ConnectCare and Wellness LLC.

PATIENT INFORMATION AND INSURANCE FORM

First Name: _____ MI: _____ Last Name: _____

Preferred Name: _____ DOB: _____ Gender: ☐Male ☐Female

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Email: _____

Occupation: _____ Employer Phone: _____

Preferred Communication: ☐Home Phone ☐Cellphone ☐ Text

Race *(choose one)*:

☐ American Indian / Alaska Native
☐ African American
☐ Asian
☐ Native Hawaiian / Pacific Islander
☐ White / Caucasian
☐ Other / Decline

Ethnicity *(choose one)*:

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Declined

Marital Status *(choose one)*:

☐ Single
☐ Married
☐ Divorced
☐ Widowed
☐ Other

INSURANCE INFORMATION

Primary Insurance Plan: _____

Policy Number: _____ Group Number *(if any)*: _____

Claims Address: _____

Policy Holder Name & DOB: _____ Relationship to Patient: _____

Secondary Insurance Plan: _____

Policy Number: _____ Group Number *(if any)*: _____

Claims Address: _____

Policy Holder Name & DOB: _____ Relationship to Patient: _____

Emergency Contact: _____ Relationship to Patient: _____

Phone Number: _____

Preferred Pharmacy Name: _____ Address: _____

LEGAL

Do you have a medical durable power of attorney? ☐Yes ☐No Do you have an advanced directive? ☐Yes ☐No

If yes to either, please provide the office with a copy of the legal documents for our files.

Patient Name: _____ DOB: _____

MEDICAL HISTORY

Allergies *(list ALL medication, food, and environmental allergies):* _____

_____

_____

Medications *(Please list ALL medications prescribed or OTC with dose and frequency)*: _____

_____

_____

_____

Please bring copies of all immunization records

Past Medical History *(choose all that apply)*:

- ☐ A-Fib
- ☐ ADD / ADHD
- ☐ Anxiety / Depression
- ☐ Asthma
- ☐ Blood / Clotting Disorder
- ☐ Benign Prostatic Hyperplasia
- ☐ Chicken Pox
- ☐ Colon Polyps
- ☐ Concussion
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Deep Vein Thrombosis
- ☐ Dementia / Alzheimer's Disease
- ☐ Diabetes, Type I
- ☐ Diabetes, Type II
- ☐ Emphysema / COPD
- ☐ Epilepsy / Seizures
- ☐ Erectile Dysfunction
- ☐ Fibromyalgia
- ☐ Gallbladder Disease
- ☐ Gastroesophageal Reflux (GERD)
- ☐ Glaucoma
- ☐ Gonorrhea, Chlamydia, Herpes, Other
- ☐ STD
- ☐ Headaches / Migraines
- ☐ Hearing Loss
- ☐ Heart Disease / Heart Attack
- ☐ Hemorrhoids or Rectal Disease
- ☐ Hepatitis A, B or C
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Kidney Stones / Kidney Disease
- ☐ Lung Nodules
- ☐ Lyme Disease
- ☐ Mental Illness / PTSD
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Peptic Ulcers
- ☐ Pneumonia
- ☐ Psoriasis
- ☐ Pulmonary Embolism
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Seasonal Allergies
- ☐ Sleep Apnea
- ☐ Stroke / TIA
- ☐ Systemic Lupus Erythematosus
- ☐ Thyroid Disease / Hypo or Hyper
- ☐ Tuberculosis
- ☐ Ulcerative Colitis
- ☐ Other: _____

Have you ever been diagnosed with cancer? ☐ Yes ☐ No

If yes please specify type of cancer and date of diagnosis: _____

_____

Surgical History *(list ALL past surgeries)*: _____

_____

Do you use any Assistive Devices? ☐ Cane ☐ Walker ☐ Wheelchair ☐ Hearing Aids ☐ Support Cane (for seeing impaired)

Do you see any specialist? *(If yes, please list their names and specialty)* _____

_____

Patient Name: _____ DOB: _____

Tobacco: Do you smoke? ☐Yes ☐Former ☐Never If yes/former, how many packs per day? _____

Alcohol: Do you drink alcohol? ☐ Yes ☐Former ☐Never If yes/former, how frequently? _____

Other: Do you use any illegal substances? ☐ Yes ☐No Have you been treated for substance abuse problems? ☐Yes ☐No

Safety: Are there guns in your home? ☐Yes ☐ No Do you wear a seatbelt? ☐Yes ☐No

Health Maintenance:

Date of last Physical Exam: _____ Date of last Colonoscopy: _____

Date of last Tetanus Vaccine: _____ Date of last Pneumovax Vaccine: _____

Women ONLY:

Age at menses onset: _____ Date of last period: _____

Date of last PAP: _____ Colposcopy/Biopsy/Surgery: _____

Name of GYN: _____ Number of Pregnancies: _____

Number of Children: _____ Pregnancy Complications: _____

Men ONLY:

Weak Urine Stream: ☐Yes ☐No Discharge from Penis: ☐Yes ☐No

Painful/Swollen Testis: ☐Yes ☐No Prostate Trouble: ☐Yes ☐No

Review of Symptoms *(Choose ALL that apply within the past 6 months):*

☐ Black Stool	☐ Fatigue	☐ Nausea	☐ Swollen Feet
☐ Bloody Sputum / Vomit	☐ Fever / Chills	☐ Nighttime Urination	☐ Throat Discomfort
☐ Bruise Easily	☐ Hair / Nail Problem	☐ Nose Bleeds	☐ Trouble Sleeping
☐ Chest Pain	☐ Hearing Problems	☐ Numbness	☐ Trouble with Vision
☐ Cough (Unexplained)	☐ Heart Palpitations	☐ Poor Appetite	☐ Unexpected Weight Gain
☐ Diarrhea	☐ Heartburn	☐ Rectal Bleed	☐ Unexpected Weight Loss
☐ Difficulty Swallowing	☐ Incontinence	☐ Rectal Discomfort	☐ Urgent Urination
☐ Dizziness	☐ Increased Thirst	☐ Ringing of Ears	☐ Urination Problems
☐ Ear Pain / Discharge	☐ Itching	☐ Sexual Problems	☐ Voice Change
☐ Excess Sweating	☐ Joint Pain	☐ Shortness of Breath	☐ Wheezing
☐ Fainting	☐ Muscle Aches/Weakness	☐ Skin Problems	

FAMILY HISTORY

Has any of your **FIRST** or **SECOND** degree relatives been diagnosed with any of the following health conditions? If so, **please specify who the relative is and if it is maternal or paternal side.** If history of cancer or heart disease, please **indicate age** when diagnosed.

Cancer: _____ Stroke: _____

Type: _____ Mental Illness: _____

_____ Alcoholism: _____

Diabetes: _____ Suicide: _____

Thyroid Disease: _____ Asthma: _____

High Cholesterol: _____ Early Death *(prior to 55 years old)*: _____

High Blood Pressure: _____ Heart Disease: _____