Rincon Medical Center

Established Patient Information Sheet

Today's Date						
Patient Name				DOB	AGE	
Symptoms for today's vis	sit:					
Result of a vehicle accident		Result of a	Result of a work related injury			
When did symptoms b	pegin	Pain Sca	ıle (1=mild -	· 10=Extreme)		
What Medications are yo	u currently taking?		List o	on File		
Medicine Name		Dosage		Frequency		
Are you Allergic to an	y Medications?	If Yes, Please L	.ist			
Would you be interested	in filling your prescrip	ption within the office?	No L	Yes		
	•	ons cost \$10.00 per p	-	-	16 11 2	
Female: When was you	ır last normal period?	/ Are	you pregnar	it? Are you	breastfeeding?	
Since your last visit a	t Rincon Medical C	Center has there beer	n any chan	ge in:		
Address: No	Yes, explain	n				
Phone: No	Yes, explain	n				
Insurance: No	Yes, explain	n				
Surgical History:	No Y	es, explain				
Medical History:	No Y	es, explain				
Family Medical History:	NoY	Yes, explain				
Tobacco Use:	No \ \ \ \	Yes, explain				
Alcohol Use:	No	Yes, explain				
Drug Use:	No 🔲 📗	Yes, explain				
The signature below serves as to furnish and/or release any i order to process health care physician's office to ensure cor communicate in writing. I ackr insurance coverage. I understainsurance carrier, and any previous to furnish the signature of the signatur	information necessary to you claims. This authorization ntinuity of care. I understoomledge that Rincon Me and that I am financially response	our insurance carrier, third p n also serves as permission tand that I may withdraw thi edical Center will file my ins	party administra to release m is authorization surance as a co	ation, and or health benefy y medical records to my a to release medical informourtesy, but it is my respo	it payer representatives in designated primary care nation at any time, when in the properties of the	
Patient/Responsible Par	rty Signature:			Date:		
Physician Signaturo			Data			