Saint Joseph's Medical Practice, PC

Name:
Last: _____ First: _____ M.I.: _____ M: ____ F: ____

Ethnicity: _____ Race: _____ Language: _____

Date of Birth _____ Social Security # _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone: _____ Cell Phone: _____

May we leave a message for you on your answering machine or with a person other than you?
YES ___ NO ___ With whom _____

Email Address: _____ Who referred you? _____

Employer name and Address _____
_____

Pharmacy Name: _____ Address: _____ Phone # _____

PRIMARY INSURANCE
Company name and Phone # _____
Billing Address _____
Name if Insured/Relation to Patient _____
Insured's ID# _____ Group# _____

SECONDARY INSURANCE
Company name and Phone # _____
Billing Address _____
Name if Insured/Relation to Patient _____
Insured's ID# _____ Group# _____

Emergency Contact _____ Relationship _____ Phone # _____

I hereby authorize payment of medical benefits billed to my insurance to St. Joseph's Medical Practice, PC I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the practice does NOT participate with my insurance.
I agree to pay all copayments, coinsurance and deductibles at the time the services are rendered.

_____ _____
Signature of Patient or Guardian Date

Saint Joseph's Medical Practice, PC

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE INFORMATION

I, _____, hereby authorize St. Joseph's Medical Practice, PC to use and/ or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out treatment, payment and healthcare operations. I understand that while this consent is voluntary, if I refuse to sign this consent, the doctors can refuse to treat me.

I have been informed that St. Joseph's Medical Practice, PC has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and healthcare operations. I understand that I have a right to review such notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying St/ Joseph's Medical Practice, PC in writing, but if I revoke my consent, such revocation will not affect any actions that the doctors took before receiving my revocation.

I understand that St. Joseph's Medical Practice, PC has reserved the right to change their privacy practices and that I can obtain such changed notice upon request.

I authorize the following person(s) for St. Joseph's Medical Practice, PC physicians and staff to speak with on my behalf regarding my protected health information as well as any appointments, scheduling and/or insurance information related to treatment and/or payment.

NAME _____ Relationship _____ Phone # _____

NAME _____ Relationship _____ Phone # _____

NAME _____ Relationship _____ Phone # _____

_____ _____

Printed Name of Patient/ Representative Date

_____ _____

Signature of Patient/ Representative Date

_____ _____

Relationship to Patient Date

Saint Joseph's Medical Practice, PC

Please fill out the following information. We enter this information in our new electronic medical record system. If you are unsure of a question, or do not feel well enough to complete this form you may ask for assistance from the medical staff when you are called back. Thank you.

Name
Last: _____ First: _____ M.I. _____ D.O.B. _____

Do you have a healthcare proxy? ___ Yes ___ No

If NO, would you like to add a healthcare proxy? _____

Provider you are seeing today: Dr._____

Allergies __ No __ Yes If yes, please list allergy(s) and reaction(s): **Ex: Penicillin Rash**
1. _____ _____ 2. _____ _____

Medications __ No __ Yes
If yes, please list medications and dosage: Ex: Aspirin 325mg 1 tablet daily

1._____ _____ _____ 6._____ _____ _____
2._____ _____ _____ 7._____ _____ _____
3._____ _____ _____ 8._____ _____ _____
4._____ _____ _____ 9._____ _____ _____
5._____ _____ _____ 10._____ _____ _____

Are you experiencing pain? __ Yes __ No
On a scale of 1-10? _____ Where do you feel the pain? _____

Immunizations (approximate date is okay)

Flu shot _____
Pneumonia shot _____
Tetanus shot _____

Screenings (approximate date is okay)

Mammogram _____
Pap (smear) _____
Colonoscopy _____
Dexa Scan _____

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Past Medical History Please check all that apply:

__ None __ Allergies(seasonal) __ Angina __ Arthritis __ Asthma __ Cancer(type:_____)
__ Chronic Bronchitis/ Emphysema __ Coronary Artery Disease __ Depression __ Diabetes
__ Gallbladder Disease __ GERD __ Heart Attack __ High Cholesterol __ High Blood Pressure
__ Migraines __ Osteoporosis __ Peptic Ulcer Disease __ Seizure Disorder __ Stroke
__ Thyroid Disease
__ Other (please specify): _____

Past Surgical History Please check all that apply:

__ None __Angioplasty __Back Surgery __Breast Augmentation __ Breast Reduction
__ C-Section __ Carpel Tunnel Release __ Cataracts __Colostomy __Dilation & Curettage
__ Gastric Bypass __ Gall Bladder Removal __ Hernia Repair __ Hip Replacement
__ Hysterectomy __ Knee Scope __ Knee Replacement __ LASIK __ Mastectomy
__ Pacemaker __ Thyroid Removal __ Tonsil Removal __ Tubal Ligation
__ Other (please specify): _____

Family History Please check all that apply: __ None __ I'm Adopted

	Family Member:		Family Member:
_ ADD/ ADHD	_____	_ High Blood Pressure	_____
_ Alcoholism	_____	_ Irritable Bowel Disease	_____
_ Alzheimer's	_____	_ Learning Disability	_____
_ Arthritis	_____	_ Mental Illness	_____
_ Asthma	_____	_ Migraines	_____
_ Coronary Artery Disease	_____	_ Obesity	_____
_ Cancer (type:_____)	_____	_ Osteoporosis	_____
_ Depression	_____	_ Kidney Disease	_____
_ Diabetes	_____	_ Seizure Disorder	_____
_ Eczema	_____	_ Stroke	_____
_ High Cholesterol	_____		

Social History

Are there any occupational hazards at your place of emplyoement such as: asbestos, chemicals, excessive noise, potentially toxic fumes? __No __Yes
If yes, please list: _____
Do you use tobacco products? __No __Yes
If yes: Type: _____ Ammount per day: _____ Number of Yrs: _____
Do you drink alcohol? __No __Yes
If Yes: Type: _____ How often? (ex: weekly, daily) _____
Do you drink __ Coffee? __ Tea? __ Soda? __No __Yes: Amount per day (ex: 2 cups)_____
Do you use any recreational/ illegal drugs? __No __Yes Type: _____