Patients Information: **Date:________________________**

Last Name: _______________________________ First Name: ______________________ M.I. ____

Address: ____ Apt# __________

City/ State/ Zip: ____

Home Phone: _________________ Cell Phone: _______________ Work Phone: ________________

Email Address: ____

Date of Birth: __________ Sex: ___ Male ___ Female Social Security #: _____________________

Marital Status: ____________________________ Employer Name: __________________________

Alternate Address if Applicable: ____

City/ State/ Zip: ____

Emergency Contact Name: ____

Emergency Contact Phone #: ______________________ Relationship to Patient: _______________

Race:

_____ White ____ African American ____ American Indian/Alaska Native ____ Asian ____ Hispanic
____ Other _____ Decline

Ethnicity:

_____ Hispanic or Latino _____ Not Hispanic or Latino ______ Decline

Home Phone: ________________ Cell Phone: _______________ Work Phone: _______________

Preferred Pharmacy Name and Address____

Medical Insurance Information:

Primary Medical Insurance **Secondary Medical Insurance**

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder Date of Birth	Policy Holder Date of Birth
Policy Holder SS#	Policy Holder SS#
Patient Relationship to Policy Holder	Patient Relationship to Policy Holder

Patient Acknowledgement:

To the best of my knowledge, the information provided above is accurate and complete.

____ ___________________________

Patient or Authorized Person's Signature Date

Patient History Form

Name: ____ Date of Birth: ________________

Describe your present symptoms: ____

____

Current Medications:

Name of drug | Dose | Start Date | Stop Date

1____

2____

3____

4____

5____

6____

7____

8____

9____

10____

11____

12____

13____

14____

15____

16____

Other/Supplemental Vitamins or Medications:

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

Past Medical History:

Do you now or have ever had:

___ Anemia
___ Angina
___ Asthma
___ Cancer (type) ___________
___ Cataracts
___ Colitis
___ Crohn's disease
___ Diabetes
___ Emphysema
___ Epilepsy (seizures)
___ Goiter
___ Heart Murmur
___ Heart problems
___ Hepatitis
___ High blood pressure
___ High Cholesterol
___ HIV/ AIDS
___ Hypothyroidism
___ Jaundice
___ Kidney disease
___ Kidney Stones
___ Leukemia
___ Pneumonia
___ Psoriasis
___ Pulmonary embolism
___ Rheumatic fever
___Stomach or peptic ulcer
___ Stroke
___ Tuberculosis
___Other medical conditions (please list):
____

____

Allergies:

If you have no known allergies, please check the box at right. _____ No known allergies to report

1 Medication: ___________________________________ Reaction: _______________________________

2 Medication: ___________________________________ Reaction: _______________________________

3 Food or other allergies: ____

Surgeries (please list all major surgeries with estimated dates)

If you have no surgeries, please check. _____ No surgeries to report

____

____

____

____

Hospitalization:

Have you ever been hospitalized? Date (Month/ Year) Reason

____

____

____

Family History:

Mother (Alive/Deceased) _ __ Hypertension ___ Diabetes ___ Cancer ___ Other (specify)__________________

Father (Alive/Deceased) ___ Hypertension ___ Diabetes ___ Cancer ___ Other (specify) _________________

Social History:

Drink Alcohol: ___ Currently ___ In the past ___ Never How much and how often? ______

Use tobacco products: ___ Currently ___ In the past ___ Never How much? ____________________

Substance Abuse: ___ Currently ___ In the past ___ Never What substance? ________________

Psychiatric History: ____

____

Patient Consent for Treatment:

1 I voluntarily consent to all health care treatment and diagnostic procedures provided by Goodwin Medical Center and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other health care processions is not an exact science and I further state that I understand that no guarantee has been or can be made to the results of the treatment and examinations of Goodwin Medical Center.
2 I consent to the use and disclosure of my/ the patient's protected health information for purposes of obtaining payment for services rendered to me/ the patients, treatment and health care operations and consistent with the Goodwin Medical Center of Privacy Practices.
3 I authorize payment of medical benefits to Goodwin Medical Center physicians or their designee for services rendered.
4 I give permission to obtain all my medication/ prescription history when using an electronic system to process prescriptions for my medical treatment.

I have received a copy of the HIPPA Policy, Financial Policy Notice and the Release of Information.
___ Yes ___ No Initial _________

____ ____________________
Patient or Authorized Person's Signature Date