

Please update the form for any changes after 6 months

**Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT NAME** (last, first, Ml): **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DO YOU HAVE ALLERGIES: Yes No**

**IF YES, PLEASE LIST:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Change in address, phone number, PCP or insurance? \_\_\_\_\_\_\_\_\_NO \_\_\_\_\_\_\_\_YES

If yes; please complete

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State/Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Local Phone No: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone No: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name/No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Please add **Email Address**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Please check the following: \_\_\_\_\_\_\_\_\_\_\_OK to email brief message \_\_\_\_\_\_\_\_OK to email statement

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Primary Insurance Provider Information:**  **PLEASE COMPLETE IF ANY CHANGES AND SUPPLY UPDATED INSRUANCE CARD.**  **NO changes \_\_\_\_\_\_\_\_\_\_\_**  Primary Insurance Carrier:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Group No.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy No.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship to Subscriber:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (If relationship SELF, Do Not Fill in Subscriber’s Info)  Subscriber’s First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial:\_\_\_\_\_ Last\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Subscriber’s Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State/Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Subscriber’s Phone No.: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Sex:  Male  Female Subscriber’s SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Secondary Insurance Provider Information**  **Provider Information: PLEASE COMPLETE IF ANY CHANGES**  **AND SUPPLY UPDATED INSRUANCE CARD**  **No changes \_\_\_\_\_\_\_\_\_\_\_\_\_no secondary \_\_\_\_\_\_\_\_\_\_\_\_\_**  Secondary Insurance Carrier:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Group No.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy No.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship to Subscriber:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (If relationship is SELF, Do Not Fill in Subscriber’s Info)  Subscriber’s First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial:\_\_\_\_\_\_ Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Subscriber’s Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State/Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Subscriber’s Phone No.: (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Sex:  Male  Female Subscriber’s SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Copay/Deductible Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Legal information or lawyer or letter of protection update complete as applies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**ALLERGIES PLEASE LIST ANY ALLERGIES TO MEDICATION OR FOOD:**

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| --- | --- |
| **MEDICATION NAME** | **SYMPTOMS/REACTION** |
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|  |  |
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|  |  |
|  |  |

**MEDICATIONS LIST**

**CURRENT MEDICATIONS, OVER THE COUNTER, HERBS & SUPPLEMENTS:**

|  |  |  |  |
| --- | --- | --- | --- |
| **NAME** | **STRENGTH/FREQUENCY** | **NAME** | **STRENGTH/FREQUENCY** |
|  |  |  |  |
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**SOCIAL HISTORY**

**DO YOU CURRENTLY USE OR HAVE YOU EVER USED TOBACCO? YES NO**

**IF YES, PLEASE CIRCLE THE TYPE: CIGARS CIGARETTES PIPE CHEWING TOBACCO**

**HOW MANY YEARS? HOW MUCH PER DAY? YEAR YOU QUIT-**

**ALCOHOL USE: YES NO IF YES, HOW MANY DRINKS/HOW OFTEN?**

**CAFFEINE USE: YES NO IF YES, PLEASE CIRCLE THE TYPE: COFFEE TEA SODA**

**HOW MANY DRINKS/HOW OFTEN?**

**FAMILY HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
| **RELATIONSHIP** | **LIVING YES/NO** | **AGE** | **MAJOR MEDICAL PROBLEMS/CAUSE OF DEATH** |
| **FATHER** |  |  |  |
| **MOTHER** |  |  |  |
| **SIBLING(S)** |  |  |  |
|  |  |  |  |
| **CHILDREN** |  |  |  |
|  |  |  |  |

**HAVE YOU HAD ANY OF THE FOLLOWING PROCEDURES (CHECK ALL THAT APPLY)**

|  |  |  |  |
| --- | --- | --- | --- |
| **PROCEDURE** | **YEAR** | **PROCEDURE** | **YEAR** |
| **□ APPENDIX REMOVED** |  | **□ HYSTERECTOMY** |  |
| **□ ABDOMINAL ANEURYSM REPAIR** |  | **□ KNEE JOINT REPLACEMENT L/R/BIL** |  |
| **□ BRAIN SURGERY** |  | **□ LEG ARTERY BYPASS** |  |
| **□ BREAST CANCER SURGERY** |  | **□ PACEMAKER/DEFIBRLLATOR** |  |
| **□ CARDIAC CATHETERIZATION** |  | **□ PROSTATE CANCER SURGERY** |  |
| **□ CAROTID ARTERY SURGERY** |  | **□ PTCA (ANGIOPLASTY)** |  |
| **□ GALLBLADDER REMOVED** |  | **□ SPINE SURGERY NECK/BACK** |  |
| **□ HEART SURGERY** |  | **□ STEROID/EPIDURAL/SPINE INJECTIONS** |  |
| **□ HEART VALVE REPLACEMENT** |  | **□ STRESS TEST** |  |
| **□ HERNIA SURGERY** |  | **□ TONSILLECTOMY** |  |
| **□ HIP JOINT REPLACEMENT L/R/BIL** |  | **□ VASCULAR SURGERY STENT** |  |
| **□ OTHER:** |  | **□ OTHER:** |  |

**PERSONAL HEALTH HISTORY (CHECK ALL THAT APPLY)**

**□ ABNORMAL ELECTROCARDIOGRAM □ HEART MURMUR**

**□ ADDICTION ISSUES □ HEART STENTS**

**□ ALLERGIES/SINUS DIFFICULTIES □ HERNIA**

**□ ANEMIA □ HIGH BLOOD PRESSURE**

**□ ARTHRITIS OF: □ HIGH CHOLESTEROL**

**□ ASTHMA/ BREATHING DIFFICULTIES □ KIDNEY PROBLEMS**

**□ BLEEDING DISORDER □ LIVER PROBLEMS**

**□ BLOOD CLOTS □ MENTAL ILLNESS**

**□ BOWEL/DIGESTIVE PROBLEMS □ OSTEOPOROSIS/OSTEOPENIA**

**□ CANCER OF: □ PALPITATIONS**

**□ C.O.P.D/EMPHYSEMA/CHRONIC BRONCHITIS □ PNEUMONIA**

**□ DEPRESSION/ANXIETY □ REFLUX DISEASE**

**□ DIABETES – DIET/PILLS/INSULIN □ RHEUMATIC FEVER**

**□ DIALYSIS TREATMENTS □ SEIZURES**

**□ FIBROMYALGIA □ STROKE/TIA**

**□ GALLBLADDER PROBLEMS □ THYROID PROBLEMS**

**□ GOUT □ URINARY TRACT INFECTIONS**

**□ HEADACHES/MIGRAINES □ ULCERS**

**□ HEART ATTACK/CONGESTIVE HEART FAILURE/ANGINA □ OTHER:**

Please let the front know if you need to update your HIPAA:

SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_