PATIENT DEMOGRAPHIC VERIFICATION FORM

Patient Name:
Appointment Date & Time:
Appointment Provider: HUTTON,CONNIE C

Patient ID:
Primary Insurance Copay:
Specialty Copay:

		UPDATE INFORMATION BELOW
Responsible Party		
Name		
Address		
Phone Number		
Patient Information		
Name		
Spouse Name/Cell #		
Mailing Address		
Alternate/Local Address		
Phone Number		
Cell Phone Number		
Email Address		
Date of Birth		
Patient Sex		
Marital Status		
Age		
Social Security Number		
Primary Care Physician		
Preferred Language		
Race:	❑ American Indian or Alaskan Native ❑ Asian ❑ Native Hawaiian or other Pacific Islander ❑ Black or African American ❑ White ❑ Other Race ❑ Unreported/Refused to Report	
Ethnicity (Cultural Background)	❑ Hispanic or Latino ❑ Non-Hispanic or Latino ❑ Refused to Report	
How did you hear about us?	❑ Doctor or PCP ❑ Website/Search Engine ❑ Newspaper/Magazine ❑ Family or Friend ❑ Other _____	
Employer Information		
Name of Employer		
Employer Address		
Employer Phone Number		
Health Insurance		
Primary Insurance Name		
Primary Claim Address		
Primary Phone Number		
Primary Policyholder		
Primary Subscriber Number		
Primary Group Number		
Secondary Insurance Name		
Secondary Subscriber Number		
Secondary Group Number		
Pharmacy Information		
Pharmacy Name		
Pharmacy Address		
Pharmacy Phone Number		

I certify the above demographic and insurance information listed above to be correct. I hereby authorize any insurance benefits to be paid directly to the physician providing services and recognize my responsibility to pay for all non-covered services. I also authorize the physician to release any information necessary to process an insurance claim

X	**Date**

Medication List

Patient Name: _____ DOB: _____

Date List Started: _____ Page: _____ of _____

A Current Medication List Helps Prevent Errors.

RX Date	Medication Name & Strength To include over the counter meds such as vitamins, herbs, diet supplements	Dosage (mg, ml, etc)	How & When to Use (Daily, at bedtime, etc)	Stop Date

ALWAYS KEEP THIS FORM WITH YOU – Take it with you to all healthcare visits.

USE THIS FORM TO DOCUMENT ALL CHANGES MADE TO YOUR MEDICATIONS – Taking an active role in your healthcare can help prevent medication errors and **KEEP YOU SAFE!**

HEALTH HISTORY

Name: _____ Birth date: _____

Today's Date: _____ Date of last physical examination: _____

SYMPTOMS - Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ❑Chills
- ❑Dizziness
- ❑Fainting
- ❑Fever
- ❑Loss of weight
- ❑Numbness
- ❑Sweats

EYE, EAR, NOSE, THROAT
- ❑Bleeding Gums
- ❑Blurred vision
- ❑Crossed eyes
- ❑Difficulty swallowing
- ❑Double vision
- ❑Earache
- ❑Ear discharge
- ❑Hay fever
- ❑Hoarseness
- ❑Loss of hearing
- ❑Nosebleeds
- ❑Persistent cough
- ❑Ringing in ears
- ❑Sinus problems

CARDIOVASCULAR
- ❑Chest pain
- ❑High blood pressure
- ❑Irregular heart beat
- ❑Low blood pressure
- ❑Poor circulation
- ❑Rapid heart beat
- ❑Swelling in ankles

RESPIRATORY
- ❑Cough
- ❑Shortness of Breath
- ❑Decrease in exercise capacity

GASTROINTESTINAL
- ❑Abdominal pain
- ❑Appetite poor
- ❑Bloating
- ❑Bowel changes
- ❑Constipation or diarrhea
- ❑Gas
- ❑Heartburn or indigestion
- ❑Hemorrhoids
- ❑Nausea or vomiting

GENITO-URINARY
- ❑Blood in urine
- ❑Frequent urinating
- ❑Lack of bladder control
- ❑Painful Urination

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:
- ❑Arms ❑Hips
- ❑Back ❑Legs
- ❑Feet ❑Neck
- ❑Hands ❑Shoulders

SKIN
- ❑Bruise easily
- ❑Hives
- ❑Itching
- ❑Change in moles
- ❑Rash
- ❑Scars
- ❑Sore that won't heal

NEUROLOGICAL
- ❑Dizziness or lightheadedness
- ❑Weakness
- ❑Fainting
- ❑Seizures

PSYCHIATRIC
- ❑Depression
- ❑Headache
- ❑Loss of sleep
- ❑Nervousness
- ❑Stress
- ❑Trouble concentrating

ENDOCRINE
- ❑Diabetes
- ❑Hypertension
- ❑Thyroid disease

HEMATOLOGICAL
- ❑Anemia
- ❑Bleeding disorder

ALLERGIES
- ❑Asthma
- ❑Hayfever or allergic rhinitis

WOMEN only
- ❑Abnormal pap smear
- ❑Bleeding between periods
- ❑Breast lump
- ❑Extreme menstrual pain
- ❑Hot flashes
- ❑Nipple discharge
- ❑Painful intercourse
- ❑Vaginal discharge

Date of last menstrual period _____

Date of last pap smear _____

Have you had a mammogram?_____

Are you pregnant?_____

Number of children_____

MEN only
- ❑Erection difficulties
- ❑Lump in testicles
- ❑Penis discharge

Date of last prostate exam _____

CONDITIONS - Check (✓) conditions you have or have had in the past.

- ❑AIDS
- ❑Alcoholism
- ❑Anemia
- ❑Anorexia
- ❑Appendicitis
- ❑Arthritis
- ❑Asthma
- ❑Bronchitis
- ❑Bulimia
- ❑Cancer
- ❑Cataracts
- ❑Chemical dependency
- ❑Chicken pox
- ❑Emphysema
- ❑Epilepsy
- ❑Glaucoma
- ❑Goiter
- ❑Gonorrhea
- ❑Gout
- ❑Heart disease
- ❑Hepatitis
- ❑Hernia
- ❑Herpes
- ❑HIV positive
- ❑Kidney disease
- ❑Liver disease
- ❑Measles
- ❑Migraines
- ❑Miscarriage
- ❑Mononucleosis
- ❑Mumps
- ❑Pacemaker
- ❑Pneumonia
- ❑Polio
- ❑Prostate problem
- ❑Psychiatric care
- ❑Rheumatic fever
- ❑Scarlet fever
- ❑Stroke
- ❑Tonsilitis
- ❑Tuberculosis
- ❑Typhoid fever
- ❑Ulcers
- ❑Venereal disease

Please complete the back of this form also

PAST MEDICAL HISTORY: List surgeries you have had and the year	
1.	2.
3.	4.

MEDICATIONS: List medications you are currently taking.		ALLERGIES: To medication or substances
1.	8.	
2.	9.	
3.	10.	
4.	11.	
5.	12.	
6.	13.	
7.	14.	
Pharmacy Name:		**Phone:**

Fill in health information about your family				
	Age	**State of Health**	**Age at Death**	**Cause of Death**
Father				
Mother				
Brothers				
Sisters				

PREGNANCY HISTORY:

Year of Birth	Sex of Birth	Delivery Type	Complications if any

SOCIAL HISTORY:

Check (✓) the substance you use and describe how much you use.		
	Caffeine	
	Tobacco	
	Alcohol	
	Other	

FAMILY HISTORY:

List any illnesses that run in your family.	
1.	**5.**
2.	**6.**
3.	**7.**
4.	**8.**

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ **Date** _____

Physician Signature _____ **Date Reviewed** _____

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	**Date**
Printed Name of Patient or Personal Representative	**Relationship to Patient**
Printed Name of Witness	Employee Job Title
Signature of Witness	**Date**