

PARK MEDICAL CENTERS PATIENT INFORMATION FORM (PAGE 1)

Patient Name: _____ Social Security Number: _____
(Last) (First) (Middle Initial)

Address #1: _____ City: _____ State: _____ Zip: _____
(Street)(Apt. #) Building #

Address #2: _____ City: _____ State: _____ Zip: _____

Home Phone#: [] _____ Cell Phone # [] _____ [] No phone

Work Phone: [] _____ Preferred Contact #: [] _____ E-Mail Address: _____

Date of Birth: _____ Sex M F Marital Status: S M D W

Race: Black White Other Ethnicity: Hispanic/Latino Not Hispanic/Latino Refused

Language Spoken at Home _____

Emergency Contact: _____ Relationship: _____ Emergency Phone #: [] _____

Parent/Guardian: _____ Parent/Guardian Address: _____

INSURANCE INFORMATION (Please provide Insurance Card(s) and Photo ID to Receptionist)

Primary Insurance Company Name: _____ Name of Policy Holder: _____

Policy Holder's Birth Date: _____ Insurance ID # _____ Group #: _____

Patient's relationship to insured Self Spouse Child College Student Parent Guardian

Secondary Insurance Name: _____ Name of Policy Holder: _____

Date of Policy Holders Birth: _____ Insurance ID # _____ Group #: _____

Are you covered by Medicare or a Medicare Advantage Plan: YES NO

If YES, please advise eligibility date of: _____ Medicare A _____ Medicare B

GUARANTOR/PARENT INFORMATION

Responsible Party Name (if other than patient): _____

Relationship to Patient: _____ Responsible Party DOB: _____ Telephone Number [] _____

Guarantor's Address: _____ City _____ State: _____ Zip _____

Cell Phone #: [] _____ Employer Name: _____ Work Phone: [] _____

Insured's relationship to patient Self Child College Student Mother Father Spouse Guardian

Please read and sign: I hereby authorize my insurance benefits to be paid directly to Park Family Health Care, P.C. and I realize that I am responsible for paying for non-covered services and added costs incurred for services rendered. I hereby authorize the release of pertinent medical record information to insurance carriers.

Patient or Responsible Party _____ Today's Date: _____

PARK MEDICAL CENTERS PATIENT INFORMATION FORM (PAGE 2)

Patient Name: _____ Date of Birth: _____ Age: _____

Patient Medical/Social History

The following information is very important to your health. Please take the time to fully and completely fill out the sheet. This sheet should be updated yearly. This is important information and we are counting on you. If you have previously completed this sheet, please only provide new information.

CHRONIC ILLNESSES - CIRCLE

ASTHMA DIABETES HIGH BLOOD PRESSURE OTHER _____

ALLERGIES:

Are you allergic to medicines/foods (including tape, iodine or latex) Yes No

If yes, please complete the allergy information below:

Medicine, Food, Tape, Dye, Latex	Type of reaction you experience

SOCIAL HISTORY

Do you smoke? Yes No If YES how many per day? 1-5 6-10 11-15 16-20 2packs or more

If NO have you ever smoked? Yes No When did you quit? _____ Exposure to 2nd Hand Smoke? Yes No

Do you drink alcohol? Yes No If YES how much, how often? _____

Have you ever had sexual contact with a person who may have been exposed or infected with the AIDS virus? Yes No

Do you use any illegal drugs? Yes No Refuse To Answer

CURRENT MEDICATIONS additional meds on back

Medication	Dose	How Often	Medication	Dose	How Often

PAST SURGICAL HISTORY

Type of Operation	Date or Age at Time of Operation

FAMILY MEDICAL HISTORY - ANSWER 'Y' OR 'N'

CONDITION	MOTHER	FATHER	BROTHER/SISTER	AUNT/UNCLE	GRANDPARENT
Cancer					
Diabetes					
High Blood Pressure					
Heart Problems					
Hepatitis					
Stroke					
Bleeding Problem					
Seizures/Epilepsy					
Asthma					
Other					

Unusual reaction to anesthesia? _____

FEMALES ONLY

How many pregnancies have you had? _____ Have many life births? _____ Last Menstrual period? _____

Have you ever had a pap smear Yes No If YES, When _____ Where _____

Have you ever had a hysterectomy? Yes No If YES, When _____ Where _____

Have you ever had any breast surgery? What _____ When _____ Where _____

Have you ever had a mammogram? Yes No If YES, When _____ Where _____

The information provided by me on this form is true and correct to the best of my belief.

Patient or Responsible Party: _____ Today's Date: _____