NEW PATIENT INFORMATION

DATE:_____

PATIENT NAME:_____ **DATE OF BIRTH:**_____

ADDRESS:_____
CITY **STATE** **ZIP**

SS:_____ **RACE:**_____

HOME #:_____ **WORK #:**_____ **CELL #:**_____

EMPLOYER:_____

NEXT OF KIN:_____ **PHONE #:**_____

FIRST INSURANCE:_____ **INSURANCE PHONE#:**_____

POLICY HOLDER:_____

POLICY #:_____ **GROUP #:**_____

ADDRESS TO MAIL CLAIMS TO:_____

_____

SECOND INSURANCE:_____ **INSURANCE PHONE#:**_____

POLICY HOLDER:_____

POLICY #:_____ **GROUP #:**_____

ADDRESS TO MAIL CLAIMS TO:_____

_____

PATIENT NAME:_____

MEDICATIONS

List medicines you are currently taking

NAME	DOSE	PILLS EACH TIME	TIMES /DAY
1)			
2)			
3)			
4)			
5)			

SURGERIES

List surgeries you have had such as tonsils, appendix, gallbladder, or female surgeries

1) 4)

2) 5)

3) 6)

MEDICAL HISTORY

List other practices or specialists that you see

_____

List how much tobacco, alcohol, or caffeine (coffee, cola) you use in a week

_____

List allergies to medicines and what happens when you take them

_____

List your interests and hobbies

_____

PATIENT NAME:_____

Check symptoms you currently have or have had in the past

__Abdominal pain	__Allergies	__Anemia	__Black tarry stools
__Blurred vision	__Bright red bleeding	__Broken bones	__Chest pain
__Chronic cough	__Chronic headaches	__Colitis	__Color blindness
__Diarrhea	__Gallbladder disease	__Hearing changes	__Indigestion/heartburn
__Kidney stones	__Loss of consciousness	__Muscle aches	__Nausea
__Numbness/tingling	__Pancreatitis	__Seizures	__Shortness of breath
__Trouble swallowing	__Using cane/walker	__Using glasses/lens	__Using hearing aid
__Vomiting	__Weakness or fatigue		

__Other(list):_____

Reason for current visit_____

Please put the most recent date you had the following done:

_____ Bone Density Test

_____ Colonoscopy

_____ Mammogram

_____ PSA (Prostate test)

_____ Tetanus shot

_____ Pap Smear

Patient Name (Last, First, Middle Initial) | Date of Birth | Social Security/ID Number

SIGNIFICANT MEDICAL HISTORY

Please check any problem that the patient or an immediate family member has or had:

	Patient	Mother	Father	Brother	Sister
Acne					
Attention deficit disorder					
Anemia (low blood count)					
Aneurysm-abdomen					
Aneurysm-brain					
Anxiety					
Asthma					
Abnormal pap smear					
Back pain-chronic					
Bleeding disorder					
Breast problem					
Cancer					
Irregular heart rhythm					
Chronic fatigue syndrome					
Carotid artery disease					
Coronary artery disease					
Depression					
Diabetes mellitus					
Dysfunctional uterine bleeding					
Dysmenorrhea					
Eating disorder					
Eczema					
Emphyzema					
Endometriosis					
Epilepsy/seizure					
Gallbladder disease					
Gastritis (stomach problems)					
Gastroesophageal reflux					

	Patient	Mother	Father	Brother	Sister
Headaches-chronic					
Hearing impaired					
Heart attack/heart failure					
Hepatitis/liver failure					
Hypercholesterolemia (high cholesterol)					
Hypertension (high blood pressure)					
Hyperthyroidism					
Hypothyroidism					
Irritable bowel syndrome					
Kidney stones					
Leukemia					
Lymphoma (lymph node cancer)					
Mitral valve prolapse (heart valve problems)					
Mobility impaired					
Ovarian cyst					
Peptic ulcer disease					
Pneumonia					
Premenstrual syndrome					
Pulmonary embolism (blood clots)					
Schizophrenia/mood disorder/bipolar					
Sinusitis,chronic					
Substance abuse (alcohol, drugs)					
Thyroid disease					
Thrombophlebitis					
Tobacco use					
Ulcerative colitis/colitis					
Uterine fibroids					
Vision impaired					

Other Significant Medical Problems:

FAMILY MEDICINE OF WARREN, PA, P.C.

143 Pleasant Drive, Warren, PA 16365

Phone: 814-726-3310 Fax: 814-723-1338

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Family Medicine to use, disclose, and/or receive certain protected health information (PHI) and me to/from:

___ **SEND COPIES TO** Name:_____

___ **REQUEST FROM** Address:_____

___ **TRANSFER TO** City, State, Zip_____

PLEASE SEND THE MOST RECENT LAST TWO YEARS OF MEDICAL INFORMATION. NO CD's

Name of patient: _____

This authorization permits Family Medicine to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used/disclosed, such as dates of services, types of services, level of detail etc.). Federal rules prohibit Family Medicine from re-disclosure of this information unless further disclosure is permitted by the patient with written consent.

This authorization pertains to the disclosure of the record types indicated below between the following dates of service: from_____to_____or all records retained by facility, circle one or all.

Progress notes Laboratory tests Immunization records Operative reports

Hospital records Imaging reports Other specified information:_____

The information will be used/disclosed for the following purpose (purpose may be listed as "at the request of the individual"): Circle one or all.

Continuing Care Insurance Legal Personal Use Transfer of care Other: _____

This authorization will expire on:_____or be valid until such time that you receive written notice from me revoking this release:

I have read and understand this authorization, and authorize use/disclosure of health information about the named patient as described in this authorization.

_____ _____ _____

SIGNATURE OF PATIENT/GUARDIAN **PATIENT DOB** **DATE**

_____ _____

PRINTED NAME PATIENT/GUARDIAN **RELATIONSHIP TO PATIENT**

RECEIPT OF THE NOTICE OF PRIVACY PRACTICES FOR FAMILY MEDICINE OF WARREN, PA, PC

I ACKNOWLEDGE THAT I HAVE RECEIVED AND REVIEWED FAMILY MEDICINE'S PRIVACY PRACTICES NOTIFICATION

_____ _____

PATIENT NAME PATIENT DATE OF BIRTH

_____ _____

PATIENT SIGNATURE DATE

PATIENT AUTHORIZATION TO RELEASE HEALTH INFORMATION

I, _____give Family Medicine of Warren, PA permission to disclose and release my protected health information to:

Name(s): **Relationship:** **Phone:**

_____

_____

Health Information to be disclosed: (check all that apply)

____ My complete health record (including diagnoses and billing) **OR**

____ My complete health record with the **exception** of the following: (check as appropriate)

- ____ Mental health records
- ____ Communicable diseases (including HIV/AIDS)
- ____ Alcohol/drug abuse treatment
- ____ Other

(This authorization may be revoked at any time by notifying us in writing)

HOW WOULD YOU LIKE US TO CONTACT YOU?

Leave appointment message on:		**Leave medical information on:**	
Home phone?	___	Home phone?	___
Cell phone?	___	Cell phone?	___
Office voice mail?	___	Office voice mail?	___
Via mail?	___	Via mail?	___
Via email?	___	Via email?	___
With someone	___	With someone	___

Check all that apply