

Today's Date

PATIENT INFORMATION

Name		last	first	initial	suffix (Jr, III, Title, Etc.)
Social Security#		Date of Birth		Sex	
Mailing Address					
city		state	ZIP		
Home Ph#		Work Ph#		Cell Ph#	
Marital Status		Student (please circle) <small>no</small> yes /		Email	
Employer Name		Employer Ph#		Employment Status (please circle) full time / part time	
Employer Address		city	state	ZIP	
Emergency Contact		Ph#		Relationship to Patient	

Primary Insurance			Policy #	
Subscriber's Name		last	first initial	
Subscriber's Relation to Patient				
Social Security#		Date of Birth		Sex
Subscriber's Employer			Phone #	
Employer Address		city	state	ZIP

Secondary Insurance			Policy #	
Subscriber's Name		last	first initial	
Subscriber's Relation to Patient				
Social Security#		Date of Birth		Sex
Subscriber's Employer			Phone #	
Employer Address		city	state	ZIP

Consent For Treatment

The undersigned hereby consents to examination and treatment by a Family Care Physician or Certified Physician's Assistant and to the performance of any laboratory work or diagnostic procedure which the treating physician may deem necessary under the circumstances.

Authorization to Release Information

I hereby authorize Family Care to release information concerning examination, testing and treatment of the above patient to any insurance company requesting the same for purposes of determining eligibility for payment of insurance benefits.

Authorization to Pay Insurance Benefits and Guarantee of Payment

I understand I am financially responsible to Family Care for charges that may not be covered by my insurance policy. I hereby authorize payment of insurance benefits to Family Care for services rendered.

Patient's Signature

Date

Patient Name: _____

Date of Birth: _____

1. Please list all medications and dosages that you take. _____

2. Any vitamins or over-the-counter supplements? _____

3. Have you had any medication allergies? Please list and describe the reaction. _____

4. Are you allergic to anything else such as bees, peanuts or latex? Please List _____

5. Have you had any of the following medical conditions? Please list with year diagnosed:

Heart Disease _____ Migraine Headache _____ HIV _____

High Blood Pressure _____ Anemia _____ Kidney Problems _____

Diabetes _____ High Cholesterol _____ Cancer of any kind _____

Blood Clots _____ Liver Problems _____ MRSA _____

Stroke or TIA _____ Hepatitis _____ Asthma or Resp. Problems _____

6. Has anyone in your family been treated or diagnosed with the following? Relation to you?

Sudden Cardiac Arrest _____ High Cholesterol _____ Age of parents living/diseased: _____

Heart Disease/Attack _____ Colon Cancer or Polyps _____ _____

Stroke _____ Diabetes _____ Any other condition you are aware of that

Blood Clots _____ Breast Cancer _____ might be hereditary? _____

High Blood Pressure _____ Prostate Cancer _____ _____

7. Please list household members and relationship. Spouse, partner, child. _____

8. Have you ever used tobacco? _____ How much? _____ How long? _____ When did you quit? _____

9. Do you drink Alcohol? _____ How much? _____ Per week or per month.

10. Have you ever had a problem with alcohol or substance abuse of any kind? _____

11. Please give dates for most recent vaccinations

Tetanus Booster _____ Pneumonia _____ Flu Shot _____ Hepatitis _____

12. Have you completed routine childhood vaccinations? _____

13. Please list any surgeries or hospitalizations _____

14. Have you had any mental health treatment or been treated for depression? _____

Compound Authorization for Release of Information / Acknowledgement of Receipt of NPP

Name of Patient _____ Date of Birth _____

Family Care is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	Description of information to be released. Check each that can be given to person/entity on the left in the same section.
<input type="checkbox"/> Voice Mail	<input type="checkbox"/> Results of lab tests/x-rays <input type="checkbox"/> Other _____
<input type="checkbox"/> Give information to employer <input type="checkbox"/> Give information to school	<input type="checkbox"/> Appointment absentee information
<input type="checkbox"/> Spouse	<input type="checkbox"/> Family billing information <input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____
<input type="checkbox"/> Parent (provide name) _____ _____	<input type="checkbox"/> Family Billing Information <input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____
<input type="checkbox"/> Other (provide name) _____ _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows _____
<input type="checkbox"/> Support Group (provide name) _____	<input type="checkbox"/> Demographic Information

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to the Privacy Officer. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ Date _____

(Signature of Patient or Personal Representative)

Description of Personal Representative's Authority (attach necessary documentation):
