Faith Family Medical Services, L.L.C

Patient Information

Please Print

Date: _____ Patient Name: _____

SS#: _____ ☐ Male ☐ Female Birthdate: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

E-Mail: _____ Home Phone: _____

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or Parent/Guardian's Employer: _____ Work #: _____

Spouse or Parent/Guardian's Name: _____ Contact #: _____

Person to contact in case of emergency: _____ Contact #: _____

Relationship to Patient: _____ Whom can we thank for referring you: _____

Responsible Party

Name responsible for this account: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Birthdate: _____ Employer: _____ Work Phone: _____

Is this person currently a patient at our office? ☐ Yes ☐ No

Insurance Information

Name of insured: _____ Relationship to patient: _____

Birthdate: _____ SS #: _____ Date employed: _____

Name of employer: _____ Work Phone: _____

Address of employer: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ ID#: _____ Group#: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Co-Pay: _____ Deductible: _____

Do you have additional insurance? ☐ **Yes** ☐ **No** **If yes, complete the following:**

Name of insured: _____ Relationship to patient: _____

Birthdate: _____ SS #: _____ Date employed: _____

Name of employer: _____ Work Phone: _____

Address of employer: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ ID#: _____ Group#: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Co-Pay: _____ Deductible: _____

Pharmacy Information

Pharmacy: _____ **City:** _____ **Phone #:** _____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also, hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

_____ _____

Signature of patient or parent/guardian if minor Date

Faith Family Medical Services, LLC
Medical History

Briefly describe what problem brings you to the doctor: _____

_____

List all medications you are currently taking (Including the dosage, frequency, and any non-prescription medications):

_____ _____

_____ _____

Medication Allergies:

_____ _____

_____ _____

Past Medical History: Please place a check mark if you or your family has ever had any of the following:

Allergic Rhinitis ___ You ___ Family
Anemia ___ You ___ Family
Anxiety ___ You ___ Family
Arthritis ___ You ___ Family
Asthma ___ You ___ Family
Atrial Fibrillation ___ You ___ Family
Allergic Rhinitis ___ You ___ Family
Cancer ___ You ___ Family (type_____)
Chest pain ___ You ___ Family
Congestive Heart Failure ___ You ___ Family
Depression ___ You ___ Family
Diabetes ___ You ___ Family
Emphysema ___ You ___ Family
Gout ___ You ___ Family
Hearing Loss ___ You ___ Family
Heart Attack ___ You ___ Family
Heartburn ___ You ___ Family
Herniated Disc ___ You ___ Family
High Blood Pressure ___ You ___ Family
High Cholesterol ___ You ___ Family
Hypothyroid ___ You ___ Family
Insomnia ___ You ___ Family
IBS ___ You ___ Family
Kidney Failure ___ You ___ Family
Migraine ___ You ___ Family
Mitral Valve Disorder ___ You ___ Family
Osteoporosis ___ You ___ Family
Stroke ___ You ___ Family
Visual Impairment ___ You ___ Family

Additional Past Medical History:

_____ _____

_____ _____

Past Gynecological History:

Last Menstrual Period: _____ Number of Pregnancies: _____ Live Births: _____

Past Surgical History:

Surgery	Date	Surgery	Date
_____		_____	
_____		_____	

Family Medical History:

				Cause of Death
Father	Age_____	___ Living	___ Deceased	_____
Mother	Age_____	___ Living	___ Deceased	_____
Brother	Age_____	___ Living	___ Deceased	_____
Brother	Age_____	___ Living	___ Deceased	_____
Sister	Age_____	___ Living	___ Deceased	_____
Sister	Age_____	___ Living	___ Deceased	_____

Immunizations: Last Tetanus Shot? _____

Pneumonia Vaccine? _____

Flu Shot? _____

If patient is a child, are immunizations up to date? Yes No

Social History: Single Married Divorced Widowed

Do you or have you ever:

Used Tobacco ___Yes ___No If, yes how much? _____

If quit, when? _____

Used Drugs ___Yes ___No If, yes how much? _____

If quit, when? _____

Drink Alcohol ___Yes ___No If, yes how much? _____

If quit, when? _____

Occupation: _____

Religion: _____

Do you have a Living Will: Yes No (If yes, please provide our office with a copy)

11-2-16

I give permission for Amy Kerns, MS, PA-C to exam my son _____ during wrestling skin checks and to provide treatment as necessary.

_____ _____

Parent signature Date