

Patient Name: _____
Date of Birth: (M/D/Y) _____ **Birth Sex:** [] Male [] Female **SSN:** (patient) _____
Previous and/or Maiden Name: _____
Parent/Legal Guardian Name: (if patient is a minor) _____ **SSN :**(Parent/guardian) _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____
Email: _____ **Marital Status:** [] Single [] Married
Language: [] English [] Spanish [] Other: _____
Race: [] Caucasian/White [] Black/African American [] American Indian [] Asian [] Hispanic/ Latino
[] Other: _____

EMPLOYMENT AND INSURANCE

Patient or Parent's Employer: _____ **Occupation:** _____
Primary Insurance Company: _____
Policy Holder's Name: _____ **Date of Birth:** _____
Policy Holder's Employer: _____ **Occupation:** _____
Relationship to Patient: _____ **SSN:** _____
Secondary Insurance Company: _____
Policy Holder's Name: _____ **Date of Birth:** _____
Policy Holder's Employer: _____ **Occupation:** _____
Relationship to Patient: _____ **SSN:** _____

EMERGENCY CONTACT

Name: _____ **Relationship:** _____
Phone Number: _____ **Date of Birth:** _____
Name: _____ **Relationship:** _____
Phone Number: _____ **Date of Birth:** _____

Power of Attorney: _____

Do you have an Advanced Directive? (End of Life Care) [] Yes [] No

I consent for staff to leave a voice mail pertaining to your health information. [] Yes [] No

Signature of Patient or Guardian

Date

Patient Name: _____

Date of Birth: _____

Reason for Visit: _____

Primary Care Physician: _____

Referring Physician: _____

Any religious, cultural or spiritual beliefs that may affect your treatment? Yes No

If yes, please explain: _____

PAST MEDICAL HISTORY (Please check all that apply):

- | | | |
|---|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> COPD | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Myocardial Infarction |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Peptic Ulcer Disease |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> GERD | <input type="checkbox"/> Renal Disease |
| <input type="checkbox"/> Benign Prostatic Hypertrophy | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> HIV | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cancer (type) | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Valve Disease |
| <input type="checkbox"/> CVA (stroke) | <input type="checkbox"/> Irritable Bowel Disease | |
| <input type="checkbox"/> Other: _____ | | |

PAST SURGICAL HISTORY (Please check all that apply):

- | | | |
|---|---|---|
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Cholecystectomy (Gall Bladder) | <input type="checkbox"/> Lasik |
| <input type="checkbox"/> Angioplasty with Stent | <input type="checkbox"/> Colectomy | <input type="checkbox"/> Liver Biopsy |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Colostomy | <input type="checkbox"/> Open Reduction Internal Fixation |
| <input type="checkbox"/> Arthroscopy Knee | <input type="checkbox"/> Ear Tubes | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Back Surgery | <input type="checkbox"/> Gastric Bypass | <input type="checkbox"/> Small Bowel Resection |
| <input type="checkbox"/> CABG (Heart Bypass) | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Thyroidectomy |
| <input type="checkbox"/> Carpal Tunnel Release | <input type="checkbox"/> Hip Replacement | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Cataract Extraction | <input type="checkbox"/> Knee Replacement | |
| <input type="checkbox"/> Other: _____ | | |

Patient Name: _____

Date of Birth: _____

SOCIAL HISTORY

Been exposed to Hazardous Materials (examples: asbestos, radiation, TB, etc.): Yes No

Special Diet Restrictions: _____

Frequency of Exercise: None/Occasionally 1-2 times/week 3-5 times/week Every day

Type of Exercise (ex: aerobic, walking, martial arts, etc.): _____

Drug Usage: Never Occasionally Regularly Used in the past – Year Quit: _____

Type of Drug(s) (ex: acid, cocaine, marijuana, etc.): _____

Route of Drug(s) (ex: inhale, in muscle, oral, etc.): _____

Alcohol Usage: Never Occasionally Regularly Used in the past – Year Quit: _____

Alcohol Type: _____ Drinks Per Week: _____ Years Used: _____

Tobacco Usage: Never Occasionally Regularly Used in the past – Year Quit: _____

Type: _____ Packs/Cans Per Day: _____ Years Used: _____

Exposed to second hand smoke: Yes No

Patient Name: _____

Date of Birth: _____

FAMILY HISTORY (Please check all that apply):

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other
<input type="checkbox"/> Allergies	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other
<input type="checkbox"/> Asthma	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other
<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other
<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other
<input type="checkbox"/> CVA (stroke)	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other
<input type="checkbox"/> Depression	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other
<input type="checkbox"/> Developmental Delay	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other
<input type="checkbox"/> Eczema	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other
<input type="checkbox"/> Hearing Deficiency	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other
<input type="checkbox"/> Hyperlipidemia	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other
<input type="checkbox"/> Irritable Bowel Disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other
<input type="checkbox"/> Learning Disability	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other
<input type="checkbox"/> Lung Cancer	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other
<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other
<input type="checkbox"/> Migraines	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other
<input type="checkbox"/> Obesity	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other
<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other
<input type="checkbox"/> Prostate Cancer	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other
<input type="checkbox"/> PVD (Blood flow problems: arms, legs, neck)	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other
<input type="checkbox"/> Renal Disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other
<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other

Other: _____

Patient Name: _____
Date of Birth: _____

PHARMACY INFORMATION

Pharmacy Name: _____
Location: _____

ALLERGIES None Penicillin Sulfa Drugs IVP Dye
 Food: _____
 Other: _____

MEDICATIONS

NAME	DOSAGE	HOW OFTEN?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
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_____	_____	_____



PATIENT AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

Patient Printed Name

Date of Birth

Med. Record Number

To our valued patients:

While coordinating care during your treatment at Southeast Health, our healthcare professionals may be asked to discuss your health information with a family member or friend involved in your care (i.e., to make arrangements for physician appointments, discuss diet, care, or medication instructions, discuss information related to any of your medical/health-related conditions, answer financial/billing questions, etc.).

You may also find it necessary to have a family member or friend pick up your prescription that can't be called in or e-prescribed.

We ask that provide the names and relationships of family member(s) and friend(s) who you authorize to have access to your health information and/or pick up prescriptions during your treatment at Southeast Health.

Permission to Discuss PHI and Release Prescriptions:

Please check box if permitted to pick up your prescriptions:

Name

Relationship to Patient

Name

Relationship to Patient

Name

Relationship to Patient

Name

Relationship to Patient

Name

Relationship to Patient



PATIENT AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION CONT.

Patient Printed Name

Date of Birth

Med. Record Number

Additional Disclosure Permissions:

If this patient has a legal representative or Durable Power of Attorney for Healthcare, please note here and provide a copy of the legal documentation for filing with the patient's electronic medical record:

Name of Rep or DPOA

Type of Representative

Phone Number

I further understand that this authorization will remain in effect until and/or may be revoked at any time by myself, my legal representative, or my Durable Power of Attorney for Healthcare.

Patient Signature

Date

Time

Witness Printed Name

Relationship or Title

Witness Signature

Date

Time

Thank you. Southeast Health respects your right to privacy.