpes, Syphilis, Gonorrhea, Chlamydia, Trichomonas, Venereal Warts, HPV
Uncontrolled leakage of bladder or bowels?
Breast problems

List Previous Pregnancies:

Year	Sex	Wt.	Type of delivery	Complications
___	___	____	_____	_____
___	___	____	_____	_____
___	___	____	_____	_____
___	___	____	_____	_____
___	___	___	_____	_____

SURGERIES:

Year	Type of surgery
____	_____
____	_____
____	_____
____	_____
____	_____

PAST HISTORY: (Circle all that apply)

MEASLES	HEART ATTACK	DIABETES
MIGRAINE HEADACHE	HEART MURMUR	KIDNEY STONE
PROLONGED DIZZINESS	RHEUMATIC FEVER	KIDNEY INFECTION
GLASSES/CONTACTS	OTHER HEART DISEASE	OTHER KIDNEY DISEASE
DENTURES	HIGH BLOOD PRESSURE	FREQUENT BLADDER INFECTIONS
THYROID TROUBLE	BREAST TUMOR/MASS	ARTHRITIS
PNEUMONIA	ULCER	NEUROLOGICAL DISEASE
TUBERCULOSIS	HEPATITIS	PARALYSIS
ASTHMA	INTESTINAL BLEEDING	REACTION TO ANESTHESIA
CANCER	BLOOD CLOTS / *DVT*	COLONOSCOPY/UPPER ENDOSCOPY
	PULMONARY EMBOLISM	

Allergies: _____
_____
_____

Do you smoke? yes/no How many packs per day? _____ How many years? _____
Previous smoker? Yes When did you quit? _____

Do you drink alcohol? yes/no How much? _____
Do you or have you used recreational drugs? _____
Hx or at risk for AIDS? yes/no: _____

Social: what kind of work do you do?_____
Hobbies/ special interests: _____

Any other medical information you think I need to know?
_____

Family History:

1. Diabetes:_____
2. Heart disease:_____
3. Hypertension:_____
4. Kidney disease:_____
5. Cancer: _____
_____
6. Congenital (inherited) diseases :_____
7. Other:

Notes:

Medication List

please list all medications and vitamins/supplements

Name/strength/dose

General Consent for Treatment

I, _____, knowing that I may have a condition requiring diagnostic, medical or surgical treatment, do hereby voluntarily consent to such procedures and care to such medical, surgical, or other services under the general and specific instructions of Dr Fred Williams, his assistants, or designated person, as is necessary in his judgment. Such procedures may include but are not limited to, routine blood drawing and physical exams, including breast, pelvic, pap and rectal exams.

I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of treatment or examination by Dr Fred Williams.

Signature: _____

If minor, parent or guardian signature: _____
Relationship: _____

Witness: _____

Date: _____

Acknowledgment

Privacy Practices

Patient name: _____

Date of Birth: _____

I acknowledge that Dr Fred Williams provided me with a written copy of his Notice of Privacy Practices if I desire one.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

A copy of our Notice of Privacy Practices is also available on our website. Drfredwilliams.com

Patient signature: _____

Date: _____

Personal Representative Signature: _____
Relationship to patient: _____