FOUNDATIONS
Family Medicine

We at Foundations Family Medicine want to make sure we have the most up to date information on each one of our patients so WE can keep YOU updated on your Medical Health.

Please provide Foundations Family Medicine with the following information:

Name: _____

Address: _____

Date of Birth: _____ SSN #_____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Sex: _____ Marital Status: _____ Language:_____ Ethnicity:_____

Place of Employment: _____ Work #:_____

PRIMARY

Insurance Co.:_____ Policy #:_____

Group #_____ Policy Holder: _____

Policy Holder Date of Birth: _____ Policy Holder SSN #:_____

Secondary

Insurance Co.:_____ Policy #:_____

Group #_____ Policy Holder: _____

Policy Holder Date of Birth: _____ Policy Holder SSN #:_____

STATEMENT OF PERMIT PAYMENT OF MEDICAL BENEFITS TO PROVIDER, PHYSICIAN, AND PATIENT: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the service or authorize such physician or organization to submit a claim to Medicare for payment to me. I request that the payment under the medical insurance program be made either to me or to the above-named physician's office. I also hereby give my consent for evaluation and treatment by Foundations Family Medicine.

Signature of Patient or Guardian: _____ Date: _____

Emergency Contact Information:

Emergency Contact Name: _____
Emergency Contact #: _____
Relationship to Emergency Contact: _____

Immediate Family Members at your address that are patients at Foundations Family Medicine:

Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____

Preferred Pharmacy:

Pharmacy: _____ City: _____
Pharmacy Number: _____
What Pharmacy/Pharmacies have you used in the previous 6 months: _____

Authorization to Release Confidential Information to Other Persons and/or Leave Messages:

It is the policy of Foundations Family Medicine to not to release confidential information about you, unless it is for the care and treatment, payment, or operations. If you wish for our office staff and/or providers to leave a message for you on your home answering machine, work telephone, cell phone voicemail, or to any other person, then you must complete the following:

I authorize Foundations Family Medicine to release confidential patient information about me by the following methods and agree it is my responsibility for notifying my provider or office staff whenever I want this changed:

We can call your home:	Yes	No
We can leave a message on your home answering machine:	Yes	No
We can call you at work:	Yes	No
We can leave you a voicemail:	Yes	No
We can call your cell phone:	Yes	No
We can leave a voicemail on your cell phone:	Yes	No

Please list names of anyone and their relationship to you, if you wish us to release confidential patient information to them:

Name:_____ Relationship: _____

Name:_____ Relationship: _____

Patient/Guardian Signature: _____ Date: _____

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Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with Foundations Family Medicine. Any returned check will be subject to a $35 service fee. Necessary forms will be completed to file insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Foundations Family Medicine for medical services rendered to myself and or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Foundations Family Medicine to: (1) release any information necessary to insurance carriers regarding my illness and/or treatments: (2) process insurance claims generated in the course of examination or treatment: and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Foundations Family Medicine on behalf of myself and/or dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I fully understand that the fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Written Acknowledgement of Privacy Practices

I have been provided a copy of Foundations Family Medicine's Notice of Privacy Practices. This is to acknowledge my receipt of Foundations Family Medicine's Notice of Privacy Practices.

_____ _____

Patient/Responsible Party Signature Date

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FAMILY PRACTICE HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1.	
2.	
3.	

FAVORITE PHARMACY: _____

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, i.e., vitamins and inhalers.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

IMMUNIZATION HISTORY

Immunizations and most recent date:

☐ Chickenpox	Date:	☐ Meningococcus	Date:
☐ Flu Shot	Date:	☐ MMR (Measles, Mumps, Rubella)	Date:
☐ Gardasil/HPV	Date:	☐ Pneumonia	Date:
☐ Hepatitis A	Date:	☐ Tdap (Tetanus and pertussis)	Date:
☐ Hepatitis B	Date:	☐ Tetanus	Date:
		☐ Zostavax (Shingles)	Date:

(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear	Date:	☐ Abnormal	**CHECK BELOW IF APPLIES TO YOU:**
Last Mammogram	Date:	☐ Abnormal	☐ Bleeding between periods
Age of First Menstrual Period			☐ Heavy Periods
Last Period / Age of Menopause (Date / Age):			☐ Extreme Menstrual Pain
Number of pregnancies:			☐ Vaginal itching, burning, or discharge
Number of Miscarriages:			☐ Waking in the night to go to the bathroom
Number of Cesarean sections:			☐ Hot flashes
Number of Births:			☐ Breast lump or nipple discharge
Number of Abortions:			☐ Painful intercourse
Current sexual partner is:	☐ Female	☐ Male	☐ Sexually Active
Do you use condoms?	☐ Yes	☐ No	
Other Birth control method used:			
Interested in being screened for STDs:		☐ Yes ☐ No	

PAST MEDICAL HISTORY (Please check all that apply)

☐ Anxiety Disorder	☐ Diverticulitis	☐ Kidney Disease
☐ Arthritis	☐ Fibromyalgia	☐ Kidney Stones
☐ Asthma	☐ Gout	☐ Leg/Foot Ulcers
☐ Bleeding Disorder	☐ Has Pacemaker	☐ Liver Disease
☐ Blood Clots	☐ Heart Attack	☐ Osteoporosis
☐ Cancer	☐ Heart Murmur	☐ Polio
☐ Coronary Artery Disease	☐ Hiatal Hernia or Reflux Disease	☐ Pulmonary Embolism
☐ Claustrophobic	☐ HIV or AIDS	☐ Reflux or Ulcers
☐ Diabetes – Insulin	☐ High Cholesterol	☐ Stroke
☐ Diabetes – Non-Insulin	☐ High Blood Pressure	☐ Tuberculosis
☐ Dialysis	☐ Overactive Thyroid	☐ Other

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL
1.			
2.			
3.			
4.			
5.			

FAMILY HEALTH HISTORY

			SIGNIFICANT HEALTH PROBLEMS IN MY FAMILY									
RELATION	ALIVE?	AGE	ALCOHOLISM	ARTHRITIS	DEPRESSION	CANCER	DIABETES	GENETIC DISEASE	HEART DISEASE	HYPERTENSION	OSTEOPOROSIS	STROKE
GRANDMOTHER (MATERNAL)	☐ Y ☐ N											
GRANDFATHER (MATERNAL)	☐ Y ☐ N											
GRANDMOTHER (PATERNAL)	☐ Y ☐ N											
GRANDFATHER (PATERNAL)	☐ Y ☐ N											
FATHER	☐ Y ☐ N											
MOTHER	☐ Y ☐ N											
BROTHER/SISTER	☐ Y ☐ N											
BROTHER/SISTER	☐ Y ☐ N											
OTHER:	☐ Y ☐ N											

SOCIAL HISTORY

EDUCATION	MARITAL STATUS	EXERCISE	CAFFEINE
☐ < 8th grade ☐ High School ☐ 2 Yr College ☐ 4 Yr College ☐ Post Graduate	☐ Married ☐ Separated ☐ Single ☐ Widowed ☐ Divorced ☐ Domestic Partner	☐ No exercise ☐ Occasional exercise ☐ Moderate exercise ☐ High level exercise	☐ None ☐ Occasional ☐ Moderate ☐ Heavy # cups/cans per day? ____

ALCOHOL	TOBACCO	DRUGS
Drink Alcohol?	Do you use Tobacco? Yes ☐ No ☐	Do you currently use recreational or street drugs? Yes ☐ No ☐ If yes, please list:
Yes ☐ No ☐	If not now, did you ever use tobacco? Yes ☐ No ☐	
How often?	☐ Cigarettes ____ pks./day	
☐ Occasionally	☐ Chew ____ /day	
☐ < 3 times/week	☐ Cigars ____/day	
☐ > 3 times/week	# Years Used ____	
# Drinks/week? ____	Or year quit ____	

ADDITIONAL HEALTH FACTS

Please add other information about your health that you would like your provider to know here:

PARENT, GUARDIAN OR CAREGIVER SIGNATURE _____ DATE _____