Heritage Medicine

Patient's Name	Sex M F	Birth Date ____/____/_____ Age_____	Marital Status Single [ ] Married [ ] Widowed [ ] Divorced [ ]
Residence address City State Zip			Patient's Social Security #
At what number would you like us to communicate with you regarding lab results, appointment reminders, etc? Cell phone _____ Ok to leave Message? Yes / No Home phone _____ Ok to leave Message? Yes / No		Email:	Drivers License # State_____ Number_____
Referred By:		PCP:	
Name of Spouse/Parent		Spouse Birth date	Phone #
Name of employer Address		Business Phone	Occupation

IN CASE OF EMERGENCY

Person to contact in case of emergency:	Relationship to patient	Phone

INSURANCE INFORMATION

Primary insurance company Address			Is insurance through your employer?
Subscriber Name	Subscriber birth date	Policy #	Group #
Secondary insurance name Address		Policy #	Group #

Notice of Privacy Practices Acknowledgement:

I certify that I have received a copy of Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Herirtage Medicine's health care operations. The Notice of Privacy Practices also describes my rights and Herirtage Medicine's duties with respect to my protected health information. The Notice of Privacy Practices is posted in the lobby and on Herirtage Medicine's website at www.heritagemedicine.net

_____ _____

Patient Signature Date

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Practice Name for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. Should my account go unpaid I will be responsible for any and all collection costs associated with collection of my balance. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

_____ _____

Patient, Parent or Guardian Signature (if child is under 18 years old) Date

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Name: _____ Today's date: _____

To help us get the most out of today's visit, please answer the following questions:

1. What is your main purpose in coming to our office today? (If you have a new complaint, indicate how long it has been present, what it feels like, what makes it better or worse, and what you are concerned the problem might be?)

_____

2. Are you experiencing any of the following symptoms in relation to your main concern?

(Answer "yes" by circling the appropriate symptom.)

Constitutional symptoms: fever, weight loss, fatigue

Eyes: double vision, sudden loss of vision

Ears, nose, mouth and throat: sore throat, runny nose, ear pain

Cardiovascular: chest pain, palpitations

Respiratory: cough, wheezing, shortness of breath

Gastrointestinal: nausea, vomiting, abdominal pain, constipation, diarrhea, blood in stools

Genitourinary: irregular menses, vaginal bleeding, frequent or painful urination, bloody urine, impotence

Skin: rash, changing mole

Neurological: headache, persistent weakness or numbness on one side of the body, falling

Musculoskeletal: joint pain, muscle weakness

Psychiatric: depression, anxiety, suicidal thoughts

Endocrine: excessive thirst, cold or heat intolerance, breast mass

Hematologic: unusual bruising or bleeding, enlarged lymph nodes

Female Hormones: hot flashes, night sweats, mood instability, anxiety, irritability, fatigue, depression, low sex drive, weight gain, poor focus/concentration, memory loss, unrestful sleep

Male Hormones: Erectile dysfunction, low sex drive, lack of stamina, low energy.

3. Do you have any other concerns? Yes (list) No _____

4. Family history? (For example, have any of your blood relatives been diagnosed with any chronic illness?) Yes (list) No _____

5. Do you have any drug allergies? Yes (list) No _____

6. How much tobacco do you smoke or chew per day? _____

7. How much alcohol do you consume per week? _ _____

8. How much caffeine do you consume per day? (i.e., coffee, tea, chocolate, soda) _____

9. What is your occupation? _____

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10. Past Medical History: Please list any significant medical problems you have had in the past.

_____

_____

_____

11. Please list any past surgeries:

_____

_____

_____

12. Please list all medications you are currently on: (included strength and dosage):

_____

_____

_____

13. What method of birth control do you use? : _____

<u>Females Only:</u>

14. (Females only): When was your last pap smear? _____ Mammo:_____

15. Number of Pregnancies _____ Number of Live Births _____

16. Cycle Length (ex:28 days)_____ Period Length (ex: 4 days) _____

<u>Weight Loss Patients Only:</u>

17. Current Weight: _____ Desired Weight: _____

18. Past diets tried: _____

Outcome of Past efforts: _____