PHYSICIANS MEDICAL HEALTH GROUP PC
INTERNAL MEDICINE

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PATIENT INFORMATION

Date Completed: ________________

Last Name:________________________**First Name:**______________________**Middle:** ________________

Gender: Male/Female/Other **DOB:** /____/______ **Marital Status:** Single/Married/Divorced/Widowed

Social Security Number:______-_____-_______

Home address:___________________________**City:**_________________**State:**_______**Zip:** ________

Home Phone: (_____)_______-__________**Work Phone**: (_____)_______-__________

Cell Phone: (_____)_______-__________ **Email address:** ________________________

Employer: __________________________________

Work Address:_______________________________**City:**__________________**State:**_______**Zip:** _______

Alternate/Emergency Contact Name:______________________________**Relationship:**_______________

Alternate/Emergency Contact Phone: __( )__________________________

INSURANCE INFORMATION

Primary Insurance Company:___________________**ID#**____________**Group #**________**Co-pay Amt**_____

Secondary Insurance Company:_________________**ID#**____________**Group#**_________**Co-pay Amt**_____

Guarantor(Insured) name if other than the patient:

Last name:________________________**First Name:**_______________________**Middle:**________________

Relationship to a patient ______________ **DOB:**_____/____/_____ **SSN:**_____-______-_______

Guarantor(Insured) Address: ____

City:_______________________**State:**_________**Zip:**_______________**Phone**: (_______)_____-________

Primary Insurance Company:___________________**ID#**____________**Group #**________**Co-pay Amt**_____

Secondary Insurance Company:_________________**ID#**____________**Group#**_________**Co-pay Amt**_____

CONCERNING INSURANCE

I AUTHORIZE (1)Use of my signature on all my insurance submissions, (2)Release of info to all my insurance companies,(3)My doctor to act as my agent in helping me obtain payment from my insurance carrier, (4)Payment made directly to Physicians Medical Health Group PC,(5)Permit a copy of this authorization to be used in place of the original,(6)I Understand that I am financially responsible for charges not paid by my insurance company

APPOINTMENT CANCELLATION POLICY

Patient agrees to call the office at least 24 hours in advance to avoid cancellation charges. If patient does not give advance notice , or misses her/his appointment, there will be a $35.00 fee

Signature of patient:_____________________________ Date: ___________________________

HEALTH HISTORY

Name:____Date: ______________________________

Age:______________Date of Birth:________________________Sex: ______________________________

Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed ○ Separated
Number of Children: Boys ___ Girls ___

HEALTH HABITS

Do you now, or have you ever smoked?

○ Yes ○ No No. of Years: __________ Pack/Day: __________ Date Quit: ____________________

Do you drink alcoholic beverages? ○ Every Day ○ Most Days ○ Rarely ○ No

Illicit Drugs? ○ Yes ○ No

Blood Transfusion? ○ Yes ○ No

Do you exercise? ○ Regularly ○ Occasionally ○ Rarely

Do you drive? ○ Yes ○ No Seatbelt? ○ Yes ○ No

Do you live alone? ○ Yes ○ No

FAMILY RECORD

	Alive	Deceased	Age at Death	Cause of Death
Mother:	_________	_________	_________	_________________________
Father:	_________	_________	_________	_________________________
Other:	_________	_________	_________	_________________________

FAMILY HISTORY

(Circle the appropriate letter for Mother, Father, Brother, Sister, and Children)

Arthritis	M	F	S	B	C	Thyroid dz.	M	F	S	B	C
Asthma	M	F	S	B	C	Kidney dz.	M	F	S	B	C
Angina	M	F	S	B	C	Heart dz.	M	F	S	B	C
Hypertension	M	F	S	B	C	Cancer	M	F	S	B	C
Stroke	M	F	S	B	C	Seizures	M	F	S	B	C
Diabetes	M	F	S	B	C	Hepatitis	M	F	S	B	C

Other Diseases or Illnesses in Family: ____

____

Is your Spouse in Good Health? ____

____

Name:______________________________DOB: ____________________

List All Current Medications

____
____
____
____
____
____
____
____
____
____

List All Previous Surgeries or Hospitalizations

____
____
____
____
____

Food and/or Medications you are Allergic to:

____
____
____

Symptoms Check (√) symptoms you currently have or have had in the past year.

General

- □ Chills
- □ Depression
- □ Dizziness
- □ Fainting
- □ Fever
- □ Forgetfulness
- □ Headache
- □ Loss of Sleep
- □ Loss of Weight
- □ Nervousness
- □ Numbness
- □ Sweats

Gastrointestinal

- □ Appetite Poor
- □ Bloating
- □ Bowel Changes
- □ Constipation
- □ Diarrhea
- □ Excessive Hunger
- □ Excessive Thirst
- □ Gas
- □ Hemorrhoids
- □ Indigestion
- □ Nausea
- □ Rectal Bleeding
- □ Stomach Pain
- □ Vomiting
- □ Vomiting Blood

Eye, Ear, Nose, Throat

- □ Bleeding Gums
- □ Blurred Vision
- □ Crossed Eyes
- □ Difficulty Swallowing
- □ Double Vision
- □ Earache
- □ Ear Discharge
- □ Hay Fever
- □ Hoarseness
- □ Loss of Hearing
- □ Nose Bleeds
- □ Persistent Cough
- □ Ringing in Ears
- □ Sinus Problems
- □ Vision Flashes
- □ Vision Halos

Men Only

- □ Breast Lump
- □ Erection Difficulties
- □ Lump in Testicles
- □ Penis Discharge
- □ Sore on Penis
- □ Prostate disease
- □ Poor Urinary Stream

Women Only

- □ Abnormal Pap smear
- □ Bleeding btw. Period
- □ Breast Lump
- □ Extreme Menstrual Pain
- □ Hot Flashes
- □ Nipple Discharge
- □ Painful Intercourse
- □ Vaginal Discharge

Date of Last Period ______________

Date of Last Pap smear ______________

Have you had a Mammogram □Yes □No

Pregnant? □ Yes □ No

Number of Children?

Muscle/Joint/Bone

Pain, Weakness, Numbness

- □ Arms □ Hips □ Back
- □ Legs □ Feet □ Neck
- □ Hands □ Shoulders

Genito-Urinary

- □ Blood in Urine
- □ Frequent Urination
- □ Lack of Bladder Control
- □ Painful Urination

Cardiovascular

- □ Chest Pain
- □ High Blood Pressure
- □ Irregular Heartbeat
- □ Low Blood Pressure
- □ Poor Circulation
- □ Rapid Heartbeat
- □ Welling of Ankle
- □ Varicose Veins

Skin

- □ Bruise Easily
- □ Hives
- □ Itching
- □ Change in Moles
- □ Rash
- □ Scars
- □ Sore that won't Heal

Conditions Check (√) conditions which you have or have had in the past years.

- □ AIDS
- □ Alcoholism
- □ Anemia
- □ Anorexia
- □ Arthritis
- □ Asthma
- □ Bleeding Disorders
- □ Breast Lump
- □ Bronchitis
- □ Bulimia
- □ Hepatitis
- □ Chemical Dependency
- □ Chicken Pox
- □ Diabetes
- □ Emphysema
- □ Epilepsy
- □ Glaucoma
- □ Goiter
- □ Gonorrhea
- □ Gout
- □ heart disease
- □ High Cholesterol
- □ HIV Positive
- □ kidney disease
- □ Liver Disease
- □ Measles
- □ Migraine Headaches
- □ Miscarriage
- □ Mononucleosis
- □ Multiple Sclerosis
- □ Mumps
- □ Prostate Problem
- □ Psychiatric Care
- □ Rheumatic Fever
- □ Scarlet Fever
- □ Stroke
- □ Suicide Attempt
- □ Thyroid Problems
- □ Tonsillitis
- □ Tuberculosis
- □ Typhoid Fever

____

Patient Signature

Reviewed by OFFICE USE ONLY

Name____

I furthermore authorize the physician, nurse, and his representatives to release the results of medical exams and reports to the following person:

Name ____

Address____

Phone number_____(   )________________

Do you have an advance directive in health? If yes, please bring a copy to the office

At times that you may not be able to make your own health decisions, have you appointed anyone to act on your behalf? If yes, please provide the details here.

Name ____

Address____

Phone number_____(   )   _______________________

I understand that this office will release any information to those persons who I have appointed. Other physicians may receive this information without a separate consent as needed for maintaining my health. I also understand that this relates to all medical, as well as billing information.

_____________________________________   __________________________
Signature   Date

Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal information is protected for privacy. The Privacy Rule was also created to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health care operations. As our patient we want you to know that we respect the privacy of your personal medical information and will do all we can to secure and protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel need your health care information and information about treatment, payment, or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationship with you (such as laboratories that only interact with physicians and not patients) and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use of disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to give your Personal Health Information (PHI). You may not revoke actions that have already been taken which relied on this or previously signed consent.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: ____

Signature: ____

Date: ____