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 _____ Other_____Decline

Preferred Pharmacy Name and Address_____

How did you hear about us? _____

ADVANCE DIRECTIVE(*check appropriate*) ____DNR ____FULL CODE ____UNDECIDED ___DNI

Medical Insurance Information:

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
Policy Number	Policy Number

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_____

Circle of Care: Other Doctors you see

1._____

2._____

3._____

4._____

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? _____

Caffeine Use:_____What product?_____How much?_____

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

Patient Signature _____ Date:_____