# Patient Information and Consent

| Patient Information | | | | | |
|---|---|---|---|---|---|
| Name | | Sex ☐ M ☐ F | Birth Day | | SSN |
| Address | | City | | State | ZIP |
| Home Phone Ok to Text ☐ Yes ☐ No | Cell Phone Ok to Text ☐ Yes ☐ No | | Work Phone | | |
| Email Address | | | | | |
| Emergency Contact Name | | Emergency Contact Phone | | Emergency Contact Relationship | |
| Preferred Language | Race ☐ Black ☐ White ☐ Asian | | Ethnicity ☐ Hispanic ☐ Non-Hispanic | Marital Status ☐ Single ☐ Married ☐ Widow ☐ Divorced | |

**Authorization for Release of Information**

Who do you authorize to receive information on your behalf regarding testing, results, or referrals?

**Preferred Pharmacy**

Do you prefer Grove Park? ☐ Yes ☐ No If not, please list who you prefer:

**No Show Policy**

We ask patients to call and cancel appointments 24 hours in advance if possible to allow for better use of our staff and provider's time. Patients who do not show up for a scheduled appointment and do not call to give notice will be considered a "no show." "No shows" will be billed a $25 fee.

**Patient Consent for Treatment**

By signing below I agree to the following:

1. I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Grove Park Pharmacy Medical Clinic and its associated physicians, clinicians, and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatment or examinations at Grove Park Pharmacy Medical Clinic.
2. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with the Grove Park Pharmacy Medical Clinic Notice of Privacy Practices.
3. I authorize payment of medical benefits to Grove Park physicians or their designee for services rendered.
4. I give permission to obtain all my medical/prescription/vaccine history when using an electronic system to process transactions for my medical treatment.
5. I reviewed the Notice of Privacy Practice that is posted in the waiting area and was offered a copy.
6. I understand that I am responsible for any copay and deductible amounts as well as any charges not covered by my insurance.

Signature of Patient / Guardian / Guarantor

Date

# Medical History

| Patient Information | |
|---|---|
| Name | Birth Day |

**Allergies** ☐ No Known Allergies

**Current Medications** (include over the counter medicines) ☐ No Current Medications

**Family History**

| | | | | | | |
|---|---|---|---|---|---|---|
| Mother: | ☐ Hypertension | ☐ Diabetes | ☐ Cancer | ☐ Other (please specify) | _____ | ☐ N/A |
| Father: | ☐ Hypertension | ☐ Diabetes | ☐ Cancer | ☐ Other (please specify) | _____ | ☐ N/A |
| Brother: | ☐ Hypertension | ☐ Diabetes | ☐ Cancer | ☐ Other (please specify) | _____ | ☐ N/A |
| Sister: | ☐ Hypertension | ☐ Diabetes | ☐ Cancer | ☐ Other (please specify) | | ☐ N/A |

**Social History**

| | | | | | |
|---|---|---|---|---|---|
| Have you ever smoked tobacco? | ☐ Never | ☐ Former | ☐ Current | How much? | |
| Have you ever used e-cigarettes or vape? | ☐ Never | ☐ Former | ☐ Current | How much? | |
| Have you ever used smokeless tobacco? | ☐ Never | ☐ Former | ☐ Current | How much? | |
| Do you drink alcohol? | ☐ None | ☐ Occasionally | ☐ Moderate | ☐ Heavy | |
| What is your caffeine consumption? | ☐ None | ☐ Occasionally | ☐ Moderate | ☐ Heavy | |
| Do you use any illicit or recreational drugs? | ☐ No | ☐ Yes | | | |

**Surgical History** ☐ No Surgeries

**Past Medical History** ☐ None apply

Please mark an (x) by any of these conditions you may have had in the past:

| | | | |
|---|---|---|---|
| ☐ Anemia or blood disorders | ☐ Depression | ☐ Joint Replacement | ☐ Seizures |
| ☐ Anxiety | ☐ Diabetes | ☐ Kidney, Bladder or Prostate | ☐ Severe Headache / Migraine |
| ☐ Arthritis | ☐ Diverticulitis | ☐ Liver Disease | ☐ Sleep Apnea |
| ☐ Asthma | ☐ Fibromyalgia | ☐ Lumbar Spine Disorder | ☐ Stomach Disease |
| ☐ Bleeding Tendency | ☐ Gout | ☐Lung Disease | ☐ Stroke |
| ☐ Blood Clots | ☐ Heart Disease | ☐ Mental Health Problems | ☐ TB / Tuberculosis |
| ☐ Bowel Disease | ☐ High Cholesterol | ☐ Muscle Disease | ☐ Thyroid Disease |
| ☐ COPD | ☐ High Blood Pressure | ☐ Nerve Impairment | ☐ Other: |
| ☐ Cancer | ☐ Hyperthyroidism | ☐ Osteoporosis | _____ |
| ☐ Cervical Spine Disorder | ☐ Hypoglycemia | ☐ Pulmonary Embolism | _____ |
| ☐ Coronary Artery Disease | ☐ Hypothyroidism | ☐ Reflux / GERD | |