# WELCH FAMILY MEDICINE
# CONTINI FAMILY MEDICINE

PERSONAL/MEDICAL HISTORY FORM

ALL INFORMATION IS CONFIDENTIAL,EXCEPT AS REQUIRED BY LAW

DATE OF BIRTH: _____ GENDER: M F SOCIAL SECUIRTY #: _____-_____-_____

LAST NAME:_____ FIRST NAME:_____ MI: _____

PARENT/GAURDIAN NAMES (IF MINOR): _____

RACE/ETHNICITY: _____

ADDRESS:_____

CITY:_____ STATE:_____ZIP CODE: _____

PRIMARY PHONE #:(_____) _____ - _____ SECONDARY #:(_____) _____ - _____

EMPLOYER/OCCUPATION:_____WORK PHONE #:(_____) _____ - _____

SPOUSE NAME:_____SPOUSE PHONE #::(_____) _____ - _____

ALTERNATE EMERGENCY CONTACT NAME: _____

RELATION: _____ PHONE #: (_____) _____ - _____

## OK TO RELEASE INFORMATION TO THE FOLLOWING FAMILY/FRIENDS:

(CIRCLE ALL THAT APPLY)

1. NAME: _____ RELATION:_____

**1.** MEDICAL RECORDS **2.** SCHEDULE **3**. BALANCE/PAYMENT **4**. INSURANCE

IF PATIENT IS A MINOR – THIS PERSON HAS PERMISSION TO BRING CHILD IN: **YES OR NO**

2. NAME: _____ RELATION:_____

**1.** MEDICAL RECORDS **2.** SCHEDULE **3**. BALANCE/PAYMENT **4**. INSURANCE

IF PATIENT IS A MINOR – THIS PERSON HAS PERMISSION TO BRING CHILD IN: **YES OR NO**

**3.** NAME: _____ RELATION:_____

**1.** MEDICAL RECORDS **2.** SCHEDULE **3**. BALANCE/PAYMENT **4**. INSURANCE

IF PATIENT IS A MINOR – THIS PERSON HAS PERMISSION TO BRING CHILD IN: **YES OR NO**

## INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

POLICY HOLDERS NAME: _____ POLICY HOLDER DATE OF BIRTH : _____

SECONDARY INSURANCE COMPANY: _____

POLICY HOLDERS NAME: _____ POLICY HOLDER DATE OF BIRTH : _____

## HOW DID YOU HEAR ABOUT OUR OFFICE?

FAMILY/FRIEND: _____ ADVERTISEMENT (WHERE): _____

DOCTORS OFFICE: _____ OTHER: _____

**PATIENT NAME:**_____ **DATE OF BIRTH:** _____

## CURRENT MEDICATION LIST

| | MEDICATION NAME | DOSAGE | HOW OFTEN |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |
| 9. | | | |
| 10. | | | |

## ALLERGIES TO MEDICATIONS

| | MEDICATION NAME | REACTION |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |

## PAST MEDICAL PROBLEMS: CIRCLE ALL THAT APPLY

| | | | | |
|---|---|---|---|---|
| NEUROLOGICAL: | TREMORS | HEADACHES | | |
| PSYCHIATRIC: | ANXIETY | DEPRESSION | | |
| CARDIOVASCULAR: | VASCULAR | HEART PROBLEMS | HIGH BLOOD PRESSURE | |
| GASTRO/INTESTINAL: | REFLUX | COLITIS | GALLBLADDER | LIVER PROBLEMS |
| URINARY: | PROSTATE | KIDNEY STONES | URINE INFECTIONS | |
| SKELETAL/MUSCULAR: | NECK PAIN | BACK PAIN | CRAMPS | |
| ENDOCRINE: | DIABETES | TESTOSTERONE | THYROID | |

| TYPE OF SURGERY | DATE OF SURGERY |
|---|---|
| | |
| | |
| | |

**PATIENT/GAURDIAN SIGNATURE**:_____

**PATIENT NAME:**_____ **DATE OF BIRTH:** _____

## **SOCIAL HISTORY:** (CIRCLE ALL THAT APPLY)

DO YOU USE RECREATIONAL DRUGS: YES NO

DO YOU DRINK ALCOHOL? YES NO

DO YOU DIP OR CHEW ? YES NO

DO YOU SMOKE? YES NO HOW MANY PACKS PER DAY? _____

HOW MANY YEARS HAVE YOU SMOKED?____

## **LIVING SITUATION:** (CIRCLE ALL THAT APPLY)

LIVE WITH: ALONE SPOUSE FAMILY FRIEND

WHERE YOU ARE LIVING: ALF APARTMENT HOUSE OTHER

## **FAMILY HISTORY:** (CIRCLE ALL THAT APPLY)

FATHER: LIVING DECEASED

MOTHER: LIVING DECEASED

PLEASE PUT AN **X** TO ALL THAT APPLY BELOW:

| | HEART ISSUES | STROKE | CANCER | DIABETES | HIGH CHOLESTEROL | HIGH BLOOD PRESSURE |
|---|---|---|---|---|---|---|
| **FATHER** | | | | | | |
| **MOTHER** | | | | | | |
| **OTHER FAMILY** | | | | | | |

LIST ANY OTHER FAMILY MEDICAL PROBLEMS:_____

_____

_____

_____

_____

**PATIENT/GAURDIAN SIGNATURE**:_____

**WELCH FAMILY MEDICINE & CONTINI FAMILY MEDICINE**

**PRIVACY NOTICE**

The following notice describes how your medical information may be used & disclosed,and how you can get access to this information. Please review the information carefully. Your confidential health care information may **NOT** be released for any purpose other than that which is identified in this notice.

Your confidential health care information may be released to the other healthcare professionals within the office/hospital for the purpose of providing you with quality healthcare.

You confidential health care information may be released to your insurance provider for the purpose of the office receiving payment for providing you with needed health care services.

Your confidential health care information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime and/or domestic violence.

Your confidential health care information may be released to other healthcare providers in the event of an emergency care.

Your confidential health care information may be released to public health organizations or federal organizations in the event of a communicable disease, to report a defect device, or untoward event to a biological product (food/medicine).

Your confidential health care information may be released only after receiving written authorization from you. You may revoke your permission to release confidential healthcare information at any time. You may be contacted by the office to remind you of any appointments, healthcare treatment options or other health services that me of of interest to you. You have the right to restrict the use of your confidential healthcare information. However, the office may choose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.

You have the right to received confidential communication about your health status. You have the right to review & photocopy and/all portions of your healthcare information, a fee of $1 per page will be charged.

You have the right to make changes to your healthcare information.

You have the right to know who accessed your confidential healthcare information & for what purpose.

You have the right to possess a copy of this Privacy Notice upon request.

This office is required by law to protect the privacy of its patients. It will keep confidential any/all patient healthcare information & will provide patients with a list of duties or practices that protect confidential healthcare information.

This office will abide by the terms in this notice. The office reserves the right to make changes to this notice & continue to maintain the confidentiality to all healthcare information. Patients will receives a mailed copy of any changes to this notice within 60 days of making changes.

You have the right to complain to the office/hospital if you believe your rights to privacy have been violated. Please notify us as soon as possible. All complaints will be investigated. No personal issues will be raised for filing a complaint. For further information about this Privacy notice, please contact Leo Welch MD.

**OUR FINANCIAL POLICY**

We are dedicated to providing you with the best possible care & services, and regard you understanding of our financial policies as an essential element of you care & treatment.

Full payment is due at the time of service, unless other arrangements have been made in advance.

**YOUR INSURANCE**

We have made prior arrangements with many Insurers & other health plans. We will bill those plans with which we have an agreement & will collect any required co-payment at the time of service. Your co-payment must be collected at the time of service according to your agreement with your insurance carrier. In the event your health plan determines a service to be “not covered”, you will be responsible for payment of that service upon receipt of a statement or an explanation of benefits from your insurance carrier.

**MINOR PATIENTS**

The adult accompanying patients who is/are children are responsible for payment of all services rendered on that date of service, unless prior arrangements have been made.

**OTHER FINANCIAL SERVICES**

In many cases the physician orders an x-ray or lab test. In the event that these tests are sent out to be interpreted by a specialists, you will receive a separate bill from that facility or specialists.

*I have read the above financial policy & agree to pay all bulls on the date of service or as otherwise agreed.*

**PATIENT NAME: _____ DATE OF BIRTH:_____**

**SIGNATURE OF RESPONSIBLE PARTY: _____ DATE: _____**