



Patient Registration Form

Date: \_\_\_\_\_

Patient Information:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_
Sex: \_\_\_ Male \_\_\_ Female Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_ Home Phone: \_\_\_\_\_
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
Work Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Patient Referred By: \_\_\_\_\_
Marital Status: \_\_\_ Single \_\_\_ Married \_\_\_ Other (widow,divorced,separated) Patient PCP: \_\_\_\_\_
Spouse's Name: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_ Spouse's Employer Phone: \_\_\_\_\_

Guardian Information (If Applicable):

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Phone: \_\_\_\_\_
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_
SS#: \_\_\_\_\_ DOB: \_\_\_\_\_ Employer Name: \_\_\_\_\_
Employer Address: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Emergency Contact Information:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Employer Information:

Employer Name: \_\_\_\_\_ Employer Phone: \_\_\_\_\_
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Guarantor Information:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Phone: \_\_\_\_\_
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
SS#: \_\_\_\_\_ DOB: \_\_\_\_\_ Employer Name: \_\_\_\_\_
Employer Address: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Insurance Information:

Insurance Plan Name: \_\_\_\_\_ Insurance Phone Number: \_\_\_\_\_ Policy ID Number: \_\_\_\_\_
Street Address for Claims: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
Patient's Relationship to Policy Holder: \_\_\_\_\_ Policy Group Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_
Policy Holder Last Name: \_\_\_\_\_ Policy Holder First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Policy Holder Sex: \_\_\_ Male \_\_\_ Female
Policy Holder Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
Policy Holder SS#: \_\_\_\_\_ Policy Holder DOB: \_\_\_\_\_ Policy Holder Employer Name: \_\_\_\_\_
Policy Holder Employer Address: \_\_\_\_\_ Policy Holder Employer Phone: \_\_\_\_\_

Injury and Workman's Compensation Information:

Is Injury Related to: \_\_\_ Work \_\_\_ Auto Accident \_\_\_ Other Date of Injury: \_\_\_\_\_ Work Comp Claim #: \_\_\_\_\_
Case Manager/Adjuster Name: \_\_\_\_\_ Case Manager/Adjuster Phone Number: \_\_\_\_\_

**Please read each of the following statements carefully and sign as your authorization, understanding and agreement to each statement.**

ASSIGNMENT AND RELEASE: I hereby assign my insurance benefits to be paid directly to the physician. I also authorize the physician to release any information required to process this claim to my employer, prospective employer and/or insurance carrier.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

MEDICARE BENEFICIARY ASSIGNMENT AND RELEASE: I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by \_\_\_\_\_. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

FINANCIAL OBLIGATION: I hereby acknowledge that I understand there may be services provided that will not be covered by my insurance carrier, and fully understand that I am fully responsible for any and all charges not covered by my insurance carrier. I understand that payment may be requested at the time of service or I may be billed for such services subsequently.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

CONSENT FOR TREATMENT: I hereby authorize the physician, nurses, medical assistants and staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

ADVANCED DIRECTIVE: Do you have an advance directive (living will/power of attorney)?

\_\_\_\_ Yes \_\_\_\_ No If yes, please provide a copy for our records.

**For Office Use Only:**

**New Patient**

- Registration Form
- Completed Signatures on Back of Registration Form
- Insurance Verification Form
- Copy of Patient Insurance Card
- Obtained Patient Signature on Encounter Form
- Copy of Picture ID of Patient
- Patient Rights and Responsibilities – Notification to Patient
- Advanced Directive Information Provided
- HIPAA Notice of Privacy Practices
- Patient Medical History Form
- Authorization/Referral Form
- Any Prior Medical Records, Lab Tests, X-rays Needed for Visit
- If Applicable, Notice of Hospital Based
- If Medicare, Medicare Secondary Payor Form
- If Workman's Compensation – State Required Forms
- Collected CoPay
- Collected or Notified Patient of Any Prior Balance Due
- If Applicable, ABN or Notice of Non-Coverage

**Registration Staff Confirmation Checklist Completed:**

- Registration Staff Member Initials: \_\_\_\_\_ Date: \_\_\_\_\_
- Registration Staff Member Initials: \_\_\_\_\_ Date: \_\_\_\_\_
- Registration Staff Member Initials: \_\_\_\_\_ Date: \_\_\_\_\_
- Registration Staff Member Initials: \_\_\_\_\_ Date: \_\_\_\_\_
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- Registration Staff Member Initials: \_\_\_\_\_ Date: \_\_\_\_\_

**Established Patient**

- Registration Form – Insure 1 Year Current (if not, follow New Pt Cklist)
- Verified Patient Demographic Information
- Insurance Verification
- Obtained Patient Signature On Encounter Form
- Reviewed Patient Insurance Card and Compared to Copy in Chart
- Copy of Insurance Card for Billing Staff or Update for Chart
- Confirmed Copy of Picture ID in Chart
- Patient Rights and Responsibilities – Notification to Patient
- HIPAA Notice of Privacy Practices – Insure 1 Year Current
- Request to Change Release of Confidential Medical Information Form
- Patient Medical History Form
- Authorization/Referral Form
- Any Prior Medical Records, Lab Tests, X-rays Needed for Visit
- If Applicable, Notice of Hospital Based
- If Medicare, Medicare Secondary Payor Form
- If Workman's Compensation – State Required Forms
- Collected CoPay
- Collected or Notified Patient of Any Prior Balance Due
- If Applicable, ABN or Notice of Non-Coverage

**Discharge Staff Confirmation Checklist Completed:**

- Discharge Staff Member Initials: \_\_\_\_\_ Date: \_\_\_\_\_
- Discharge Staff Member Initials: \_\_\_\_\_ Date: \_\_\_\_\_
- Discharge Staff Member Initials: \_\_\_\_\_ Date: \_\_\_\_\_
- Discharge Staff Member Initials: \_\_\_\_\_ Date: \_\_\_\_\_
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- Discharge Staff Member Initials: \_\_\_\_\_ Date: \_\_\_\_\_

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are committed to protecting the confidentiality of your medical information, and are required by law to do so. This notice describes how we may use your medical information within the physician's office and how we may disclose it to others outside the physician's office. This notice also describes the rights you have concerning your own medical information. Please review it carefully and let us know if you have questions.

**HOW WILL WE USE AND DISCLOSE YOUR MEDICAL INFORMATION?**

**Treatment:** We may use your medical information to provide you with medical services and supplies. We may also disclose your medical information to others who need that information to treat you, such as doctors, physician assistants, nurses, medical and nursing students, technicians, therapists, emergency service and medical transportation providers, medical equipment providers, and others involved in your care. For example, we will allow the hospital to have access to your medical records to assist in your treatment at the hospital for your care.

We also may use and disclose your medical information to contact you to remind you of an upcoming appointment, to inform you about possible treatment options or alternatives, or to tell you about health-related services available to you.

**Family Members and Others Involved in Your Care:** We may disclose your medical information to a family member or friend who is involved in your medical care, or to someone who helps to pay for your care. We also may disclose your medical information to disaster relief organizations to help locate a family member or friend in a disaster. If you do not want the office to disclose your medical information to family members or others who will visit you, **you must talk to the Privacy Official**. You can reach our Privacy Official using contact information listed on the last page of this notice.

**Payment:** We may use and disclose your medical information to get paid for the medical services and supplies we provide to you. For example, your health plan or health insurance company may ask to see parts of your medical record before they will pay us for your treatment.

**Hospital Operations:** We may use and disclose your medical information if it is necessary to improve the quality of care we provide to patients or to run the Hospital. We may use your medical information to conduct quality improvement activities, to obtain audit, accounting or legal services, or to conduct business management and planning. For example, we may look at your medical record to evaluate whether Hospital personnel, your doctors, or other health care professionals did a good job.

**Research:** We may use or disclose your medical information for research projects, such as studying the effectiveness of a treatment you received. These research projects must go through a special process that protects the confidentiality of your medical information.

**Required by Law:** Federal, state, or local laws sometimes require us to disclose patients' medical information. For instance, we are required to report child abuse or neglect and must provide certain information to law enforcement officials in domestic violence cases. We also are required to give information to the State Workers' Compensation Program for work-related injuries.

**Public Health:** We also may report certain medical information for public health purposes. For instance, we are required to report births, deaths, and communicable diseases to the State. We also may need to report patient problems with medications or medical products to the FDA, or may notify patients of recalls of products they are using.

**Public Safety:** We may disclose medical information for public safety purposes in limited circumstances. We may disclose medical information to law enforcement officials in response to a search warrant or a grand jury subpoena. We also may disclose medical information to assist law enforcement officials in identifying or locating a person, to prosecute a crime of violence, to report deaths that may have resulted from criminal conduct, and to report criminal conduct at the physician's office. We also may disclose your medical information to law enforcement officials and others to prevent a serious threat to health or safety.

**Health Oversight Activities:** We may disclose medical information to a government agency that oversees the office or its personnel, such as the State Department of Health, the federal agencies that oversee Medicare, the Board of Medical Examiners or the Board of Nursing. These agencies need medical information to monitor the office's compliance with state and federal laws.

**CHANGES TO THIS NOTICE**

Updated 04/08

**Coroners, Medical Examiners and Funeral Directors:** We may disclose medical information concerning deceased patients to coroners, medical examiners and funeral directors to assist them in carrying out their duties.

**Organ and Tissue Donation:** We may disclose medical information to organizations that handle organ, eye or tissue donation or transplantation.

**Military, Veterans, National Security and Other Government Purposes:** If you are a member of the armed forces, we may release your medical information as required by military command authorities or to the Department of Veterans Affairs. The office may also disclose medical information to federal officials for intelligence and national security purposes, or for presidential Protective Services.

**Judicial Proceedings:** The Physician Office may disclose medical information if the office is ordered to do so by a court or if the office receives a subpoena or a search warrant. You will receive advance notice about this disclosure in most situations so that you will have a chance to object to sharing your medical information.

**Information with Additional Protection:** Certain types of medical information have additional protection under state or federal law. For instance, medical information about communicable disease and HIV/AIDS, and evaluation and treatment for a serious mental illness is treated differently than other types of medical information. For those types of information, the office is required to get your permission before disclosing that information to others in many circumstances.

**Other Uses and Disclosures:** If the office wishes to use or disclose your medical information for a purpose that is not discussed in this Notice, the office will seek your permission. If you give your permission to the office, you may take back that permission any time, unless we have already relied on your permission to use or disclose the information. If you ever would like to revoke your permission, please notify the Privacy Official in writing.

#### **WHAT ARE YOUR RIGHTS?**

**Right to Request Your Medical Information:** You have the right to look at your own medical information and to get a copy of that information. (The law requires us to keep the original record.) This includes your medical record, your billing record, and other records we use to make decisions about your care. To request your medical information, write to the Privacy Official. If you request a copy of your information, we will charge you for our costs to copy the information. We will tell you in advance what this copying will cost. You can look at your record at no cost.

**Right to Request Amendment of Medical Information You Believe Is Erroneous or Incomplete:** If you examine your medical information and believe that some of the information is wrong or incomplete, you may ask us to amend your record. To ask us to amend your medical information, write to the Privacy Official.

**Right to Get a List of Certain Disclosures of Your Medical Information:** You have the right to request a list of many of the disclosures we make of your medical information. If you would like to receive such a list, write to the Privacy Official. We will provide the first list to you free, but we may charge you for any additional lists you request during the same year. We will tell you in advance what this list will cost.

**Right to Request Restrictions on How the Hospital Will Use or Disclose Your Medical Information for Treatment, Payment, or Health Care Operations:** You have the right to request us not to make uses or disclosures of your medical information to treat you, to seek payment for care, or to operate the office. We are not required to agree to your request, but if we do agree, we will comply with that agreement. If you want to request a restriction, write to the Privacy Official and describe your request in detail.

**Right to Request Confidential Communications:** You have the right to ask us to communicate with you in a way that you feel is more confidential. For example, you can ask us not to call your home, but to communicate only by mail. To do this, write to the Privacy Official. You can also ask to speak with your health care providers in private outside the presence of other patients – just ask them!

**Right to a Paper Copy:** If you have received this notice electronically, you have the right to a paper copy at any time. You may download a paper copy of the notice from our Web site, at PENDING , or you may obtain a paper copy of the notice from the Privacy Official.

#### **CHANGES TO THIS NOTICE**

Updated 04/08



## NOTICE OF PRIVACY PRACTICES

From time to time, we may change our practices concerning how we use or disclose patient medical information, or how we will implement patient rights concerning their information. We reserve the right to change this Notice and to make the provisions in our new Notice effective for all medical information we maintain. If we change these practices, we will publish a revised Notice of Privacy Practices. You can get a copy of our current notice of Privacy Practices at any time by contacting the Privacy Official.

### WHICH HEALTH CARE PROVIDERS ARE COVERED BY THIS NOTICE?

This Notice of Privacy Practices applies to the Hospital and its personnel, volunteers, students, and trainees. The Notice also applies to other health care providers that come to the office to care for patients, such as physicians, physician assistants, therapists, other health care providers who are not employed by the office, emergency service providers, medical transportation companies, and medical equipment and suppliers who come to the office. The office may share your medical information with these providers for treatment purposes, to get paid for treatment, or to conduct health care operations. These health care providers will follow this Notice for information they receive about you from the Hospital. These other health care providers may follow different practices at their own offices or facilities. A list of these health care providers is available for your review in the Admissions Office by contacting the Privacy Official.

### DO YOU HAVE CONCERNS OR COMPLAINTS

Please tell us about any problems or concerns you have with your privacy rights or how the Hospital uses or discloses your medical information. If you have a concern, please contact

Local Privacy Official	210-297-1094
Corporate Privacy Official	1-888-895-9945
Corporate Compliance Hotline - Washington DC	1-800-300-9876

If for some reason the Hospital cannot resolve your concern, you may also file a complaint (in writing) with the federal government at the OCR/DHHS regional office.

We will not penalize you or retaliate against you in any way for filing a complaint with the federal government.

### DO YOU HAVE QUESTIONS?

The Hospital is required by law to give you this Notice and to follow the terms of the Notice that is currently in effect. If you have any questions about this Notice, or have further questions about how the Hospital may use and disclose your medical information, please contact the Privacy Official.

Effective date: April 14, 2003.

### Privacy Official Contact Information:

Name:	Baptist Physician Network - HIPAA Privacy Officer
Mailing Address:	8711 Village Drive, Suite 320 San Antonio, TX 78217
Phone:	210-297-2240

### CHANGES TO THIS NOTICE

Updated 04/08

**REQUEST FOR MEDICAL RECORDS**

Date: \_\_\_\_\_

Name of patient: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Social Security # \_\_\_\_\_

I \_\_\_\_\_ request that all my records be sent to the following physician.

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If you have any question please call us at: \_\_\_\_\_.

Thank you for your prompt attention in this matter.

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date



**ACKNOWLEDGEMENT OF  
RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

*\*You May Refuse to Sign This Acknowledgement\**

I, \_\_\_\_\_, DOB, \_\_\_\_\_,

have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**For Office Use Only:**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

\_\_\_\_\_ Individual refused to \_\_\_\_\_ accept Notice \_\_\_\_\_ sign Acknowledgement

\_\_\_\_\_ Communications barriers prohibited obtaining the acknowledgement

\_\_\_\_\_ An emergency situation prevented us from obtaining acknowledgement

Other (Please specify)

\_\_\_\_\_

Patients who fail to present for a scheduled appointment without contacting the practice to cancel the appointment within 24 hours will be considered a “no-show”. Patients who consistently fail to present for scheduled appointments will be considered a “chronic no-show”.

It is the policy of this practice that a patient determined to be a “chronic no-show” will be charged \$25.00 after the 3<sup>rd</sup> missed appointment.

A chronic “no-show” is defined as having 3 missed appointments in a rolling 12-month period.

- Patient will be notified of the “no-show” policy at the time of registration.
- Patient appointment status will be updated in Athena as a “no-show”
- Patient will be called within 24 hours and notified of a missed appointment. Patient will be reminded of the “no-show” policy and the \$25.00 charge due.
- A note must be made in the chart stating the patient was a “no-show”, indicate appointment rescheduled date or left message. Sign, date and time in chart.
- The 3 missed appointments will be documented as follows:
  - 1<sup>st</sup> missed appointment, patient will be called to reschedule appointment along with a letter reminding patient of their appointment.
  - 2<sup>nd</sup> missed appointment patient will be called to reschedule appointment along with letter reminding patient of their appointment and reminding patient of the No-Show policy fee.
  - 3<sup>rd</sup> missed appointment patient is billed \$25.00 and sent a letter discharging them from the practice. Discharging a patient from a practice is the decision of the physician.

\_\_\_\_\_ has read and understand the above stated policy.  
Patient Signature



Communication with family & others involved in your care

Patient Information

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, indicate what kinds of information may be shared with each individual.

<u>Name</u>	<u>Relationship to Patient</u>	<u>Type of information</u>			
		All	Schedule	Medical	Billing
_____	_____	Y/N	Y/N	Y/N	Y/N
_____	_____	Y/N	Y/N	Y/N	Y/N
_____	_____	Y/N	Y/N	Y/N	Y/N
_____	_____	Y/N	Y/N	Y/N	Y/N

Specific Instructions or Limitations: \_\_\_\_\_

Validation Code \_\_\_\_\_ Please provide this code to any individual who may be involved in coordination you care or payment of care. They will be asked for this code before information will be released by phone.

We will continue to relay on the information in this when communicating with family members or others involved in you care unless you request changes. Please promptly notify you Physician’s office if you wish to alter the designations above.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

To revoke this authorization, please send a written request with a copy of this form to the Physician’s office.

If you have any questions please call the Physician’s office and ask for the Office Manager.

# MEDFIRST

## PRIMARY CARE

### New Patient Questionnaire

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**All Prior Physician(s):**

Name:	Address	Phone/Fax:
_____	_____	_____
_____	_____	_____

**CURRENT MEDICAL PROBLEM**

What problem brought you here?  
 \_\_\_\_\_

What symptoms are you having?  
 \_\_\_\_\_

When did the symptoms begin?  
 \_\_\_\_\_

Has your appetite changed in the last six months?    Increased       Decreased       stayed the same

Current    Height \_\_\_\_\_    Weight \_\_\_\_\_

Has your weight changed in the last six months?    No    Yes    If yes, Gained \_\_\_\_\_lbs    Lost \_\_\_\_\_lbs

Has your overall energy level changed?       Increased       Decreased       stayed the same

**PAST MEDICAL / SURGICAL HISTORY**

Please list any medical problems (e.g. diabetes, high blood pressure, cancer etc)

Problem:	Problem:

**Females:**

Number of times you've been pregnant? _____	Number of live births? _____
Number of miscarriages? _____	Number of abortions? _____
Age you started your period? _____	Age at menopause? _____
Hormone replacement?                      No    Yes	Number of years? _____

Please list any previous operations or procedures

Procedure / Operation	Date	Surgeon	Hospital

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**FAMILY HISTORY**

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Stroke						
Heart Disease						
Diabetes						
Hypertension						
Cancer						
Other						

**Pharmacy of Choice:**

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**MEDICATIONS:**

Please list all medications or pills that you take, whether or not prescribed by a physician. Record them as they are on the drug box/bottle. Please include all vitamins, herbal supplements, and/or over the counter medications.

Medicine or pill name	Dose (e.g., 50 mg)	How many times per day?	Why do you take this?

Are you allergic to any medications, pills, food, etc.?

Item	Reactions?	Item	Reactions?

Are you allergic to shellfish, eggs?      Yes      No      Don't know  
 Are you allergic to contrast or dye injected in a medical test?      Yes      No      Don't know  
 If so, what happened?      Rash      Short of breath      Other \_\_\_\_\_

**VACCINATIONS**

Have you received a pneumonia vaccine with the past 5 years.      No      Yes, date \_\_\_\_\_      Don't know  
 Have you received a flu vaccine this season?      No      Yes, date \_\_\_\_\_      Don't know  
 When was your last tetanus?      Date: \_\_\_\_\_      Don't know

**PREVENTATIVE CARE**

When was your last physical?      \_\_\_\_\_      When was your last mammogram?      \_\_\_\_\_  
 When was your last pap smear?      \_\_\_\_\_      When was your last colonoscopy?      \_\_\_\_\_  
 When was your last prostate exam?      \_\_\_\_\_

**SOCIAL HISTORY**

SINGLE      MARRIED      SEPARATED/DIVORCED      WIDOWED

What is your current or former occupation?  
\_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Do you currently or have you ever used tobacco products?** Never No/Quit Yes Would like to quit  
If yes or quit, how much per day? \_\_\_\_\_ Age started? \_\_\_\_\_ Age quit? \_\_\_\_\_  
Type: Pipe Cigars Smokeless tobacco  
Cigarettes, have you smoked this past year? No Yes

**Do you or have you used alcohol?** Never No/Quit Yes  
If yes or quit, how much per day? \_\_\_\_\_  
Type: Beer Wine Liquor Moonshine

**Do you or have you used recreational drugs?** Never No/Quit Yes, type: \_\_\_\_\_

**Do you have an advance directive** (living will, durable power of attorney)? No Yes (please provide copy)

**Do you have any religious or cultural beliefs that you would like your doctor to know about?** No/Yes  
If yes, please explain; \_\_\_\_\_  
\_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_