

PATIENT INFORMATION

Patient's name: _____ Date of birth: _____

CURRENT MEDICATION

Please list any medications you are currently taking:

Drug: _____	Dose: _____	Drug: _____	Dose: _____
Drug: _____	Dose: _____	Drug: _____	Dose: _____
Drug: _____	Dose: _____	Drug: _____	Dose: _____
Drug: _____	Dose: _____	Drug: _____	Dose: _____

HISTORY OF ILLNESS

Have you ever had any of the following illnesses?	Yes	No		Yes	No
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Peptic ulcer/heartburn/GERD	<input type="checkbox"/>	<input type="checkbox"/>
Depression/anxiety.....	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia.....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Other (if yes, please explain below).....	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____		

Operations/surgeries:

Please list any serious injuries or accidents:

FAMILY HISTORY

Do any of your family members, such as parents, grandparents, siblings, aunts and uncles, have a history of the following illnesses: cancer, diabetes, heart disease, high blood pressure or other major illness? Please list below.

PATIENT INFORMATION

Have you been a patient here before? Yes No

Is the patient a minor? Yes No Gender: Male Female

Social Security number: _____

Legal name: _____

Date of birth: _____

Race: White African-American Hispanic American Indian

Other: _____

Preferred language: English Spanish Other: _____

Address: _____ Apt.: _____

Home phone: _____

City: _____ State: _____ ZIP: _____

Cell phone: _____

Employer: _____

Work phone: _____

Marital status: Single Married Widowed Divorced

Spouse's name: _____

Spouse's phone: _____

Nearest relative (not living with you): _____

Relative's phone: _____

Emergency contact: _____

Emergency phone: _____

*If the patient is a minor, please fill out the following information for **the minor's responsible party**:*

Legal name: _____

Social Security number: _____

Gender: Male Female

Date of birth: _____

INSURANCE INFORMATION

Gender: Male Female

Policyholder's name: _____

Social Security number: _____

Employer: _____

Date of birth: _____

ABOUT TODAY'S VISIT

Present symptoms or services requested: _____

Drug allergies: _____

How did you hear about us?: Yellow Pages Radio Website Newspaper Patient referral Physician referral

Referring patient's name: _____

Referring physician's name: _____

Referring physician's office: _____

Continued on reverse

MEDICAL RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, authorize Immediate Convenient Care to release my protected health information to
Patient name
_____. My relationship to the patient is _____.
Name (Specify)

Furthermore, I acknowledge that it will be my responsibility to inform Immediate Convenient Care should I wish to terminate this agreement.

Immediate Convenient Care requires payment in full at time of service. We accept cash, check and credit cards. As a courtesy, Immediate Convenient Care will file your health insurance claims. If we are a participating provider for your health insurance, we will require payment of all deductibles and/or co-insurance at time of service. If we are not a participating provider for your health insurance, we will require that your services be paid in their entirety at time of service. Please be advised that as a nonparticipating provider, your insurance company may deny some or all of the charges as not covered. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract as a nonparticipating provider. I authorize all insurance companies, other medical providers and any other entity having information concerning my healthcare to release such information to Immediate Convenient Care. I further authorize Immediate Convenient Care to release information to assist in the processing of my healthcare claims to my insurance company. If further collection efforts are required, I understand I will be responsible for attorney's fees and/or court costs.

Signature of patient or responsible party: _____ Date: _____

PATIENT INFORMATION

This survey is required at each visit as part of our accreditation standards for this office. Today's date: _____

Legal name: _____ Date of birth: _____

Address: _____ Apt.: _____ Home phone: _____

City: _____ State: _____ ZIP: _____ Cell phone: _____

Insurance: _____ Policy #: _____

REASON FOR TODAY'S VISIT

What are you seeing the doctor for today? _____

Please indicate if there have been any changes in the following since your last visit:

	Yes	No	
Have you had any undesirable weight loss or weight gain?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have difficulty feeding or dressing yourself?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you felt threatened?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you having any vision or hearing problems?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you experienced any recent falls, dizziness or weakness?.....	<input type="checkbox"/>	<input type="checkbox"/>	
Are you having any pain?	<input type="checkbox"/>	<input type="checkbox"/>	Location: _____

Please rate your level of pain on the scale below by circling the corresponding number:

0	1	2	3	4	5	6	7	8	9	10
none		mild		discomforting		distressing		severe		excruciating

Have there been any other changes since your last visit? _____

Nurse/physician signature: _____

INFORMATION REQUEST

Would you like more information on any medical condition? Yes No Patient initials: _____

I would like information from today's visit sent to another physician. Yes No

My physician is {Immediate Convenient Care} / { _____ }

Physician's phone number: _____