MEDICAL PATIENT INFORMATION

South Suburban Family Medicine

Patient Information:

Patient Name:_____

Date of Birth:_____ **S.S.#**_____ **Sex M / F**

Home Address:_____

City, State, Zip:_____

Phone: Home_____ **Cellular**_____

Patient E-mail: _____

☐ **Check this box to receive office newsletters and happenings**

Emergency Contact :

Name_____**Phone**_____

This does not authorize us to discuss anything with the person listed above except in the event of an emergency. If you would like us to be able to discuss anything related to you, your bills, or your health with someone, please list their name(s) below.

Understand your health insurance benefits: Each plan covers different services; it is your responsibility to know what is or is not covered. We encourage patients to call their insurance ahead of time to confirm coverage. This includes referral needs, copayments, coinsurance, deductibles, and out of pocket costs. You must pay any copays at the time of service; failure to do so may result in cancellation of your appointment. ***It is patient responsibility to inform us of any changes to your insurance in a timely fashion, failure to do so may result in your claims being rejected by your insurance. You are responsible for any bills received from our office. Failure to pay bills in a timely fashion may result in those bills being sent to collections.***

Missed Appointment Policy: Beginning 1/1/2017, we require a minimum of a 24hr notice to cancel or change any appointment. If insufficient notice is given, you will receive one warning before being charged for each subsequent missed appointment. The fee for this is $25.00 per missed appointment. If you miss more than three appointments, you are subject to being discharged from our practice.

Office Communication: We make it a priority to return calls or emails as soon as possible. Please be aware that it could take up to 72 business hours for a response from our office. We encourage patients to call at least a week before any medication refills are needed, failure to do so may result in a delay in getting prescriptions renewed.

I authorize this office to contact or leave messages about my labs, x-rays and other tests at:

☐ **Home** ☐ **Cellular** ☐ **The following persons:**_____

For more detailed information please request a copy of the *Notice Of Privacy Policies* brochure.

Treatment consent: I hereby voluntarily agree to diagnostic procedures, medical and surgical treatment for myself and/or dependents. By signing below I accept the terms of this agreement and acknowledge I have had the option to review the *Notice Of Privacy Policies* brochure.

***Patient/Responsible Party*:**_____ ***Date*:**_____

MEDICAL HEALTH FORM

South Suburban Family Medicine

Name _____ Appointment Date_____

Date of Birth _____ Age_____ Occupation _____

Spouse/Significant Other Name _____

Children's Names _____

Parents/Legal Guardian's Names _____

Preferred Pharmacy _____

Pharmacy Phone Number_____ Pharmacy Fax Number _____

**Please list name and major cross streets if you do not know the exact address of your pharmacy*

Reason For Appointment	
List Medical History	Year
List Injuries, Hospitalizations, And Surgeries	

List All Medications (Including Over the Counter)
List All Medication Allergies ☐ None Known

Habits/Social History	Yes	No	Details
Smoking			
Alcohol			
Caffeine			
Exercises			
Hobbies			
Illicit Drugs			

Family History	Living Y / N	Name	Age	List Family Member Medical Problems
Mother				
Father				
Brother/Sister #1				
Brother/Sister #2				
Brother/Sister #3				
Brother/Sister #4				
Brother/Sister #5				

Please checkmark any items, which currently apply to you

	☒
Weight gain	
Weight loss	
Unusual Fatigue	
Sleep Disorder	
Disabled	
Hepatitis	
Rheumatic Fever	
Tuberculosis	
Venereal Disease	
Asthma	
Eczema	
Hay Fever	
Hives	
Diabetes	
High Cholesterol	
Thyroid Problem	
Anemia	
Bruising	
Unusual Lumps	
Skin Problem	
Glaucoma	

	☒
Hearing Problem	
Ringing in Ears	
Sinus Infections	
Cough	
Breathing Problem	
Pneumonia	
Abdominal Pain	
Ulcers	
Vomiting Blood	
Bloody Stools	
Heartburn	
Gallbladder	
Appetite Change	
Hernia	
Hemorrhoids	
Polyps	
Arthritis/Gout	
Bursitis	
Fractured Bones	
Back Problem	

	☒
Headaches	
Seizures	
Tremors	
Fainting	
Speech Problem	
Paralysis	
Memory Loss	
Dizziness	
Heart Murmur	
Chest Pain	
Ankle Swelling	
High Blood Pressure	
Racing/pounding Heart	
Bowel Control Problem	
Leaking Urine	
Kidney/Bladder Infections	

	☒
Females Only…	
Menstrual Trouble	
Vaginal Discharge	
Abnormal Bleeding	
Tubal Infections	
Infertility	
Breast lumps/pain	
Sex Concerns	
Age Periods Began	
Number of pregnancies	
Number of miscarriages	
Number of abortions	
Caesarean Sections	
Impotence	
Birth control	
Type:	
Males Only…	
Changes in Urination	
Prostate Problems	
Lumps on Testicles	
Impotence	