EAST BRAINERD FAMILY MEDICINE

REASON FOR TODAY'S VISIT: _____

Was this an accident? YES / NO Circle one: Auto (Attorney Name_____) or Work Comp

PATIENT INFORMATION:

NAME: _____
(FIRST) (MI) (LAST)

MAILING ADDRESS_____
(STREET) (APT) (CITY) (ST) (ZIP CODE)

(_____) - (_____) - _____
cell phone number home phone

_____ _____ - _____ - _____ female/male
Date of Birth Social Security Number (circle)

I GIVE MY CONSENT FOR EBFM TO SEND TEXT MESSAGE REMINDERS OF APPTS: ___YES ____NO

Marital Status: SINGLE MARRIED DIVORCED SEPARATED WIDOW/WIDOWER

Patient's Employer _____
Name Phone Number

Pharmacy: Walmart Walgreens CVS Publix Food City _____
Other Zip Code

INSURANCE INFORMATION

PRIMARY INSURANCE

_____
INSURANCE COMPANY NAME SUBSCRIBER ID# GROUP

_____
CARD HOLDER NAME (IF DIFFERENT) CARD HOLDER DOB RELATIONSHIP TO CARDHOLDER

SECONDARY INSURANCE

_____
INSURANCE COMPANY NAME SUBSCRIBER ID# GROUP

_____
CARD HOLDER NAME (IF DIFFERENT) CARD HOLDER DOB RELATIONSHIP TO CARDHOLDER

I have understand and accept Rights and Responsibilities that are posted at the sign-in area in the waiting room.

_____ _____
Patient/Parent/Guardian Signature Date

I give my consent for EBFM to send me information to my email at my request: ____ YES ____ NO

Email address: _____@_____.com

EMERGENCY CONTACT NAME: _____

_____

EMERGENCY CONTACT RELATIONSHIP EMERGENCY CONTACT PH NUMBER

Do we have permission to call the person listed above to discuss appointments, scheduling of exams and results of tests? YES_____ NO_____

In an effort to protect each person's privacy, the staff is not allowed to give information to anyone whether by phone or in person without written permission from the patient. We will NOT allow persons other than yourself to pick up medical records, test results, disability forms, prescriptions, etc. unless prior written permission is obtained from you the patient.
**PLEASE SPECIFY ANY OTHERS YOU ARE GIVING WRITTEN PERMISSION FOR:

_____

*Do we have permission to call your home to discuss appointments, scheduling of tests and/or procedures, and results of tests/procedures?
YES_____ NO_____
*May we leave a message at your home to persons other than yourself, or on an answering machine?
YES_____ NO_____

Signature _____ Date_____

FINANCIAL POLICY

INITIAL BOTH
_____ I hereby authorize the release of any information necessary to process insurance claims and request payment of benefits to be made for services rendered to my dependents or myself.

_____ I understand I am responsible at the time of services for paying any required co-payment, coinsurance deductible, any charges not covered by insurance. I understand that am am responsible for payment of services rendered to myself or dependents if I have no insurance coverage. I understand if I fail to pay amounts owed, the clinic has the right to secure an outside collection agency and/or attorney to collect the unpaid debt and to report the unpaid debt to a credit-reporting agency. I further understand that I will be responsible for any additional charges, copayments, coinsurance or fees necessitated by securing the collecting agency or attorney, including reasonable attorney's fees.

[THERE WILL BE A $35 CHARGE ON ALL RETURNED CHECKS.]

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY OF THIS OFFICE AND AGREE TO ABIDE BY SAID POLICY.

_____ _____

Patient/Parent/Guardian Date

Please present both your insurance card and valid picture ID so we may make copies for our records.

TREATMENT AUTHORIZATION

I authorize East Brainerd Family Medicine to be able to render care and obtain any medical records needed for treatment.

Signature _____ Date_____

HEALTH HISTORY QUESTIONNAIRE

Surgeries and other hospitalizations (include year and reason) _____ hysterectomy

___tonsillectomy ____ heart stent/bypass _____ pacemaker/AICD _____ appendectomy

___Cholecystectomy _____ C-section ____ back surgery _____ joint surgery

Other: _____

List medical problems that other doctors have diagnosed: __high blood pressure ___ heart attack

___ Diabetes ___ Heart Failure (CHF) ___ Kidney Disease ____ History of Stroke ___ Asthma

___Arthritis ___ COPD/Emphysema ___Hepatitis other_____

IF FEMALE: Are you pregnant? ____ Breastfeeding ____ Birth control/type _____ LMP _____
(last menstrual period)

LIST PRESCRIBED AND OTC DRUGS, INCLUDING VITAMINS AND INHALERS: ____NONE

Name of Drug	Strength	Frequency Taken
		/day
		/day
		/day
		/day
		/day
		/day
		/day

ALLERGIES TO MEDICATIONS ____NONE

Name of Drug (circle one)	Reaction (rash/vomiting/hives,etc)	Severity
		very mild, mild, moderate, severe
		very mild, mild, moderate, severe
		very mild, mild, moderate, severe
		very mild, mild, moderate, severe

Have you ever had a blood transfusion? Yes No

Medical History for _____ _____

(PATIENT NAME) (DATE)

_____ I'm doing well and have no current complaints

Today my main concern is: _____

_____ Significant family history: high blood pressure/diabetes/heart disease/other _____

_____

Please circle any and all that apply:

General: I am generally healthy/I have been experiencing weight change/I am concerned about a change in my strength or exercise tolerance.

Head: I am experiencing regular headaches/vertigo/head injury.

Eyes: I am experiencing double vision/tearing/blind spots/loss of vision/eye pain.

Ears: I am experiencing changes in my hearing/ringing/buzzing sounds/bleeding/vertigo or dizziness.

Nose: I am experiencing nose bleeds/inflammation/sinus problems/obstruction/discharge.

Mouth: I am experiencing dental difficulties/bleeding gums/I have dentures, partials/broken teeth/cavities

Neck: I am experiencing stiffness/neck pain/neck tenderness.

Breast: I am experiencing lumps in my breast(s)/breast tenderness/swelling/nipple discharge.

Chest: I am experiencing labored breathing/wheezing/coughing/coughing up blood.

Heart: I am experiencing chest pains/heart palpitations/shortness of breath/temporary loss of consciousness/shortness of breath when laying down.

Abdomen: I am experiencing changes in my appetite/I have had difficulty swallowing/I have abdominal pains/there has been a change in my bowel habits/vomiting/dark feces/blood in stool

GU: I am experiencing changes in urinary urgency/pain in urination/change in nature of urine.

Gyn: I am experiencing changes in my monthly period/painful menses/ vaginal/ discharge/pelvic pain.

Musculoskeletal: I am experiencing changes in my muscles/joints/limitation of range of motion/tingling/ numbness.

Skin: I am experiencing rashes/itching/pigmentation changes/hair changes/nail changes.

Neurologic: I am experiencing weakness/tremors/seizures/changes in mental activity/loss of body motion.

Psychiatric: I am experiencing depressive symptoms/changes in my sleep habits/changes in thought content/thoughts of hurting myself or others (current or in the past)

Social: Do you drink alcohol? __yes ___no If so how much _____

Do you use tobacco (cigarette/dip/cigars)? __yes ___no If so how much _____

Do you vape? ____yes ___ no

Do you use recreational drugs? Yes / No If yes, what kind? _____

Any recent travel? _____

Reviewed by _____ Date _____