GRAYHAWK FAMILY PRACTICE

Patient Name: ____ Date form filled out: _______________________________

NEW PATIENTS: PLEASE FILL OUT FORM IN ITS ENTIRETY.
CURRENT PATIENTS: ONLY FILL OUT WHAT NEEDS TO BE UPDATED.
THANK YOU!

Emergency Contacts and Authorized Persons

Name	Relationship	Phone #	*Emergency Contact	Permission to discuss financial information (monthly payments)	Permission to make, cancel & reschedule appointments on your behalf	Authorized to obtain medical information & speak to our office regarding your medical care
			Yes ☐ No☐	Yes ☐ No☐	Yes ☐ No☐	Yes ☐ No☐
			Yes ☐ No☐	Yes ☐ No☐	Yes ☐ No☐	Yes ☐ No☐
			Yes ☐ No☐	Yes ☐ No☐	Yes ☐ No☐	Yes ☐ No☐

***At least one person must be listed above for an emergency contact.**

Preferred Pharmacy: ____ Major cross streets: ______________________________

Additional Pharmacy: ____ Major cross streets: _____________________________
(For patients who live in the local area and another state)

Name of previous physician and phone number if known: ____

Medical Insurance Company: __________________________________Claims Zip Code (Usually on back of card) _________

Policy # or Employee #: ________________________________ ___________Group Number: ____________________________

Deductible: Yes ☐ No☐ If yes, what is your deductible: ___________ Appx. Amount you have met to-date: ________

Secondary Insurance Company: ____

Policy Number: ________________________________ ___________Group Number: ___________________________________

How did you hear about us? ____

Patient or Guardian Signature: _______________________________________ Relationship (If applicable): ________________

GRAYHAWK FAMILY PRACTICE

Patient Name: ____ Date form filled out: ______________________________

Current approximate Height:________ **Weight:** ________
Allergies/reaction:____
Past surgeries and hospital stays (use second page for additional space):

Type of surgery or reason for hospital stay:	Appx date (month and year is okay)

Current medications taking, prescribed, over the counter and vitamins (use second page for additional space):

Name of medication:	Current dose:	Frequency taken:	Reason for taking:

Medical diagnoses (i.e. High blood Pressure, High Cholesterol etc. use second page for additional space):

Diagnoses:	Appx. Date diagnosed:

Family History (use second page for additional space):

Medical diagnosis:	Who was diagnosed, alive or deceased, Current age or age at death

- **Please provide immunization record if available. If not, are your immunizations up to date ☐Yes ☐No If no, what immunization do you think you need:** ____
- **Have you ever had an abnormal lab (for women this includes PAP's), study or test? date ☐Yes ☐No If yes, what was it and when was the appx. Date?** ____

Patient or Guardian Signature: ______________________________________ Relationship (If applicable): ________________

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Past surgeries and hospital stays (use second page for additional space):

Type of surgery or reason for hospital stay:	Appx date (month and year is okay)

Current medications taking, prescribed, over the counter and vitamins (use second page for additional space):

Name of medication:	Current dose:	Frequency taken:	Reason for taking:

Medical diagnoses (i.e. High blood Pressure, High Cholesterol etc. use second page for additional space):

Diagnoses:	Appx. Date diagnosed:

Family History (use second page for additional space):

Medical diagnosis:	Who in your family was diagnosed:

____

PATIENT INITIALS