38 Rowe Drive
Guntersville, AL 35976
PH: 256-571-8460
FX: 256-571-8464

FAMILY MEDICINE
Lakeside North
OPEN 7 DAYS A WEEK
DR. CLAY CAMPBELL

PATIENT MEDICAL HISTORY Date:_____

NAME (LAST, FIRST, MIDDLE)	SOCIAL SECURITY #	DATE OF BIRTH AGE

**IN ORDER TO PROVIDE ADEQUATE TREATMENT, GATHERING DETAILED INFORMATION ABOUT YOUR PAST MEDICAL HISTORY, PAST PSYCHOLOGICAL HISTORY, FAMILY, AND SOCIAL HISTORY ARE VERY IMPORTANT. PLEASE ANSWER THE FOLLOWING QUESTIONS OPENLY AND SPECIFICALLY.

PLEASE CHECK THE BOX IF YOU HAVE EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING PROBLEMS:

- ☐ Anemia
- ☐ Blood Clots or Free Bleeding
- ☐ Cancer
- ☐ Chronic Sinusitis
- ☐ Chronic Pain
- ☐ Depression/emotional/mental disorder
- ☐ Diabetes Type _____
- ☐ Diverticulitis
- ☐ Erectile Dysfunction
- ☐ Eye Disorder retinopathy/glaucoma
- ☐ Fibromyalgia
- ☐ GERD
- ☐ Gout
- ☐ Heart Disease (CHF/MI)
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Joint Disease (gout/arthritis)
- ☐ Kidney Disease (including stones)
- ☐ Lung Disorder
- ☐ Migraine
- ☐ Seizures
- ☐ Skin Disorders
- ☐ Stroke
- ☐ Vascular Problems
- ☐ Other: _____

PLEASE LIST ANY FAMILY MEMBER (mother,father,sibling,etc) THAT HAS OR IS CURRENTLY SUFFERING FROM THE ABOVE LISTED:

Condition:_____ Specific Family Member:_____
Condition:_____ Specific Family Member:_____
Condition:_____ Specific Family Member:_____
Condition:_____ Specific Family Member:_____

PLEASE LIST ALL MEDICATIONS THAT ARE CURRENTLY PRESCRIBED TO YOU or OTC MEDS THAT YOU ARE TAKING:

Name/Strength/How you take it/Prescribing Doctor	Name/Strength/How you take it/Prescribing Doctor

*DO YOU HAVE AN ALLERGY TO ANY MEDICATION(S)? ☐NO ☐YES; If yes, please list the medication(s) below:

_____

SOCIAL HISTORY: ☐SINGLE ☐MARRIED ☐DIVORCED
IF IN SCHOOL, GRADE:_____
ARE YOU A ☐NONUSER OF TOBACCO ☐SMOKER ☐FORMER SMOKER ☐USER OF SMOKELESS TOBACCO

PLEASE LIST PRIOR SURGERIES, PROCEDURES, OR HOSPITALIZATIONS AND THE PHYSICIAN PERFORMED/ADMITTED BY:

DATE	SURGERY/PROCEDURE/HOSPITALIZATION	PHYSICIAN

I certify by my signature that the information given on this form is correct to the best of my knowledge.

Patient's Signature: _____ Date: _____

Parent and/or Guardian's Signature: _____ Date: _____

Lakeside North
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Date: _____ Paperwork Completed by: _____ Preferred Pharmacy: _____

PATIENT Name-Last: _____ First: _____ Middle: _____

Date of Birth: _____ Sex: ____M ____F SS#: _____ Race: _____

Ethnicity: _____ Marital Status: _____ Address: _____

City: _____ State: _____ Zip: _____ Home Phone: ( ) _____

Work: ( ) _____ Cell: ( ) _____ Email: _____ Preferred Communication: _____

Emergency Contact: _____ Telephone: _____ Relationship: _____

Employer: _____ Employer Phone: _____ Occupation: _____

INSURANCE Carrier: _____ Policy Number: _____ Group Number: _____

Policy Holder: _____ Policy Holder DOB: _____

Secondary Insurance Carrier: _____ Policy Number: _____

IF MINOR

Father's Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Employer Phone: _____

Mother's Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Employer Phone: _____

PRIVACY COMPLIANCE

Please list the family members or other persons, if any, we may inform about your general medical condition and your diagnosis, which might include medical history, treatment, lab reports, x-rays, and treatment and/or reference to any mental or nervous disorders, drug and /or alcohol abuse, or sexually transmitted disease and billing inquiries.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

***Can confidential messages be left on your home answering machine or voice mail (for ex—appointment info)?** Yes ____ No ___

I hereby authorize Lakeside North to furnish to my primary physician and insurance company(s) all information which said physician or insurance company(s) may request. I hereby assign to Lakeside North all money to which I am entitled for medical/surgical expense relative to the services rendered but not to exceed my indebtedness to the professional company. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby waive claims of exemption under the State of Alabama. I understand there will be a $30.00 fee for returned checks. I agree to pay 27.00% of principal balance for collection costs should account be placed with a collection agency or attorney, plus court costs expended. I hereby give permission to Lakeside North to contact me via the numbers I have provided on issues associated with my account to include cellular numbers connected with me or my account. I understand that Lakeside North has a policy of random urine drug testing for all patients who are prescribed scheduled medications. Failure to provide a sample will disqualify me from receiving treatment at this facility. I permit a copy of this authorization to be used in place of this original. I hereby consent to treatment.

Patient's Signature: _____ Date: _____

Parent and/or Guardian's Signature _____ Date: _____

***Would you like a copy of our privacy practices? Yes _____ No _____**

Lakeside North

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: _____ **Date of Birth:** _____

Address: _____
City: _____ **State:** _____ **Zip:** _____

SS#: _____ **Phone:** _____

Date of Request: _____ **Type of Records Requested:** _____
****Please send Medical Records Upon Request****

I authorize Lakeside North to **RELEASE or RECEIVE (circle one)** information to/from:

_____
Name of Provider/Facility

_____
Address

_____
City, State, Zip

_____
Phone/Fax Number

I HEREBY AUTHORIZE THE RELEASE OF ANY AND ALL MEDICAL INFORMATION. INCLUDING DIAGNOSIS, TREATMENT, PROGNOSIS, ETC. OF THE INJURIES AND/OR ILLNESS RECEIVED BY THE ABOVE NAME PERSON ON AND SUBSEQUENT TO THE DATE OF THE INJURIES AND/OR ILLNESS. AUTHORIZATION IS KEPT ON FILE UNLESS REVOKED IN WRITING.

_____ _____
Signature of Patient/Legal Guardian Date