PARK MEDICAL CENTERS PATIENT INFORMATION FORM (page 1)

Patient Name: _____ Date of Birth: _____ SSN (Last 4 Only):_____

Address:_____City:_____State:_____Zip: _____

Home Phone [___]_____ Cell Phone [_]_____ Work Phone [____]_____ [_] No phone

Email address: _____Preferred method of Contact: [ ] Home [ ] Cell [ ]Text [ ] Email

[ ] I authorize Park Medical Centers to notify me by email of information including but not limited to appointments.

Preferred Language _____ Marital Status: [_]S [_]M [_]D [ ]W Gender at Birth: [ ] Male [ ] Female

Gender Identity: [ ] Male [ ] Female [ ] Female-to-Male [ ] Male-to-Female [ ] Gender Queer [ ] Choose not to disclose [ ] Other

Sexual Orientation:[ ]Straight or Heterosexual [ ]Lesbian, Gay or Homosexual [ ]Bisexual [ ]Don't know [ ] Choose not to disclose [ ]Other

Race: [__]Black [__]White [__]Other Ethnicity: [_]Hispanic/Latino [_]Not Hispanic/Latino [_]Refused

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 #:_____Employer: _____

Patient's relationship to insured [_]Self [_]Spouse [_]Child [_]Dependent [_]Parent [_]Guardian [ ]Other

Secondary Insurance Name:_____Name of Policy Holder:_____

Date of Policy Holders Birth:_____Insurance ID #_____Group #:_____Employer: _____

Are you covered by Medicare or a Medicare Advantage Plan: [__] YES [_] NO

If YES, what is the 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 [_]Dependent [_]Mother [_]Father [_]Spouse [_]Guardian [ ]Other

Signature to authorize treatment and payment for services:

I hereby authorize my insurance benefits to be paid directly to Park Medical Centers 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 Signature_____Today's Date: _____

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 and we are counting on you. If you have previously completed this sheet, please provide only the new information.

CHRONIC ILLNESSES - CIRCLE
ASTHMA DIABETES HIGH BLOOD PRESSURE OTHER_____

ALLERGIES:
Are you allergic to medicines, foods, other? (including tape, iodine, latex) [__]Yes [__]No
If yes, please complete the allergy information below:

What are you allergic to?	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?[ ]Yes [ ]No If YES, 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 Signature:_____Today's Date: _____