ACUTE CARE + FAMILY CLINIC OF PONTOTOC

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Name: _____

Mailing Address: _____City: _____State: _____Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Preferred method of contact: Home Phone: _____ Cell: _____ Email: ___ Language Preference: _____

Social Security No._____ Date of Birth: _____ Sex: _____ Race: _____

Marital Status: Married ____ Single____ Widow ____ Divorced _____

Employer: _____ Contact Name/Supervisor: _____

Work Phone: _____ Occupation: _____

Spouse's Name: _____ Spouse's Phone: _____

If we are unable to reach you, please provide an emergency contact:

Name: _____ **Phone Number:** _____

Relationship to patient: _____

Other Nurse Practitioner or Physician: _____ Phone: _____

How were you referred to this practice? _____

Insured's Name _____ Birthday_____

Relationship to Patient _____ Insured's Employer _____

AUTHORIZATION AGREEMENT:

I hereby irrevocably authorize Acute Care + Family Clinic of Pontotoc for the purpose of billing, to furnish insurance carriers concerning any illness/accident for which I am treated in this clinic, and I hereby irrevocably assign to Acute Care + Family Clinic of Pontotoc all payments for medical services rendered. I understand that I am financially responsible for charges whether or not covered by insurance, and if I fail to pay any amount due, I will be responsible for all collection fees, court costs, attorney fees, and any other charges incurred in the collection of the balance due.

I authorize Acute Care + Family Clinic of Pontotoc to initiate a complaint to the insurance commissioner for any reason on my behalf.

I consent to care encompassing diagnostic procedures and medical treatment by any physician, nurse practitioner, or other medical professionals in this office, as my health care provider deems necessary. I understand that I will be billed for services performed. I acknowledge that no guarantees have been made as to the results of treatment or examinations. I further agree not to file any claims against this clinic or any health care provider employed by Acute Care + Family Clinic of Pontotoc I accept their decisions in full faith that they are providing proper treatment to the best of his/her knowledge and medical training.

I give permission for my work/school excuse to be faxed to the appropriate facility when necessary.

I acknowledge that I have received, read, and understand the "Notice of Privacy Practice" given to me by this clinic. I understand it is my responsibility to notify the office personnel of this clinic if I wish to amend this "Notice of Privacy Practice."

The following people have permission to discuss/review my healthcare information:

_____

Signature of Patient or Responsible Party _____Date: _____

IF PATIENT IS A MINOR,
I give the following individuals permission to bring my child to the clinic to receive medical care.

_____

PARENT SIGNATURE _____

Name: _____ **Allergies:** _____

Past Medical History **DATE:**_____

Check conditions you currently have or have had in the past.

- ☐ AIDS
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bipolar Disease
- ☐ Bleeding Disorders
- ☐ Breast Disease
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Difficulty Sleeping
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Illness
- ☐ Migraine Headaches
- ☐ Mood Disorder
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Prostate Problems
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Sleep Apnea
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

Surgeries/Hospitalizations **Pregnancies**

Year	Reason for Surgery or Hospitalization	Year	Sex of baby	Complications?

Medications

Please list any medications you are currently taking: _____

_____

_____

Pharmacy: _____

Family Medical History

Check conditions that apply to your family and indicate which family member(s) had the condition.

- ☐ Alcoholism _____
- ☐ Anemia_____

Family Medical History Continued

- ☐ Anxiety_____
- ☐ Asthma_____
- ☐ Bipolar Disease_____
- ☐ Bleeding Disorders_____
- ☐ Breast Cancer_____
- ☐ Cancer_____
- ☐ Depression_____
- ☐ Diabetes_____
- ☐ Drug Abuse_____
- ☐ Heart Attack_____
- ☐ Heart Disease_____
- ☐ Hepatitis_____
- ☐ High Blood Pressure_____
- ☐ High Cholesterol_____
- ☐ Kidney Disease_____
- ☐ Liver Disease_____
- ☐ Mental Illness_____
- ☐ Migraine Headaches_____
- ☐ Mood Disorder_____
- ☐ Multiple Sclerosis_____
- ☐ Osteoporosis_____
- ☐ Pacemaker_____
- ☐ Prostate Cancer_____
- ☐ Stroke_____
- ☐ Suicide_____
- ☐ Thyroid Problems_____

Occupational

Check all that apply and give a description.

	Stress	
	Heavy Lifting	
	Hazardous Substances	
	Shift Work	
	Other	

Health Habits

Check all that apply and give a description.

	Caffeine	
	Alcohol	
	Tobacco	
	Drugs	
	Diet: Excessive salt or fat	
	Exercise Routine	
	Sleep Difficulty	

** Please complete this form if child is under the age of 18 **

ACUTE CARE + FAMILY CLINIC OF PONTOTOC

Responsible Party Information Form for Minors

Name of Child: _____

Who Has Legal Custody of This Child?_____

Mother's Name:_____ Phone No:_____

Mother's
Address:_____ City:_____ State:_____ Zip:_____

Mother's Employer:_____ Work Phone:_____

Mother's Social Security No._____ Mother's Date of Birth:_____

Father's Name:_____ Phone No:_____

Father's
Address:_____ City:_____ State:_____ Zip:_____

Father's Employer:_____ Work Phone:_____

Father's Social Security No._____ Father's Date of Birth:_____

Responsible Party Signature:_____
Date:_____