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| **Patient Information** | | | | | | | | | | | | | | |
| Date: | | |  | |  | |  | | | | New Patient | | Update |  |
| Patient: | | |  | |  | |  | | | |  | |  |  |
|  | | | Last | | First | | MI | | | | Preferred | | Title |  |
|  | | | Male Female | | Child\*Student\*\* | | | | | SingleMarriedDivorcedWidowed | | | | |
| \*If child, provide parent/guardian name(s) below: | | | | | | | | \*\*If student, please complete: Full-time Part-Time | | | | | |  |
|  |  | | | | |  | |  |  | | | | |  |
|  | Parent/Guardian Name(s) | | | | |  | |  | School/Location | | | | |  |
| Patient Date of Birth: | | | |  | | | Patient SSN: | | | |  | | |  |
| Address: | |  | | | | | | | | |  | | |  |
|  | | Address Line 1 | | | | | | | | |  |  | |  |
|  | |  | | | | | | | | | Home: |  | |  |
|  | | Address Line 2 | | | | | | | | | Cell: |  | |  |
|  | |  | | |  | |  | | | | Other: |  | |  |
|  | | City | | | ST | | ZIP Code | | | | Pager: |  | |  |
| E-Mail: | |  | | | | | | | | | Fax: |  | |  |
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| **emergency Information** | | | | | |
| In case of emergency, please provide information for the nearest relative or designated contact person: | | | | | |
|  |  |  | Tel: |  |  |
|  | Name | Relationship |  |  |  |

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| **employment Information** | | | | | | | |
| Employer: |  | | Occupation: |  | | |  |
| Address: |  | | | |  | |  |
|  | Address Line 1 | | | | Work: | X |  |
|  |  | | | | Direct: |  |  |
|  | Address Line 2 | | | | Other: |  |  |
|  |  |  |  | |  |  |  |
|  | City | ST | ZIP Code | |  |  |  |
| E-Mail: |  | | | |  |  |  |
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| **insurance Information** | | | | | | | | | | | | | | | |
| Subscriber: |  | | | | |  | |  | | | |  | |  |  |
|  | Last | | | | | First | | MI | | | | Preferred | | Title |  |
| Subscriber Date of Birth: | | |  | | | | | Subscriber SSN: | | | |  | | |  |
| Subscriber Employer: | | |  | | | | | | | | | | | |  |
| Patient Relationship to Subscriber: | | | | | Self SpouseChild Other | | | | | | | | | |  |
| **Primary Insurance Carrier:** | | | |  | | | | | | | | | | |  |
| Group/Policy No.: | |  | | | | | | | ID No.: |  | | | | |  |
|  | City | | | | | ST | ZIP Code | | | |  | |  | |  |
| **Secondary Insurance Carrier:** | | | |  | | | | | | | | | | |  |
| Group/Policy No.: | |  | | | | | | | ID No.: |  | | | | |  |
|  | City | | | | | ST | | ZIP Code | | |  | |  | |  |
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| **pharmacy information** | | | | | |
| Preferred Pharmacy | | | | | |
|  |  |  |  |  |  |
|  | name | address |  | telephone number |  |

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| **medical history** | | | | | | | | | | | |
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| All Patients: Do you have, or have you ever had any of the following? (Check all that apply): | | | | | | | | | None | |  |
| Acid Reflux | | Bulimia | Hearing Problems | | | | | Psychiatric Treatment | | | |
| ADHD | | Cancer/Malignancy | Heart Attack | | | | | Radiation/Chemo | | | |
| AIDS/HIV | | Cerebral Palsy | Heart Disease | | | | | Respiratory Disease | | | |
| Anemia | | Chemical Dependency | Heart Murmur | | | | | Rheumatic Fever | | | |
| Anorexia | | Chicken Pox | Hepatitis | | | | | Sinus Problems | | | |
| Anxiety | | Convulsions | High Blood Pressure | | | | | Stroke | | | |
| Artificial Heart Valve | | Depression | Kidney Disease | | | | | Thyroid Condition | | | |
| Artificial Joints | | Diabetes | Liver Problems | | | | | Tuberculosis | | | |
| Arthritis | | Dizziness/Fainting | Mitral Valve Prolapse | | | | | Ulcers | | | |
| Asthma | | Epilepsy/Seizures | Mononucleosis | | | | | Venereal Disease | | | |
| Autism/Asperger’s | | Frequent Ear Infections | Pacemaker | | | | |  | | | |
| Bleeding Disorder | | Frequent Headaches | Other – please list: | | | |  | | | |  |
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| are you ALLERGIC to or have you ever had any reaction to the following? (check all that apply): | | | | | |
| Aspirin | Codeine | Lactose Intolerance | Sleeping Pills | None |  |
| Anesthetic – Local | Dairy | Metal Sensitivity | Sulfa Drugs | | |
| Barbiturates | Latex | Nitrous Oxide Sedation | Penicillin/Other Antibiotics | | |
| Other – please list: |  | | | |  |
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| ***surgical/hospitalization history*** | | |
| ***procedure*** | ***year*** | ***location*** |
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| ***medication information*** | | |
| ***Drug Name*** | ***Dosage*** | ***Reason Prescribed*** |
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| **family history** | | | | | | | | | | |
| **member** | | | **age** | | | **present health or cause of death** | | | | |
| father alive deceased | | |  | | |  | | | | |
| mother alive deceased | | |  | | |  | | | | |
| sisters alive deceased | | |  | | |  | | | | |
| brothers alive deceased | | |  | | |  | | | | |
| children alive deceased | | |  | | |  | | | | |
| **social/preventative history** | | | | | | | | | | |
| **social history** | | | | **preventative care** | | | | | | |
| tobacco Y N\_\_\_\_\_\_\_\_\_\_\_\_\_ packs/day  former tobacco user \_\_\_\_\_\_\_\_\_ date quit  alcohol Y N\_\_\_\_\_\_\_\_\_\_\_\_\_ drinks/week  caffeine Y N­­­\_\_\_\_\_\_\_\_\_\_\_\_cups/day  exercise Y N­­\_\_\_\_\_\_\_\_\_\_\_\_times/week  recreational drugs Y N\_\_\_\_\_\_\_\_\_\_\_\_\_  sexual orientation\_\_\_\_\_\_\_\_\_\_\_\_\_  number of sexual partners\_\_\_\_\_\_\_\_\_\_ | | | | date of last physical exam: ­­­­­­\_\_\_\_\_\_  colonoscopy: year: \_\_\_\_\_\_\_ normal? Y N  pap: year: \_\_\_\_\_\_\_­ normal? Y N  mammograms: year: \_\_\_\_\_\_ normal? YN  dexascan: year: \_\_\_\_\_\_\_\_ normal? Y N  last tetanus: \_\_\_\_\_\_\_  last tb: \_\_\_\_\_\_\_\_  last influenza \_\_\_\_\_\_\_ | | | | | | |
| **Previous provider Information** | | | | | | | | | | |
| Provider: |  | | | | Telephone: | | |  | |  |
| Clinic/Facility: |  | | | | | | | | |  |
| Address: |  | | | | | | | | |  |
|  |  | | | | | |  | |  |  |
|  | City | | | | | | ST | | ZIP Code |  |
| Reason for changing: | |  | | | | | | | |  |
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| ***specialist doctors*** | | | ***specialty*** | | | ***reason for seeing specialist*** | | | | |
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**PRIVACY CONSENT**

Effective January 1, 2019

Please place initials on the indicated line. Your initials are representative of agreement and understanding to the corresponding statements

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I acknowledge that I have received the Notice of Privacy Practices for Hobson Meadows Family Medicine. This form is to be filed in my medical record. If, however, I choose not to acknowledge this statement, it is to be noted within my medical record and will not interfere with my treatment.
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I consent to HMFM’s use and disclosure of my Protected Health Information in order to provide proficient treatment, payment and operations of healthcare. HMFM Notice of Privacy Practices gives a complete description of such terms.
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I consent that HMFM may contact my pharmacy to discuss medical information concerning coverage, benefits, and insurance plans in order to provide me the most cost efficient and pharmaceutically appropriate care.
4. List anyone you would authorize us to share or discuss your PHI. This could include medical treatment, diagnosis, or releasing of records.

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

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

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

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I hereby agree that I will provide HMFM with new and correct information regarding personal contact information and medical data. It is annual policy that HMFM is given said information to deliver me the most efficient and best care feasible.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (please print name above)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Patient Signature Date