INITIALS(OFFICE USE):_____ DATE(OFFICE USE):_____

NEW PATIENT APPROVAL FORM

PLEASE WRITE IN DARK INK ONLY - FORM MUST BE FILLED OUT COMPLETELY OR WILL BE AUTOMATICALLY DENIED

PATIENT NAME:_____ GENDER (PLEASE CIRCLE) : M F

PRIMARY PHONE #:_____ CELL #:_____

ADDRESS:_____ CITY:_____

ZIP:_____ SOCIAL SECURITY #: _____

DATE OF BIRTH: _____

INSURANCE: _____ ID #: _____

MEDICATIONS: _____

_____

PHARMACY: _____

PAIN MEDICATION: CURRENT: _____ PAST:_____

IF YES, PAIN MANAGEMENT DOCTOR/CLINIC: _____

MEDICAL PROBLEMS: _____

_____

CURRENT PHYSICIAN: _____ REASON FOR CHANGING: _____

DOCTOR OF YOUR CHOICE: _____

PARENT INFORMATION (FOR PATIENTS UNDER 18 YEARS OF AGE)

PARENT/GUARDIAN NAME: _____ PARENT/GUARDIAN DOB: _____

FOR OFFICE USE ONLY

APPROVED **DENIED**

DR. SIGNATURE: _____

PATIENT CALLED BY: _____ DATE CALLED: _____

APPOINTMENT DATE & TIME: _____

IMPORTANT REMINDER: MUST BRING INSURANCE CARDS, PHOTO I.D., AND MEDICATIONS IN THE BOTTLE TO THE FIRST APPOINTMENT OR APPOINTMENT WILL BE RESCHEDULED! ALSO YOUR CO-PAY AND/OR $50 DEDUCTIBLE IS DUE AT TIME OF SERVICE.

HEALTH HISTORY QUESTIONNAIRE

PATIENT NAME: _____ DOB: _____

MAIN REASON FOR TODAY'S VISIT: _____

OTHER CONCERNS: _____

ALLERGIES

Please list all allergies (medications, food, bee stings, etc.) and reaction to each.

	ALLERGY	REACTION
1.		
2.		
3.		
4.		

MEDICATIONS

	DRUG NAME	STRENGTH	FREQUENCY TAKEN
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

IMMUNIZATION HISTORY

Immunization and most recent date of administration:

Chicken Pox	Date: _____	Meningococcus	Date: _____
Flu Shot	Date: _____	MMR (Measles, Mumps, Rubella)	Date: _____
Gardasil/HPV	Date: _____	Pneumonia	Date: _____
Hepatitis A	Date: _____	Tdap (Tetanus and Pertussis)	Date: _____
Hepatitis B	Date: _____	Tetanus	Date: _____
		Zostavax (Shingles)	Date: _____

PAST MEDICAL HISTORY

Please check all that apply:

_____ Anxiety Disorder
_____ Arthritis
_____ Asthma
_____ Bleeding Disorder
_____ Blood Clots (DVT)
_____ Cancer
_____ Coronary Artery Disease (CAD)
_____ Claustrophobic
_____ Diabetes – Insulin
_____ Diabetes – Non Insulin
_____ Dialysis
_____ Diverticulitis
_____ Fibromyalgia
_____ Gout
_____ Pacemaker
_____ Heart Attack
_____ Heart Murmur
_____ Hiatal Hernia
_____ HIV or AIDS
_____ High Cholesterol
_____ High Blood Pressure
_____ Overactive Thyroid
_____ Kidney Disease
_____ Kidney Stones
_____ Leg/Foot Ulcers
_____ Liver Disease
_____ Osteoporosis
_____ Polio
_____ Pulmonary Embolism
_____ Reflux Disease or Ulcers
_____ Stroke
_____ Tuberculosis
_____ Other: _____

(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY

Date of last pap smear _____ _____ Normal _____ Abnormal

Date of last mammogram _____ _____ Normal _____ Abnormal

Age of First Menstrual Cycle _____ _____ Normal _____ Abnormal

Age at Menopause _____

Number of Pregnancies: _____ Number of Births: _____ Number of Abortions: _____

Number of Miscarriages: _____ Number of Cesarean Sections: _____

FAMILY HISTORY

Grandmother (Maternal) Living: Age _____ Deceased: Age _____
_____ Alcoholism _____ Arthritis _____ Depression _____ Cancer
_____ Diabetes _____ Genetic Disease _____ Heart Disease _____ Hypertension
_____ Osteoporosis _____ Stroke

Grandfather (Maternal) Living: Age _____ Deceased: Age _____
_____ Alcoholism _____ Arthritis _____ Depression _____ Cancer
_____ Diabetes _____ Genetic Disease _____ Heart Disease _____ Hypertension
_____ Osteoporosis _____ Stroke

Grandmother (Paternal) Living: Age _____ Deceased: Age _____
_____ Alcoholism _____ Arthritis _____ Depression _____ Cancer
_____ Diabetes _____ Genetic Disease _____ Heart Disease _____ Hypertension
_____ Osteoporosis _____ Stroke

Grandfather (Paternal) Living: Age _____ Deceased: Age _____
_____ Alcoholism _____ Arthritis _____ Depression _____ Cancer
_____ Diabetes _____ Genetic Disease _____ Heart Disease _____ Hypertension
_____ Osteoporosis _____ Stroke

Mother
_____ Alcoholism
_____ Diabetes
_____ Osteoporosis

Living: Age _____
_____ Arthritis
_____ Genetic Disease
_____ Stroke

Deceased: Age _____
_____ Depression
_____ Heart Disease

_____ Cancer
_____ Hypertension

Father
_____ Alcoholism
_____ Diabetes
_____ Osteoporosis

Living: Age _____
_____ Arthritis
_____ Genetic Disease
_____ Stroke

Deceased: Age _____
_____ Depression
_____ Heart Disease

_____ Cancer
_____ Hypertension

Sister
_____ Alcoholism
_____ Diabetes
_____ Osteoporosis

Living: Age _____
_____ Arthritis
_____ Genetic Disease
_____ Stroke

Deceased: Age _____
_____ Depression
_____ Heart Disease

_____ Cancer
_____ Hypertension

Brother
_____ Alcoholism
_____ Diabetes
_____ Osteoporosis

Living: Age _____
_____ Arthritis
_____ Genetic Disease
_____ Stroke

Deceased: Age _____
_____ Depression
_____ Heart Disease

_____ Cancer
_____ Hypertension

Child
_____ Alcoholism
_____ Diabetes
_____ Osteoporosis

Living: Age _____
_____ Arthritis
_____ Genetic Disease
_____ Stroke

Deceased: Age _____
_____ Depression
_____ Heart Disease

_____ Cancer
_____ Hypertension

SOCIAL HISTORY

Education
_____ Less than 8th grade
_____ High school graduate
_____ 2 year college
_____ 4 year college
_____ Post graduate

Marital Status
_____ Married
_____ Single
_____ Divorced
_____ Separated
_____ Widowed
_____ Domestic Partner

Exercise Level
_____ None
_____ Occasional
_____ Moderate
_____ Heavy

Caffiene
_____ None
_____ Occasional
_____ Moderate
_____ Heavy
Cups/cans daily? _____

*Drugs
Do you use illicit drugs: _____ Yes _____ No
If yes, please list: _____

*Alcohol
Do you drink alcohol? _____ Yes _____ No
If so, how often? _____ Occasionally _____ Less than 3 times a week _____ More than 3 times a week

*Tobacco
Do you use tobacco? _____ Yes _____ No
If not currently, did you ever use? _____ Cigarettes _____ Packs per day
_____ Chew _____ Packs per day
_____ Cigars _____ Each per day

Number of years used: _____ How many years ago did you quit? _____

SURGICAL HISTORY

Please list all prior surgeries and approximate dates performed:

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

PATIENT INFORMATION RECORD

Patient Name: _____

Patient Date of Birth: _____ Social Security Number: _____

Marital Status: M ( ) S ( ) D ( ) W ( )

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Pharmacy: _____ Email: _____

Occupation: _____ Employer: _____

Employer Address: _____

Work Phone: ( ) _____

Preferred Method of Contact: (Circle one) Text Email Both

Spouse Name: _____ Cell Phone: _____

Emergency Contact (Not living with you): Name: _____

Home Phone: _____ Cell Phone: _____

PLEASE PRESENT YOUR DRIVER'S LICENSE & INSURANCE CARD

Payment Policy: Patients with copay, deductible, or that are private pay are required to pay on the date of service. I the patient or guardian understand that I am responsible for any amount not covered by insurance. Insurance Authorization and Assignment: I hereby authorize the release of any medical or other information (necessary to process a claim) to my insurance carrier. Furthermore, I authorize payment of medical benefits directly to the medical prover(s) who have treated me or rendered services or materials. Prescriptions: My prescriptions may be sent and retriever through the Surescripts clearinghouse.

Signature _____ Date: _____

MEDICAL INFORMATION RELEASE FORM
(HIPAA RELEASE FORM)

Name: _____ Date of Birth: _____

RELEASE OF INFORMATION

( ) I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

( ) Name of Spouse: _____ Phone: _____

( ) Name of Children: _____ Phone: _____

( ) Name of Other: _____ Phone: _____

( ) INFORMATION IS NOT TO BE RELEASED TO ANYONE

This release of information will remain in effect until terminated by me in writing.

MESSAGES

Please call ( ) My home ( ) My work ( ) My cell

Phone number: _____

If unable to reach me:

( ) You may leave a detailed message ( ) Please leave a message asking me to return your call

( ) Other: _____

The best time to reach me is: _____

Signed: _____ Date: _____

Witness: _____ Date: _____