FAMILY FIRST MEDICAL

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PATIENT INFORMATION

Date:_____

Patient Name: _____
Last First M.I.

Sex: _____ Age:_____ DOB:_____

Address:_____ _____ _____ _____
Street City State Zip code

Phone number: _____Cell:_____

Best time to be reached:_____

Email:_____

Marital status: married single widowed other

Ethnicity: Hispanic Non-Hispanic

Race: White Native American Asian African American Pacific Islander Other

Spouse:_____DOB:_____

IN CASE OF EMERGENCY

Name:_____

Relationship:_____

Phone Number:_____

CONSENT OF TREATMENT

I hereby consent to the medical treatment, diagnostic and laboratory tests, and other procedures, which the physician(s) may deem advisable in treatment of my case (or as legal guardian for patient). Family First Medical will determine the proper disposition of any tissues, parts, or body fluids consistent with state and federal laws. This agreement will remain in effect until I choose to revoke it in writing.
Patient/Responsible Party Signature:

_____Date:_____

Primary Insurance Company:

_____

Claims Address: _____

City _____ State _____ Zip _____

_

Group No. _____ID No._____

Relationship of Patient to Insured: (Circle One) Self Spouse Child Other

Policy Holder:

_____

Date of Birth: _____/_____/_____
(Mo.) (Day) (Year)

Mailing Address: _____ Apt# _____

City _____ State _____ Zip _____

Preferred Phone:( )_____

Date of Birth ____/_____/____ Social Sec. No:_____

Employer: _____

_

Employer Phone: ( ) _____

Secondary Insurance
Company:_____

Claims Address: _____

City _____ State _____ Zip _____

Group No. _____ ID No._____

Relationship of Patient to Insured: (Circle One) Self Spouse Child Other

Policy Holder: _____ Date of Birth: _____/_____/_____

I understand and agree that I am financially responsible for all deductible amounts, co-insurance, non-covered services or services deemed as "non-medically necessary" by my third party insurance carrier. I agree to pay a service charge of $25.00 for each check returned to this facility.

It is understood and agreed that if I fail to pay this account in accordance with policy, then I will pay all reasonable attorney fees and other costs incurred for collection of this account.

_____ _____

Patient Signature Date

FAMILY FIRST MEDICAL

Patient Health History

Patient Name:_____Todays Date:_____

Age:_____DOB:_____Last Physical Exam:_____

Symptoms: check (X) if you currently have or have had in the past year

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Urine frequency
- ☐ Painful Urination

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sores that won't heal

GASTROINTESTINAL

- ☐ Poor appetite
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Hemorrhoids
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Bleeding

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular Heart Beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Ankle swelling
- ☐ Varicose Veins

EYES/EARS/NOSE/THROAT

- ☐ Bleeding gums
- ☐ Crossed vision
- ☐ Blurred vision
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision- flashes
- ☐ Vision- halos

MEN ONLY

- ☐ Lump in testicles
- ☐ Erection difficulties
- ☐ Penis discharge
- ☐ Sores on penis

WOMEN ONLY

- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Menstruation cramps
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge

Last pap smear_____

Last Mammogram_____

Are you pregnant: Yes No

Number of pregnancies_____

Number of live children_____

List your prescribed medications, over-the-counter drugs, and vitamins:

MEIDCATION NAME	STENGTH	FREQUENCY TAKEN

Do you smoke? No Yes, for how long?_____How many packs day_____

Do you drink alcohol? No Yes, how much?_____

Surgeries/hospitalizations:_____
_____
_____

Allergies to Medications:_____

Does anyone in your family have a history of: **Relationship to Patient?**

- ☐ Cancer If yes, what type?_____ _____
- ☐ Diabetes _____
- ☐ High blood pressure _____
- ☐ Heart disease _____
- ☐ Other:_____