

PATIENT HISTORY & PHYSICAL

Name		SS#	/	/		Date		
Address			c	ccupat	tion			
Phone (Home) ()	Date of Birth				Age	Age		
Chief Complaint								
Drug Allergies		Family History						
					Father's	Mother's		
		_	Father	Mother				Children
		Heart Disease						
		High Blood Pressure						
		Stroke						
Current Medication		Cancer						
		Glaucoma						
		Diabetes						
		Epilepsy / Convulsions						
		Bleeding Disorder						
		Kidney Disease						
		Thyroid Disease						
		Mental Illness						
		Osteoporosis						
Hospitalization or Surgery								
Reason	Date	Reason					Da	ite
Medical History								
□ Allergies / Hay Fever	☐ Fatigue			Liver Di	sease			
□ Anemia	□ Cout			Menstru	ıal Probl	ems		
□ Anxiety	☐ Headache				Mental Illness			
□ Arthritis	☐ Hearing Problems			☐ Osteoporosis				
□ Asthma	☐ Heart Attack			Pneumonia				
☐ Chest Pain / Angina	☐ Heart Birth Defect			Rheumatic Fever				
□ Colon Problems	☐ Heart Disease			Scarlet Fever				
☐ Congestive Heart Failure	☐ High Blood Pressure			Sexual dysfunction				
□ COPD / Emphysema	☐ High Cholesterol				ess of Bre	eath		
□ Diabetes	☐ Incontinence			Stroke /				
Dizziness / Fainting	☐ Irregular Heart Beat				Disease			
☐ Elevated Sleeping Position	☐ Kidney Disease			Ulcer / Acid Reflux Venereal Disease / STD				
□ Epilepsy / Seizures	Leg Cramps			Venere	ai Diseas	se/SID		
WOMEN ONLY: Pregnant? ☐ Yes	□ No Planning pr	regnancy? □ Yes	□ No	L	ast Men	strual Pe	riod	
MEN ONLY: It's common for men to occasion	onally experience erection diffic	ulties. Is this something tha	at happe	ens to yo	u?		Yes	□ No
Habits								
☐ Smoke: Packs daily	☐ Coffee: Cups daily		П	Sleep:	Difficult	y falling a	asleen	
How long?	Other caffe	ine		оксер.		-		
Interested in stopping?	☐ Alcohol: Type			Continuity disturbances Snoring				
□ Exercise routine:	Amount			Early morning awakening				
	□ Diet: Salt Intake	C Diet. Celt leteles		Daytime drowsiness				
	Fat Intake				Other			
	es with patient, > 50% counseling for		atla:	77 Att				
Counseled on: ☐ Smoking Cessation ☐ Ale	cohol □ Drugs □ ETOH	☐ Diet ☐ Lifestyle Modific	สแอก	☐ Other				

Provider Signature:



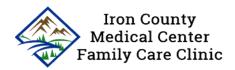
DEMOGRAPHIC SHEET

Patient Name:		First		MI		M/F
Last			MI	Sex		
DOB:	SS#		Age:	Race:		<u></u>
Mailing						
Address:			City		State	Zip
Physical			City		Claio	- .p
Address:						
			City		State	Zip
Home Phone:			Cell:			
E-Mail:			Marital Stat	us: S M D	W	
Emergency Contact:			Relationship			Phone #
Insurance:	Medicare	Medicaid	Commercial I	nsurance	Self P	ay
Insurance Policy Holder	lame		Relations	nip DOB	SS#	
Address					Phone #	
5					T Hone #	
Spouse Name and Occupation:						
Spouse DOB:		Spous	se SS#			
Is there anyone we are a	uthorized to spea	k with regard	ling your Med	ical Condit	tion?	
Name:			Rel	ationship:		
How did you hear about us?						
☐ Radio What Station(s)?			□ Walk in	0: "		
☐ Newspaper Which one(s)? _	Which one(s)? ily Member Who do we thank Emergency Room Staff Other					
	Who do we thank					
Patient/Guardian Sig	nature				Da	te



Medical (HIPAA) Information Release Form

Name:			Date of	Birth	/	/
		Release of In	<u>formation</u>			
	elease of information formation may be rel	_	ngnosis, recor	ds , exam	ination r	endered and claims
	[] Spouse					
	[] Child(ren)					
	[] Other					
[] Information may	not be released to a	inyone.				
This release of infor	mation will remain in	effect until t	erminated by	me in wi	riting.	
		Messa	iges .			
Please call: [] my h	nome	[] my work_		_ [] my ce	ell	
If unable to reach m	e:					
[] you may leave a	detailed message					
[] please leave a me	essage asking me to r	eturn your ca	ill			
[] other						
The best time to rea	nch me is [] Day [] Ev	ening				
Signed:		Date:				
Witness:		Date:	_//_			



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 1	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:				
*******	***************************************	***********				
Acknowledgen	nent 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 sodo 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:				