MEDICAL HISTORY

NAME : _____ *AGE :* _____ *DATE :* _____

PAST MEDICAL HISTORY :

[X] IF YES

[ ] ANEMIA
[ ] ASTHMA
[ ] ARTHRITIS
[ ] BLEEDING DISORDER
[ ] CANCER
[ ] DEPRESSION/ANXIETY
[ ] DIABETES
[ ] EPILEPSY
[ ] GALLBLADDER DISEASE
[ ] HEART DISEASE
[ ] HIGH BLOOD PRESSURE
[ ] KIDNEY DISEASE
[ ] LIVER DISEASE
[ ] MENTAL ILLNESS
[ ] MENSTRUAL /GYN DISORDER
[ ] NEUROLOGICAL DISEASE
[ ] RHEUMATIC FEVER
[ ] SEXUALLY TRANSMITTED DISEASE
[ ] STOMACH/BOWEL DISEASE
[ ] STROKE
[ ] THYROID DISEASE
[ ] TUBERCULOSIS

OTHER DISEASES :

_____
_____
_____
_____

SOCIAL HISTORY

[ ] smoking [ ] present or [ ] past
[ ] alcohol [ ] present or [ ] past
[ ] other [ ] present or [ ] past
[ ] regular exercise

CURRENT MEDICATIONS/DOSES :

1. _____
2. _____
3. _____
4. _____

FAMILY HISTORY (RELATIVES) :

CANCER : _____
DIABETES : _____
HEART DISEASE : _____
HIGH BLOOD PRESSURE : _____
KIDNEY DISEASE : _____
STROKE : _____
MENTAL ILLNESS/ALCOHOL ABUSE : _____
OTHER : _____

DRUG ALLERGIES :

1. _____
2. _____
3. _____
4. _____

IMMUNIZATION HISTORY (YEAR OF LAST INJECTION) :

PNEUMONIA_____ FLU VAX_____ TETANUS_____ HEPATITIS_____

HOSPITALIZATIONS AND/OR SURGERIES:

1. _____ DATE : _____
2. _____ DATE : _____
3. _____ DATE : _____
4. _____ DATE : _____
5. _____ DATE : _____
6. _____ DATE : _____

DATE : _____ **PATIENT/PARENT SIGNATURE :** _____

REASON FOR CURRENT VISIT : _____

_____

_____

_____

*Please send copy of actual med insurance card with this paperwork - both front and back

PARK PRIMARY CARE ASSOCIATES

PATIENT REGISTRATION

FILE:_____

Referred by (i.e. friend, relative, hospital)_____

LAST NAME:_____ FIRST:_____ M:_____

STREET ADDRESS:_____

CITY, STATE, ZIP:_____

DATE OF BIRTH: __/__/____ MARITAL STATUS:_____ AGE:_____

HOME PHONE: (___)_____ WORK PHONE: (___)_____

SOCIAL SECURITY #: _____ DRIVER LICENSE #:_____

EMPLOYER/ADDRESS:_____

MEDICAL INSURANCE:_____

INSURANCE ID #:_____ GROUP#:_____

MEDICARE #:_____

NAME OF SPOUSE:_____ BIRTHDATE: __/__/____ SSN:_____

SPOUSE'S MEDICAL INSURANCE, ID/GROUP#:_____

PERSON TO CONTACT IN EMERGENCY:_____ PHONE #:_____

PAYMENT REQUESTED AT THE TIME OF SERVICE - UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE

I hereby authorize direct payment of surgical/medical benefits to Dr. Rosen or Dr. Somer for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balances not covered by my insurance, including copayments and deductibles. I hereby authorize Dr. Rosen or Dr. Somer to release any medical information that may be necessary for either medical care or in processing application for financial benefit. I certify that the information given by me is all correct. I authorize Dr. Rosen or Dr. Somer and their designate, or their covering physician, to give me reasonable and proper medical care by today's standards.

AT REGISTRATION, PLEASE PRESENT YOUR INSURANCE CARD & ONE IDENTIFICATION.

PATIENT'S SIGNATURE:_____ DATE:_____

GUARDIAN'S SIGNATURE:_____ DATE:_____

*Email address (optional) :_____

*Please indicate your interest in being contacted via Email regarding medical test results, etc. :

( ) yes ( ) no ( ) not applicable