Iron County
Medical Center
Family Care Clinic

PATIENT HISTORY & PHYSICAL

Name _____ SS # ___/___/___ Date _____

Address _____ Occupation _____

Phone (Home) (___) _____ (Work) (___) _____ Date of Birth _____ Age _____

Chief Complaint _____

Drug Allergies

Current Medication

Family History

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy / Convulsions	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐

Hospitalization or Surgery

Reason	Date	Reason	Date

Medical History

☐ Allergies / Hay Fever _____
☐ Anemia _____
☐ Anxiety _____
☐ Arthritis _____
☐ Asthma _____
☐ Chest Pain / Angina _____
☐ Colon Problems _____
☐ Congestive Heart Failure _____
☐ COPD / Emphysema _____
☐ Diabetes _____
☐ Dizziness / Fainting _____
☐ Elevated Sleeping Position _____
☐ Epilepsy / Seizures _____
☐ Fatigue _____
☐ Gout _____
☐ Headache _____
☐ Hearing Problems _____
☐ Heart Attack _____
☐ Heart Birth Defect _____
☐ Heart Disease _____
☐ High Blood Pressure _____
☐ High Cholesterol _____
☐ Incontinence _____
☐ Irregular Heart Beat _____
☐ Kidney Disease _____
☐ Leg Cramps _____
☐ Liver Disease _____
☐ Menstrual Problems _____
☐ Mental Illness _____
☐ Osteoporosis _____
☐ Pneumonia _____
☐ Rheumatic Fever _____
☐ Scarlet Fever _____
☐ Sexual dysfunction _____
☐ Shortness of Breath _____
☐ Stroke / TIA's _____
☐ Thyroid Disease _____
☐ Ulcer / Acid Reflux _____
☐ Venereal Disease / STD _____

WOMEN ONLY: Pregnant? ☐ Yes ☐ No Planning pregnancy? ☐ Yes ☐ No Last Menstrual Period _____

MEN ONLY: It's common for men to occasionally experience erection difficulties. Is this something that happens to you? ☐ Yes ☐ No

Habits

☐ Smoke: Packs daily _____
How long? _____
Interested in stopping? _____
☐ Exercise routine: _____
_____
_____

☐ Coffee: Cups daily _____
Other caffeine _____
☐ Alcohol: Type _____
Amount _____
☐ Diet: Salt Intake _____
Fat Intake _____

☐ Sleep: Difficulty falling asleep _____
Continuity disturbances _____
Snoring _____
Early morning awakening _____
Daytime drowsiness _____
Other _____

I spent an estimated time of _____ minutes with patient, > 50% counseling for _____
Counseled on: ☐ Smoking Cessation ☐ Alcohol ☐ Drugs ☐ ETOH ☐ Diet ☐ Lifestyle Modification ☐ Other _____

Provider Signature: _____

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DEMOGRAPHIC SHEET

Patient Name: _____ M / F
Last First MI Sex

DOB: _____ SS# _____ Age: _____ Race: _____

Mailing
Address: _____
City State Zip

Physical
Address: _____
City State Zip

Home Phone: _____ Cell: _____

E-Mail: _____ Marital Status: S M D W

Emergency Contact: _____
Name Relationship Phone #

Insurance: Medicare Medicaid Commercial Insurance Self Pay

Insurance Policy Holder _____
Name Relationship **DOB** **SS#**

_____
Address Phone #

Patients Occupation: _____

Spouse Name and Occupation: _____

Spouse DOB: _____ Spouse SS# _____

Is there anyone we are authorized to speak with regarding your Medical Condition?

Name: _____ Relationship: _____

How did you hear about us?

☐ Radio What Station(s)? _____
☐ Newspaper Which one(s)? _____
☐ Friend/Family Member _____
Who do we thank
☐ Walk in
☐ Emergency Room Staff
☐ Other _____

_____
Patient/Guardian Signature Date

Turn over and sign twice.
If <u>Medicare</u> sign <u>3</u> times.

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Medical **(HIPAA)** Information Release Form

Name: _____ Date of Birth _____/ _____/_____

Release of Information

[ ] I authorize the release of information including diagnosis, records , examination rendered and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information may not be released to anyone.

This release of information will remain in effect until terminated by me in writing.

Messages

Please call: [ ] my home _____ [ ] my work_____ [ ] my cell_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] other_____

The best time to reach me is [ ] Day [ ] Evening

Signed: _____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____

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Financial Responsibility and Release of Information:

I directly assign all medical benefits to the Iron County Medical Center Family Care Clinic and understand that I am financially responsible for all charges not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement is as valid as the original.

Consent to Treat:

I also consent to treatment to be determined by Iron County Medical Center Family Care Clinic for any medical conditions existing while under care in this facility.

Signature:_____ Date: _____

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Acknowledgement of Receipt of Privacy Practice and Patient rights:

Iron County Medical Center Family Care Clinic reserves the right to modify the privacy practices outline in this notice.

I have received a copy of the Privacy Notice and Patient Rights and Responsibilities:

Signature:_____ Date: _____

MEDICARE PATIENTS ONLY

Do you have any coverage primary to Medicare?	Yes / No
Have you enrolled in a Medicare Advantage Plan?	Yes / No
Are you currently receiving Black Lung benefits?	Yes / No
Has the Dept of Veteran Affairs agreed to pay for coverage?	Yes / No
Are you or your spouse currently employed?	Yes / No
If so…do you have coverage through this employer?	Yes / No

I request that payment of authorized Medicare benefits be made to Iron County Medical Center for any services furnished to my by that practice. I authorize any holder of medical information about me to be released to the Centers for Medicare & Medicaid Services and it's agents any information needed to determine these benefits or the benefits payable for related services.

Signature:_____ Date: _____