Please fill out as many questions as you can. Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Information**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_

Social Security Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other Physician/Specialist you see Other Physician/Specialist you see**

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Specialty\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone number\_\_\_\_\_\_\_\_\_ Phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Fax number\_\_\_\_\_\_\_\_\_\_\_\_ Fax number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Chief complaint (briefly explain why you are here today)**

**Current medications- please list all medications from all doctors –Use back if out of space.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication** | **Dose(mg, cc’s, etc)** | **How often** | **Prescribed by**  | **Taken since?** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Do you need any refills today? If so which medicine? Please list name and dose\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do You take any over the counter drugs? Include all vitamins and dietary supplements.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have any allergies to medications? If so please list them and the reaction they cause.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have any of the following problems? Hematologic/Endocrine**

Change in appetite \_\_yes \_\_no Blood disorder \_\_yes \_\_no

Weight loss \_\_yes \_\_no Diabetes \_\_yes \_\_no

Weight gain \_\_yes \_\_no Other disorders \_\_yes \_\_no

Unable to sleep \_\_yes \_\_no

Excessive sleepiness \_\_yes \_\_no  **Musculoskeletal**

Snoring \_\_yes \_\_no low back pain \_\_yes \_\_no

Fatigue \_\_yes \_\_no neck pain \_\_yes \_\_no

Fever \_\_yes \_\_no joint pain or \_\_yes \_\_no

 Swelling.

**Skin**

Skin breakdown \_\_yes \_\_no **Gastrointestinal**

Skin rash \_\_yes \_\_no Abdominal pain \_\_yes \_\_no

 Constipation \_\_yes \_\_no

**Ears, Nose, Mouth, and Throat**  Diarrhea \_\_yes \_\_no

Hearing loss \_\_yes \_\_no Acid Reflux \_\_yes \_\_no

Trouble breathing \_\_ yes \_\_no Vomiting \_\_yes \_\_no

through nose

Headaches \_\_yes \_\_no **Respiratory**

**Urinary** Asthma \_\_yes \_\_no

Increased frequency \_\_yes \_\_no Chronic cough \_\_yes \_\_no

Incontinent of urine \_\_yes \_\_no

Frequent infection \_\_yes \_\_no **Psychiatric**

 Anxiety \_\_yes \_\_no

**Cardiovascular**  Depression \_\_ yes \_\_no

Chest pain \_\_yes \_\_no Attention Deficit \_\_yes \_\_no

Circulation problems \_\_yes \_\_no

Short of breath \_\_yes \_\_no **Neurologic**

Thyroid disease \_\_yes \_\_no Memory problems \_\_yes \_\_no

Valve replacement \_\_yes \_\_no Difficulty swallowing \_\_yes \_\_no

High blood pressure \_\_yes \_\_no Dizziness \_\_yes \_\_no

**Social History**

Who do you live with?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you \_\_\_\_\_Male \_\_\_\_\_Female Highest level of education\_\_\_\_\_grade school\_\_\_high school

\_\_\_\_vocational school \_\_\_college \_\_\_graduate school

Where do you work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have children?\_\_\_yes \_\_\_no

Do they live with you?\_\_\_yes \_\_\_no

Do you smoke? \_\_\_yes \_\_\_no

Chew tobacco? \_\_\_yes \_\_\_no

How many years? \_\_\_\_\_\_\_\_\_\_\_

**Past medical history**

Have you ever had surgery? If so, what kind and what year?

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency contact information**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do we have permission to disclose your health information Do we have permission to disclose your

To this person? \_\_\_yes \_\_\_no\_\_\_ health information to this person?\_\_\_yes

Please initial\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_no Please initial\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone Authorizations**: You hereby grant permission and consent to us, our assignees, and third party collection agencies: (1) to contact you by telephone at any telephone number associated with you, including wireless numbers; (2) to leave answering machine and voicemail messages for you, and include in any such message information required by law (including debt collection laws) and/or regarding amounts owed by you; (3) to send you text messages or emails using any email addresses you provide; (4) to use pre-recorded/artificial voices messages and/or an automatic dialing device (an “autodialer”) in connection with any communications made to you or related to your account.

**FINANCIAL ASSISTANCE:** I understand that BCMH has a financial assistance policy for which I may qualify. The income guidelines are based on Federal Poverty Limits. I understand that if my income is less than the guideline for my family size, I may qualify for assistance. I have been offered the Financial Assistance Summary. \_\_\_Accepted \_\_\_Declined

Signature:­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please present this form along with insurance cards to front desk when completed.**

**Thanks for choosing us for your health care needs!**