DC FAMILY
HEALTHCARE AND WELLNESS CLINIC

Patient Information

Patient Name: _____ Date of Birth:_____

Address: _____ Social Security Number: _____

City/State/Zip: _____ Primary Phone: _____

Race/Ethnicity: _____ Other Phone: _____

Email Address for Portal Access: _____

Pharmacy: _____ Pharmacy City/State/Zip: _____

Emergency Contact Name: _____ Relationship to Patient: _____

Emergency Contact Phone Number: _____

Subscriber and/or Guarantor's Information (if different than above)

Policy Holder Name: _____ Relationship to Patient:_____

Policy Holder Date of Birth: _____ Social Security Number: _____

Address: _____ City/State/Zip: _____

Email address: _____ Primary Phone: _____

Employer/Employer Address/Employer Phone: _____

Insurance Information

Insurance Provider: _____ Insurance ID: _____

Secondary Insurance Provider: _____ Insurance ID: _____

I certify that I, and/or my dependents have insurance coverage as listed above and assign directly to Deer Creek Family Health Care and Wellness Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Deer Creek Family Healthcare and Wellness Clinic may use my health care information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Patient/ Guardian Signature: _____ Date: _____

Signature and Consent Declaration

1. My signature below indicates that I have read and consent to the Consent for Provider Services.
2. My signature below indicates that I have read and consent to the Notice of Privacy Practices.

Patient/ Guardian Printed Name: _____

Patient/ Guardian Signature: _____ Date: _____

Medical Release Form

Due to federal guidelines under HIPPA, DCFHC is required to have a release signed by the patient before we can give out any medical or financial information to any person other than the patient.

Please list the name, relationship, and phone number of any authorized individual(s) that DCFHC may discuss medical or financial information with.

Name: _____ Relationship to Patient: _____ Phone Number: _____

Name: _____ Relationship to Patient: _____ Phone Number: _____

Name: _____ Relationship to Patient: _____ Phone Number: _____

If you do not wish to have any medical or financial information discussed with anyone other than yourself (the patient), please sign below.

Patient/ Guardian Signature: _____ Date: _____

The information is private and confidential and will be placed in your medical chart. The information on the form will be valid until DCFHC is notified otherwise.

May DCFHC leave medical information on your voicemail or home answering machine? **YES** or **NO**

May DCFHC leave appointment information on your voicemail or home answering machine? **YES** or **NO**

Patient/ Guardian Signature: _____ Date: _____

OFFICE USE ONLY INSURANCE: _____ APPT TIME: _____ RM # _____
VITAL SIGNS: HT _____ WT _____ BP _____ P _____ RR_____ T _____ O2 _____%

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NAME:_____ DOB: ____/____/____ TODAY'S DATE:____/____/____

IF female is there any chance that you might be pregnant? **YES** or **NO** Date of LMP: ___/___/___ or N/A

Please list all medications, including over the counter supplements you are currently taking, their dosages, and how many times per day you take them:

_____
_____
_____
_____
_____

Do you have any ALLERGIES or intolerances to drugs, latex, food, insects, etc? **YES** or **NO** If YES, provide a description of each allergy including the type of reaction:

_____
_____
_____

Medical History:

_____
_____
_____
_____
_____

Surgical History:

_____
_____
_____

PT NAME:

Immunization History (Please Include Dates):

_____
_____
_____

Family Medical History:

_____
_____
_____
_____
_____

Social History:

Do you use Tobacco? **YES** or **NO**

Do you smoke? **YES** or **NO** How many a day? _____ How many years? _____

Have you attempted to quit? **YES** or **NO** Are you interested in quitting? **YES** or **NO**

Do you drink? **YES** or **NO** How often (please circle)? Social Occasional Light Heavy

What do you drink (please circle)? Beer Liquor Wine

Any illicit drug use? **YES** or **NO** If so, please indicate type and last date of use: _____

Other Relevant History:

Most recent cholesterol screening: _____

Have you ever had a colonoscopy? If so, please list dates: _____

Females: When was your most recent pap smear? _____ Mammogram? _____

Males: When was your most recent Prostate exam/PSA testing? _____

	YES	**NO**
Have you had a stroke?	☐	☐
Have you had a heart attack?	☐	☐
Are you diabetic?	☐	☐
Are you currently taking Aspirin?	☐	☐
Are you currently taking statin?	☐	☐

PT NAME:

Reason for today's visit:

_____

_____

Please only check the symptoms you currently have at today's visit

Constitutional:

- ☐ Fever
- ☐ Sweats
- ☐ Chills
- ☐ Decline in health

Head:

- ☐ Dizziness
- ☐ Headaches

Eyes:

- ☐ Discharge
- ☐ Excessive tearing
- ☐ Eye pain
- ☐ Infections
- ☐ Redness
- ☐ Vision loss

Nose:

- ☐ Discharge
- ☐ Nasal obstruction
- ☐ Nosebleeds

Mouth:

- ☐ Bleeding gums
- ☐ Postnasal drip
- ☐ Tongue burning
- ☐ Voice changes

Ears:

- ☐ Discharge
- ☐ Hearing aid
- ☐ Hearing impairment
- ☐ Pain? Which ear? ____
- ☐ Ringing in ears

Throat/Neck:

- ☐ Frequent sore throat
- ☐ Lumps
- ☐ Tenderness
- ☐ Tonsils enlarged

Respiratory:

- ☐ Cough
- ☐ Productive cough
- ☐ Wheezing
- ☐ Short of breath

Cardiovascular:

- ☐ Chest pain
- ☐ Palpitations
- ☐ Varicose veins
- ☐ Leg pain when walking
- ☐ Short of breath with exertion
- ☐ Short of breath when lying flat
- ☐ Short of breath when sleeping
- ☐ Swelling of legs

Gastrointestinal:

- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Rectal bleeding
- ☐ Change in stool consistency
- ☐ Decreased appetite
- ☐ Hemorrhoids
- ☐ Nausea
- ☐ Vomiting
- ☐ Rectal pain

Gastrointestinal:

- ☐ Swallowing problems
- ☐ Vomiting blood

Musculoskeletal:

- ☐ Joint pain
- ☐ Back problems
- ☐ Joint stiffness
- ☐ Muscle cramps?
- ☐ Muscle stiffness
- ☐ Restricted motion
- ☐ Weakness

Psychiatric:

- ☐ Depression?
- ☐ Behavioral changes
- ☐ Disturbing thoughts
- ☐ Excessive stress
- ☐ Hallucinations
- ☐ Memory loss
- ☐ Mood changes?
- ☐ Nervousness

Breast:

- ☐ Discharge
- ☐ Lumps
- ☐ Pain
- ☐ Tenderness

Skin:

- ☐ Itching
- ☐ Dryness
- ☐ Hair texture change
- ☐ Hives
- ☐ Mole increased in size

PT NAME:

Neurological:

- ☐ Loss of consciousness
- ☐ Fainting
- ☐ Unsteady gait
- ☐ Memory loss
- ☐ Numbness

Endocrine:

- ☐ Weight gain
- ☐ Weight loss
- ☐ Cold intolerance
- ☐ Excessive urination
- ☐ Fatigue
- ☐ Heat intolerance
- ☐ Increased thirst
- ☐ Sweats

Hematologic/Lymph:

- ☐ Anemia
- ☐ Bleeding easily
- ☐ Easily bruised
- ☐ Swollen glands

Allergic/Immunologic:

- ☐ Recurrent infections
- ☐ Hives
- ☐ Itchy eyes
- ☐ Itchy nose
- ☐ Runny nose
- ☐ Sneezing
- ☐ Stuffy nose
- ☐ Watery eyes

Urinary:

- ☐ Awakening to urinate
- ☐ Blood in urine
- ☐ Burning
- ☐ Excessive urination
- ☐ Frequency
- ☐ Incontinence
- ☐ Infections
- ☐ Pain on urination
- ☐ Urgency

Male Genitalia:

- ☐ Discharge
- ☐ Hernias
- ☐ Lesions
- ☐ Pain
- ☐ Prostate problems

Female Genitalia:

- ☐ Bleeding between periods
- ☐ Change in periods- duration
- ☐ Change in period- flow
- ☐ Change in periods- interval
- ☐ Discharge
- ☐ Itching
- ☐ Lesions
- ☐ Menstrual pain?
- ☐ Pain on intercourse
- ☐ Postmenopausal bleeding
- ☐ Sexual problems