

**MEDICAL HISTORY FORM**

**PATIENT NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Do you have any of the following problems?

\_\_\_\_ Acid reflux
\_\_\_\_ Alcoholism/other addiction(s)
\_\_\_\_ Allergies (environmental)
\_\_\_\_ Anxiety
\_\_\_\_ Asthma
\_\_\_\_ Atrial fibrillation
\_\_\_\_ Cancer (specify type: \_\_\_\_\_\_\_\_\_\_)
\_\_\_\_ Coagulation (bleeding or clotting) problem \_\_\_\_ High cholesterol \_\_\_\_ Diabetes mellitus
\_\_\_\_ Erectile dysfunction
\_\_\_\_ Heart disease (specify type: \_\_\_\_\_\_\_\_\_\_\_\_) \_\_\_\_ Hypertension (high blood pressure) \_\_\_\_ Irritable bowel syndrome) \_\_\_\_ Migraines
\_\_\_\_ Osteopenia/osteoporosis
\_\_\_\_ Prostate problem
\_\_\_\_ Thyroid problem
\_\_\_\_ Chronic low back pain \_\_\_\_Depression
\_\_\_\_ Other problems (list below):

**Allergies:**

Medications:

Food:

Seasonal:

**Surgical History:** (Please list all prior operations and dates): \_\_\_\_\_\_\_ I have had no prior surgery.

|  |  |
| --- | --- |
| **Operation** | **Date** |
|  |  |
|  |  |
|  |  |

**Family History:** Please indicate by circling any of the following conditions of family members

\_\_\_\_\_\_\_ I do not know my family history.

**Medical Condition**

Alcoholism / Anemia / Anesthesia problem / Arthritis / Asthma / Birth defects Bleeding problem / Cancer (breast) / Cancer (colon) / Cancer (skin) / Cancer (ovarian)
Cancer (prostate) / Cancer (other) / Colon polyps / Depression / Diabetes, Type 1 Diabetes, Type 2 / Eczema Epilepsy (seizures) / Genetic diseases / Glaucoma
Hay fever (allergies) / Hearing problems / Heart attack (CAD) / High blood pressure High cholesterol / Kidney diseases / Lupus (SLE) / Mental retardation Migraine headaches / Mitral valve prolapse / Osteoarthritis / Osteoporosis Rheumatoid Arthritis / Stroke (CVA) / Thyroid disorders / Tuberculosis / Other:

Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Maternal Grandparent\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Paternal Grandparent \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sister: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION**

(Please allow 3-4 weeks for processing)
Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE OBTAIN INFORMATION FROM: PLEASE SEND INFORMATION TO:**

Name of Provider/Clinic/Organization Name of Provider/Clinic/Organization \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street Address Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip Code City, State, Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize the following information to be disclosed: (Please initial)
\_\_\_\_\_\_\_ Entire Record \_\_\_\_\_\_\_ Specific Information

May release Information to: ( ) Self Only or ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name and Relationship

**INFORMATION:** •I understand that I have the right to withdraw this authorization.
•I understand that I do not have to sign this authorization to receive treatment.
•This request shall remain in effect for 90 days unless specifically revoked in writing; however, such revocation does not affect any actions taken by MAOGB before receipt of the revocation.
•Failure to fill this authorization out in its entirety and sign will result in a delay and MUST be read completely.
•I understand that signing this authorization does not cancel any rights I have under the state/federal laws.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Signature (Legal Representative, if applicable) Relationship

\*\*HIV and AIDS information authorization: Specific authorization is required for any HIV-related information.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Client Signature (Legal Representative, if applicable) Relationship

\*\*Sensitive Information Authorization: Separate authorization is required to release sensitive information, such as: abortion, substance abuse, genetic information, mental health notes, STD’s, rape and abuse.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Signature (Legal Representative, if applicable) Relationship

**Patient Registration Form**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name Last Name

( ) Female ( ) Male Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City/Town State Zip Code

Home #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred# ( ) Home ( ) Cell ( ) Work Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Person Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Your Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Language:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ethnicity**: ( ) Native American Indian ( ) Not Hispanic or Latino ( ) Decline
( ) Asian ( ) Black or African American ( ) White ( ) Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Insurance Carrier**

Name of Insurance Co\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Subscriber\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group#\_\_\_\_\_\_\_\_\_\_ Subscriber’s DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional Insurance Carrier**

Name of Insurance Co\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Subscriber\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**Referral/PCP:**

If your insurance company requires you to choose a primary care practitioner (PCP) it is your responsibility to notify the insurance company that you have chosen your new PCP. If you need an insurance referral to see a specialist, you must notify our office before the specialist’s visit. If you have an outside PCP, you must obtain a referral for today’s visit.

Please sign acknowledging your understanding of the above statement and the above information that you have provided is true to the best of your knowledge.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient/Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date