GRACE
FAMILY MEDICINE

Date: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ M.I._____

Address:_____ City, State, Zip:_____

Home Phone:_____ Work phone:_____

Social Security #:_____ DOB:_____/_____/_____ Age:_____ Sex:_____

Employer:_____ Occupation:_____

Emergency contact
Name:_____ Phone number:_____

INSURANCE INFORMATION

Name of Insurance Carrier:_____

Address:_____ City, State, Zip:_____

Phone:_____ Insurance ID #:_____ Group ID:_____

If you are not the primary policy holder, please list the name and information of the policy holder for insurance purposes:

Name:_____ Relationship to Patient:_____

Address:_____ City, State, Zip:_____

Phone:_____ DOB:_____ Sex:_____ SS#_____

GUARANTOR INFORMATION: Complete this section only if patient is not responsible for this account
Name:_____
Address:_____ City, State, Zip:_____
Phone:_____ SS#:_____

ADDITIONAL INFORMATION:
Were you injured on the job? Yes No Date:
Were you injured in an automobile accident? Yes No Date:
When did you first consult us for this condition? Date:

I request that payment of authorized insurance benefits be made on my behalf to the provider indicated above for any services furnished me. I authorize any holder of medical information about me or my dependant to release to the insurance company any information needed to determine these benefits or the benefits payable for related services. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not covered by insurance.

Patient's/Guarantor's Signature:_____ Date:_____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING. INCLUDE DOSE AND HOW OFTEN

1. _____ 2._____
3._ _____ 4._____
5. _____ 6._____
7. _____ 8. _____
9. _____ 10. _____

PAST MEDICAL HISTORY

1. SURGICAL HISTORY (list type/ approximate date): _____
   _____
2. ANY SERIOUS INJURIES (list type/ approximate date): _____
   _____
3. OTHER HOSPITALIZATIONS (give reason/ approximate date): _____
   _____
4. ALLERGIES: _____

SOCIAL HISTORY
Do you smoke? Yes/No If so, how many per day? _____
Do you drink? Yes/No If so, how many per day? _____

PLEASE CIRCLE ANY OF THE FOLLOWING ILLNESSES YOU HAVE HAD:

Chronic skin rash	Chest pain	Heartburn	Heart problems
Glaucoma	Palplitations	Gallstones	Pancreatitis
Hearing problems	CHF	Headaches	Paralysis
Difficulty urinating	Stroke	Dizziness	Thyroid issues
Prostate issues	Diabetes	Leg cramps	Hepatitis
Shortness of breath	Anemia	Seizures	Hypertension
COPD	Arthritis	Cancer	Cirrhosis
Asthma	GI bleed	Depression	Circulation problems

FAMILY MEDICAL HISTORY (please list any health problems/ cause of death)

Mother: _____

Father: _____

Brother(s): _____

Sister(s): _____

Briefly describe the medical problems now bothering you most: _____

_____

_____