New Patient Information Sheet

Name: _____ Date of Birth: _____

Reason for appointment:

_____

_____

Past Medical History: *Please check all boxes that apply*

Childhood Illnesses:

- ☐ Measles
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Rheumatic Fever
- ☐ Whooping Cough

Cardiovascular:

- ☐ High Blood Pressure
- ☐ Chest Pain/Angina
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Abnormal Heart Rhythm
- ☐ Heart Murmur
- ☐ Abnormal Heart Valve
- ☐ High Cholesterol
- ☐ Other: _____

Endocrine:

- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Osteoporosis

Genitourinary:

- ☐ Frequent Urinary Tract Infections
- ☐ Kidney Stones
- ☐ Enlarged Prostate
- ☐ Other: _____

Neurologic:

- ☐ Seizures
- ☐ Stroke
- ☐ Numbness
- ☐ Memory Problems

Hematologic:

- ☐ Anemia
- ☐ Sickle Cell Disease
- ☐ Clotting Problems

Immunizations:

- ☐ Usual Childhood Immunizations
- ☐ Tetanus (date: _____)
- ☐ Pneumovax (date: _____)
- ☐ Shingles (date: _____)
- ☐ Flu (date: _____)

Pulmonary:

- ☐ Seasonal Allergies
- ☐ Asthma
- ☐ COPD/Emphysema/Chronic Bronchitis
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Other: _____

Gastrointestinal:

- ☐ Reflux/Heartburn
- ☐ Ulcer
- ☐ Hiatal Hernia
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Cirrhosis
- ☐ Diverticulitis
- ☐ Other: _____

Musculoskeletal:

- ☐ Arthritis
- ☐ Chronic Back Pain

Mental Health:

- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Schizophrenia

Cancer:_____

Other: _____

Name of previous primary care physician: _____

List names of all physicians who are currently treating you:

Name	Specialty	Reason

Surgical History:

- [ ] Appendix
- [ ] Gallbladder
- [ ] Hysterectomy
- [ ] Hernia Repair
- [ ] Coronary Artery
- [ ] Carotid Artery
- [ ] Prostate
- [ ] Joint – knee/hip/shoulder
- [ ] Heart Catheterization
- [ ] Colonoscopy
- [ ] Other: _____

Allergies: _____

_____

Current Medication List:
(include name, strength, and frequency):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Does anyone in your family have any of the following?

		Who?
☐	High Blood Pressure	_____
☐	Heart Disease	_____
☐	High Cholesterol	_____
☐	Diabetes	_____
☐	Stroke	_____
☐	Thyroid Disease	_____
☐	Blood Disorder	_____
☐	Depression/anxiety	_____
☐	Cancer	_____
☐	Other:	_____
☐	Other:	_____

Do you smoke?

- [ ] No, never
- [ ] Quit (Year:_____)
- [ ] Yes (# packs/day _____)

Do you drink alcohol?

- [ ] No, never
- [ ] Yes (How often?_____)

Marital status: M___ D___ S ___W___

Level of schooling completed:_____

Occupation:_____

Religious affiliation/preference:_____

Review of Systems – Please circle all that apply:

General:	weight change / fatigue / weakness / fevers / chills / night sweats
Skin:	skin change / nail changes / itching / rashes
Eyes:	tearing / itching / vision changes
Ears:	ringing in the ears / hearing loss / vertigo / earache / discharge
ENT:	runny nose / stuffiness / hoarseness / sore throat
Cardiac:	chest pain / palpitations / swelling in the legs
Respiratory:	shortness of breath / wheezing / coughing
GI:	nausea / vomiting / diarrhea / constipation / abdominal pain / rectal bleeding
Genitourinary:	urinary frequency / hesitancy / urgency / incontinence / burning
Muscular:	muscle weakness / stiffness / pain / joint swelling
Neurologic:	blackouts / dizziness / seizures / weakness in limbs
Vascular:	leg swelling / calf pain / varicose veins
Psychological:	anxiety / depression / memory loss

Do you have a living will? No ___ Yes ___
Do you have a designated Healthcare Power of Attorney? No ___ Yes___ (Name: _____)

PATIENT INFORMATION SHEET

Date	Account #	Chart 3	Primary Provider

Patient's Name	Social Security #	Telephone #

Patient's Mailing Address	City/State/Zip Code

Patient's Birthdate	Sex	Marital Status	Emergency Contact Name	Telephone #

Patient's Employer/School Name	Telephone #

Patient's Employer/School Mailing Address	City/State/Zip Code

PERSON RESPONSIBLE FOR BILL - PERSON TO RECEIVE BILLING STATEMENT

Name of Person Responsible for Bill	Telephone #

Person Responsible for Bill's Mailing Address	City/State/Zip Code

INSURANCE INFORMATION - INCLUDE MEDICARE OR MEDICAID

Primary Insurance Company Name	Effective Date of Coverage	Group #	Policy #

Person Responsible for Bill's Mailing Address	City/State/Zip Code

Policy Holder's Name	Social Security #	Birthdate	Sex

Policy Holder's Address	City/State/Zip Code	Patient's Relationship to Policy Holder: 1=Self 3=Child 2=Spouse 4=Grandchild

Policy Holder's Employer	Telephone #

Secondary Insurance Company Name	Effective Date of Coverage	Group #	Policy #

Insurance Address	City/State/Zip Code

Policy Holder's Name	Social Security #	Birthdate	Sex

Policy Holder's Address	City/State/Zip Code	Patient's Relationship to Policy Holder: 1=Self 3=Child 2=Spouse 4=Grandchild

Policy Holder's Employer	Telephone #

Please see reverse side.

By signing below:

1) I acknowledge the information in the front of this form to be accurate and complete.

2) I authorize the release of medical information necessary to process this claim and request payment of benefits either to myself or to the party who accepts assignment.

3) I accept financial responsibility for any services rendered at Woodward Medical Center if my insurance company or responsible party does not pay. I understand that any past due balance over 90 days old will be subject to the following charges:

   $20 for past due balances less than $100
   20% for past due balances over $100

Patient or Authorized Person's Signature

Date