FREDERICKSBURG FAMILY CLINIC, PA
d/b/a/ CORNERSTONE CLINIC

PATIENT REGISTRATION FORM FOR MINOR CHILDREN

Patient(s) Information

Child 1: Last Name_____ First Name_____ MI_____

Date of Birth_____/_____/_____ Sex: ❒ Male ❒Female Primary Language_____

**Ethnicity*: Hispanic / Non-Hispanic / Decline to answer **Race:* Asian / Black / Hispanic / White / More than one race / Decline to answer

Child 2: Last Name_____ First Name_____ MI_____

Date of Birth_____/_____/_____ Sex: ❒ Male ❒Female Primary Language_____

**Ethnicity*: Hispanic / Non-Hispanic / Decline to answer **Race:* Asian / Black / Hispanic / White / More than one race / Decline to answer

Child 3: Last Name_____ First Name_____ MI

Date of Birth_____/_____/_____ Sex: ❒ Male ❒Female Primary Language_____

**Ethnicity*: Hispanic / Non-Hispanic / Decline to answer **Race:* Asian / Black / Hispanic / White / More than one race / Decline to answer

Child 4: Last Name_____ First Name_____ MI_____

Date of Birth_____/_____/_____ Sex: ❒ Male ❒Female Primary Language_____

**Ethnicity*: Hispanic / Non-Hispanic / Decline to answer **Race:* Asian / Black / Hispanic / White / More than one race / Decline to answer

****Ethnicity and *Race* is *optional information requested under the American Recovery and Reinvestment Act of 2009.***

Child(ren)'s Home Address: Street Address_____

City_____ St_____ Zip_____

Parent/Guardian Contact Information

Primary: Relationship to patient:_____ Last Name:_____ First Name:_____

Lives with patient? Yes / No Date of Birth_____/_____/_____ Social Security No _____/_____/_____

Phone No: Home (_____)_____ Cell (_____)_____ Work (_____)_____

Mailing Address:_____ City_____ST_____ Zip_____

Home Email Address_____ Employer_____

Contact 2: Relationship to patient:_____ Last Name:_____ First Name:_____

Lives with patient? Yes / No Date of Birth_____/_____/_____ Social Security No _____/_____/_____

Phone No: Home (_____)_____ Cell (_____)_____ Work (_____)_____

Mailing Address:_____ City_____ST_____ Zip_____

Home Email Address_____ Employer_____

Additional Contact Questions- If parents are divorced or separated please fill out this section:

Who has primary custody?_____ Are there any legal restrictions that would prevent the non-custodial parent from consenting to medical treatment for a child or from obtaining information about the child's medical treatment? **Yes / No** If **yes,** please explain and provide a copy of any legal paperwork that supports this restriction._____

Insurance Coverage

Primary: Policy Holder's Name_____ DOB_____/_____/_____ Sex: M / F

Insurance Company_____ ID#_____ Group#_____

Other Coverage: Policy Holder's Name_____ DOB_____/_____/_____ Sex: M / F

Insurance Company_____ ID#_____ Group#_____

I hereby state that the above information is true and correct to the best of my knowledge.

SIGNATURE X_____ _____ _____

Signature of Parent or Minor's Legally Authorized Representative | Signee's Date of Birth | DATE

Printed Name of Parent or Minor's Legally Authorized Representative: _____

If representative, specify relationship to the individual: ❒ Parent ❒ Guardian ❒ Other: _____

Signatures Required on Reverse Side of Form ⇨

General Consent for Care and Treatment - Minor
Assignment of Benefits & Authorization to Release Information - Minor

Consent to Examine and/or Treatment - Minor

As a parent/legal representative of a minor, you have the right to be informed about your minor's condition and recommended surgical, medical or diagnostic procedures. It will help you make an informed decision about undergoing further treatment or procedures and the risks and hazards involved. At this point in your minor's care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. I understand this consent will remain fully effective until it is revoked by me in writing to Cornerstone Clinic. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your minor's healthcare provider about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by the healthcare provider, we encourage you to ask questions.

I voluntarily request a physician and/or mid-level provider (Nurse Practitioner/Physician Assistant), and other healthcare providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that a Nurse Practitioner/Physician Assistant is a licensed healthcare provider who may only treat and diagnose any illness or medical conditions under the supervision of a licensed physician. The "supervision" of the Nurse Practitioner/Physician Assistant is done in accordance with the rules of the Texas Medical Board.

I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

SIGNATURE X_____ _____ _____
Signature of Patient or Patient's Legally Authorized Representative | Signee's Date of Birth | Date

Printed Name of Patient or Patient's Legally Authorized Representative: _____

Assignment of Benefits and Authorization to Release Information - Minor

I hereby assign, transfer and set over to **Fredericksburg Family Clinic, PA *dba* Cornerstone Clinic** all of my rights, title and interest to mine or my dependents medical reimbursement benefits under my insurance policy, including Medicare, Medicap and/or Medicaid benefits. I hereby authorize **Cornerstone Clinic** to release any information necessary to insurance company regarding my dependents (listed on page one of this form) illnesses and treatments. I understand claims will be filed electronically or on paper claims forms and submitted to my insurance company for services rendered. I understand this assignment will remain in effect until revoked by me in writing to Cornerstone Clinic. I understand a photocopy of this authorization is valid.

I have read Cornerstone Clinic's Financial Policy and understand that I am financially responsible for any unpaid deductible and/or co-payments that are due at the time services are rendered. Charges not payable or not covered by my insurance plan are my responsibility.

SIGNATURE X_____ _____ _____
Signature of Patient or Patient's Legally Authorized Representative | Signee's Date of Birth | Date

Printed Name of Patient or Patient's Legally Authorized Representative: _____

FREDERICKSBURG FAMILY CLINIC, PA
d/b/a/ CORNERSTONE CLINIC

AUTHORIZATION FOR EVALUATION AND/OR TREATMENT OF A MINOR CHILD IN THE ABSENCE OF PARENT/LEGAL GUARDIAN

A parent or legal guardian must accompany a child younger than 18 years of age (*unless the minor is allowed to consent on their behalf according to the TX Family Code Section 32.003, see below)* to consent for all medical and/or surgical treatment provided by CORNERSTONE CLINIC. Please complete this form if your child will be coming for a visit, treatment or procedure without a parent or legal guardian.

Minor's Full Name:_____ Date of Birth_____
Minor's Full Name:_____ Date of Birth_____
Minor's Full Name:_____ Date of Birth_____
Minor's Full Name:_____ Date of Birth_____
Minor's Full Name:_____ Date of Birth_____

I authorize the individual(s) listed below to give consent to medical treatment by **CORNERSTONE CLINIC** on behalf of my child(ren) listed above. The below-named individual(s) may also receive test results and additional information pertinent to the care and treatment of this minor child.

Name of Person	Relationship To Minor	Date Of Birth

Authorization for minor patient to be unaccompanied for treatment by CORNERSTONE CLINIC: I authorize and give consent for my son/daughter who is 16 years of age or older to go independently to appointments and consent to all medical evaluation and/or treatment without the presence of a parent or legal guardian. ❒ **Yes** ❒ **No**

I understand that I am still financially responsible for all medical expenses incurred by my child(ren) during these appointments. ____Initial

This authorization shall be valid until I withdraw delegation of consent. The undersigned have executed this document as of the _____ day of _____, 20_____.

Name of Custodial Parent/Legal Guardian (print)_____ DOB_____

Signature of Custodial Parent/Legal Guardian	Relationship to Minor	Parents Telephone Numbers with Area Code

Sec 32.003.**CONSENT TO TREATMENT BY CHILD** (a) A child may consent to medical, dental, psychological, and surgical treatment for the child by a licensed physician/dentist if the child:

(1) is on active duty with the armed services of the United States of America;
(2) is: (A) 16 years of age or older and resides separate and apart from the child's parents, managing conservator, or guardian, with or without the consent of the parents, managing conservator, or guardian and regardless of the duration of the residence; and
(B) managing the child's own financial affairs, regardless of the source of the income;
(3) consents to the diagnosis and treatment of an infectious, contagious, or communicable disease that is required by law or a rule to be reported by the licensed physician or dentist to a local health officer or the Texas Department of Health, including all diseases within the scope of Section 81.041, Health and Safety Code;
(4) is unmarried and pregnant and consents to hospital, medical, or surgical treatment, other than abortion, related to the pregnancy;
(5) consents to examination and treatment for drug or chemical addiction, drug or chemical dependency, or any other condition directly related to drug or chemical use;
(6) is unmarried, is the parent of a child, and has actual custody of his or her child and consents to medical, dental, psychological, or surgical treatment for the child; or
(7) is serving a term of confinement in a facility operated by or under contract with the Texas Department of Criminal Justice, unless the treatment would constitute a prohibited practice under Section 164.052 (a)(19), Occupations Code.

(b) Consent by a child to medical, dental, psychological, and surgical treatment under this section is not subject to disaffirmance because of minority.
(c) Consent of the parents, managing conservator, or guardian of a child is not necessary in order to authorize hospital, medical, surgical, or dental care under this section.
(d) A licensed physician, dentist, or psychologist may, with or without the consent of a child who is a patient, advise the parents, managing conservator, or guardian of the child of the treatment given to or needed by the child.
(e) A physician, dentist, psychologist, hospital, or medical facility is not liable for the examination and treatment of a child under this section except for the provider's or the facility's own acts of negligence.
(f) A physician, dentist, psychologist, hospital, or medical facility may rely on the written statement of the child containing the grounds on which the child has capacity to consent to the child's medical treatment.

FREDERICKSBURG FAMILY CLINIC, PA
d/b/a/ CORNERSTONE CLINIC

514 W. WINDCREST ST., FREDERICKSBURG, TX 78624, 830.997.0330
815 FRONT ST., COMFORT, TX 78013, 830.995.5633

Patient Name:_____ **Date of Birth:**_____

CONSENT TO RELEASE PERSONAL HEALTH INFORMATION (PHI)
Effective September 23, 2013, Revised July 2015

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice **before** signing this consent and prior to any service being provided to you by the practice. The Practice reserves the right to change the Notice of Privacy Policies. If we change our notice, you may obtain a revised copy by sending a letter to the Practice's HIPAA Officer or by asking the provider's receptionist. You can also obtain a copy on the clinic's website at www.cornerstoneclinicfbg.com.

I authorize Physicians/staff of CORNERSTONE CLINIC to release information pertaining to my condition and/or care to those individuals listed below:

	Full Name	DOB		Full Name	DOB
Spouse:			Children:		
Parent:					
Children:			Other:		

CORNERSTONE CLINIC physicians/staff may contact me in the following manner (check all that apply):

HOME TELEPHONE NO:_____
- ☐ OK to leave message on machine with detailed message
- ☐ OK to leave message with call-back number only
- ☐ OK to leave message with family member
  Who? _____

CELLULAR TELEPHONE NO:_____
- ☐ OK to leave message on voicemail with detailed message
- ☐ OK to leave message with call-back number only
- ☐ OK to receive text message

WORK TELEPHONE NO:_____
- ☐ OK to leave message on machine with detailed message
- ☐ OK to leave message with call-back number only
- ☐ OK to leave message with co-worker
  Who?_____

WRITTEN COMMUNICATION
- ☐ OK to mail to my home address
- ☐ OK to mail to my work/office address
- ☐ OK to fax to this number_____
  ***See fax policy below.**

Cornerstone Clinic is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of faxing, third parties may have access to messages. When communicating from work, you should be aware that some companies consider faxes corporate property and your messages may be monitored. I understand that this office will not be responsible for information loss or delayed, or breaches in confidentiality that are due to technical factors beyond this clinic's control. **I understand and agree to this fax policy**. _____(initial)

By signing this form, you acknowledge that you have been given the opportunity to read the clinic's Notice of Privacy Practices prior to any service being provided to you by this Practice, and you consent to the use and disclosure of your medical information to other healthcare providers involved in your care and for treatment, payment and healthcare operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH).

Signature of Patient/Legal Representative	Print Name	Date

If Legal Representative, relationship to Patient:_____

Please notify receptionist if you want a copy of this signed form for your records.

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FORMULARY BENEFITS DATA CONSENT FORM

Formulary Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

By signing below I give permission for healthcare providers at **Fredericksburg Family Clinic, P.A. d/b/a Cornerstone Clinic** to access my pharmacy benefits data electronically through RxHub.

This consent will enable the healthcare providers at **Fredericksburg Family Clinic, P.A. d/b/a Cornerstone Clinic:**

- Determine the pharmacy benefits and drug copays for a patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub. I understand this consent will remain in effect until revoked by me in writing to Cornerstone Clinic.

SIGNATURE X_____ _____ _____
Signature of Patient or Patient's Legally Authorized Representative | Patient Date of Birth | DATE

Printed Name of Patient or Patient's Legally Authorized Representative: _____

This Consent applies to the dependents listed below. Specify your relationship to dependents:

❒ **Parent** ❒ **Guardian** ❒_____

Dependent's Full Name:_____ Date of Birth_____

Dependent's Full Name:_____ Date of Birth_____

Dependent's Full Name:_____ Date of Birth_____

Dependent's Full Name:_____ Date of Birth_____

Dependent's Full Name:_____ Date of Birth_____

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NO SHOW AND LATE ARRIVAL POLICY
EFFECTIVE JANUARY 01, 2015

Dear Patient,

In an effort to maximize the time the physician, nurse practitioner or the clinic's ancillary staff members spends with you and to minimize your wait time, we have made changes to our No-Show and Late Arrival Policies as follows:

No Show Policy

Effective January 01, 2015, we have implemented a ***"No-Show"*** policy which will affect all patients who do not keep their scheduled appointment or who cancel an appointment with less than 24-hour notice.

- First ***No Show*** – Patient/parent will be called to reschedule the missed appointment.
- Second ***No Show*** – Patient/parent will be sent a letter informing them that they have now missed two (2) appointments without notifying the office and a **$25.00** ***no show*** fee will be charged.
- Third ***No Show*** – Patient/parent will be sent a certified letter informing them that their account has been flagged as habitual ***no shows*** and that another ***no show*** may result in termination from the practice. Habitual ***no shows*** may also be reported to Medicaid and commercial insurance companies for non-compliance. A **$35.00** ***no show*** fee will be charged.
- Patients who ***No Show*** for a Physical/Well visit appointment will be charged **$50.00**.
- Patients who ***No Show*** for a Double appointment (two family members scheduled at the same time) may be restricted from scheduling double appointments in the future. A ***no show*** fee will be charged for each patient scheduled.

Call **830.997.0330** (Fredericksburg location) or **830.995.5633** (Comfort location) 8:00am – 5:00pm, Monday through Friday, to cancel appointment.

Late Arrival Policy

Patients arriving more than 15 minutes late for a scheduled well visit or other pre-scheduled appointment may be rescheduled for another day or worked in after the on-time scheduled patients are seen.

Patients arriving more than 15 minutes late for a same day sick appointment will be worked in and seen as soon as the schedule allows.

I have read and understand the above stated policy.

SIGNATURE X_____ _____ _____
Signature of Patient or Patient's Legally Authorized Representative | Patient Date of Birth | DATE

Printed Name of Patient or Patient's Legally Authorized Representative: _____

I understand this policy also applies to my dependents listed below. Specify your relationship to dependents
❒ Parent ❒ Guardian ❒_____

Dependent's Full Name:_____ Date of Birth_____

Dependent's Full Name:_____ Date of Birth_____

Dependent's Full Name:_____ Date of Birth_____

Dependent's Full Name:_____ Date of Birth_____

Dependent's Full Name:_____ Date of Birth_____

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Financial Policy

Thank you for choosing us as your primary care provider. We are committed to providing our patients with quality and affordable health care. To ensure that the physicians of Fredericksburg Family Clinic, P.A. d/b/a Cornerstone Clinic has financial stability and can continue to provide medical services to the community and region, the following credit policies shall be enforced. Please read this policy, ask us any questions you may have, and sign in the space provided. A signed copy of this form will be provided to you upon request.

PAYMENT RESPONSIBILITY: We understand that many patients expect their insurance company to pay for a large portion of medical claims. However, **the patient** (or legal representative of the patient) **is ultimately responsible for the bill if the insurance company does not pay.**

As a courtesy to you, we will file a claim to your primary and secondary insurance plans. Co-payments (e.g. Coinsurance, Deductibles, Non-Covered services, etc.) must be paid at the time treatment is provided. If you are unsure of your financial responsibility, please contact your insurance company in advance to obtain this information. Should you need to speak to a financial counselor to make payment arrangements prior to your scheduled appointment, please call a counselor at the Fredericksburg location at (**830)992.2705**, **(830)992.2706** or at the Comfort location at **(830)995.5633**. Any balance remaining after insurance has paid their part of the covered portion, will be due upon receipt of statement.

NON-DISCRIMINATION OF SERVICES: Necessary medical services for established patients will be provided regardless of patient's ability to pay.

PROOF OF INSURANCE: All patients must provide some form of **ID (driver's license or other photo id) and current valid insurance card to provide proof of insurance**. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

INSURANCE: We participate in most insurance plans, including Medicare and Medicaid. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we are contracted with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

CO-PAYMENTS AND DEDUCTIBLES: All co-payments and deductibles **must be paid** at the time of service or your appointment may be rescheduled. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

NON-COVERED SERVICES: Payment for all charges that are not covered by insurance is due and payable at the time of service. A pre-treatment deposit may be required. If you are unable to pay the full balance due within 30 days after treatment is rendered, please see a financial counselor to discuss monthly payment arrangements.

NONPAYMENT: If your account is over 60 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this occurs, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, your healthcare provider will only be able to treat you on an emergency basis only.

PRIOR UNPAID ACCOUNTS: Prior to providing services, payment of prior outstanding accounts may be requested and should be received or specific payment arrangements made. If the balance cannot be paid in full, then you must speak with a financial counselor to make payment arrangements prior to your appointment.

Continued on Reverse Side ⇨

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514 W. WINDCREST ST., FREDERICKSBURG, TX 78624, 830.997.0330
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METHODS OF PAYMENT: We accept cash, check, VISA, MasterCard, American Express and Discover. We do **not** accept post-dated checks, nor will we hold checks for any length of time. Payment arrangements may be made as necessary by calling a financial counselor at the Fredericksburg location at **(830)992-2705, (830)992.2706** or at the Comfort location at **(830)995-5633**.

PAYMENT ARRANGEMENTS: If a patient is unable to make full payment of the patient balance when due, periodic, partial payments may be approved in accordance with credit and collections procedures, as authorized by the physician of his designee. Members of our billing and insurance department are always available to help you with questions and or payment arrangements. Once made in writing, agreements are binding. We consider payment by the patient for services rendered to be an important part of the patient's role in the patient/healthcare provider relationship. Prompt payment for services rendered is expected and failure to comply or respond to repeated communications from our office may result in discharge from the practice and/or involvement of an outside collection agency. A patient financial evaluation may be requested to determine appropriate payment arrangements.

WORKMAN'S COMPENSATION: Cornerstone Clinic does not currently accept workman's compensation at this time. Please contact your adjuster for a listing of approved providers.

MEDICARE PATIENTS: Cornerstone Clinic accepts Medicare assignment. We will bill your secondary insurance if you provide us the proper insurance information. You are responsible for the applicable coinsurance and deductibles, and charges for non-covered services. You should receive an explanation of benefits from Medicare indicating how much you owe.

MEDICAID PATIENTS: Cornerstone Clinic accepts Medicaid assignment. You will be required to pay any co-pay at the time of service, if required by your plan. If you have exceeded the legislative limits for the year as set forth by Medicaid, you will be held responsible for the charges.

THIRD PARTY LITIGATION: If you are involved in an accident we will be pleased to provide medical care for you. We do not, however, file claims with third-party liability insurance plans. We will either file the claim with your personal medical insurance or we will expect a deposit from you and payments from you for all balances incurred.

RETURNED CHECKS: There will be a $25.00 fee assessed for any and all checks returned from the bank for any reason. Uncollected checks may be submitted to the District Attorney for criminal prosecution.

CHARITY ALLOWANCES: If a patient is determined to be financially indigent, the financial counselor will assist the patient in applying for other financial assistance. If no source of financial assistance is available, the physician will review the account for a charity allowance. All charity allowance must be approved by the physician or delegated representative.

REFUNDS: Overpayments will be refunded to the appropriate party, normally the insurance company or guarantor. Patient refund will not be processed until all active or past due accounts associated with the patient are paid in full.

MINOR PATIENTS: For all services rendered to minor patients, the adult accompanying the patient is responsible for payment. Even if the parents are divorced the parent that accompanies the minor to the doctor is responsible for payment, regardless of the terms of the custodial agreement.

I have read and understand the financial policy of Fredericksburg Family Clinic, P.A. d/b/a CORNERSTONE CLINIC and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____ _____ _____

Signature of Patient or Legal Representative of Patient | Patient's Date of Birth | Date

_____

Printed name of Patient or Legal Representative of Patient

If representative, specify relationship to patient: ❒Parent ❒Guardian ❒Other_____

Cornerstone Clinic Patient History Form

Thank you for partnering with Cornerstone Clinic for your health care.
Please take a few minutes to complete this summary of your health history.
Use the back of this form if you need more room.

NAME: _____ **Date of Birth:**_____

ALLERGIES: ***(Include drugs, foods, chemicals, insects, etc.)***

Medication or Other Item	Type of Reaction

MEDICATIONS: ***(Please list all medications that you take every day, including vitamins or herbal supplements, birth control, and over-the-counter products.)***

Medication Name	Dosage (strength and how many times per day)

HOSPITALIZATIONS ***(List overnight hospital stays)*:**

Reason for Hospital Stay	Date

FOR WOMEN:

Age at First Period:	Date of Last Period:
Number of Times Pregnant:	Date of Last Pap Smear:
Number of Babies Delivered:	Date of Last Mammogram:
Any Miscarriages or Abortions:	Date of Last Bone Density:

For Men and Women, date of last Colonoscopy: _____

IMMUNIZATIONS: ***(please enter last known date of immunization listed)***

Tetanus:	**Pneumonia:**
Influenza (Flu):	**Shingles:**

NAME: _____ **Date of Birth:**_____

PAST MEDICAL HISTORY: ***(Please circle any of these that apply to you, either now or in the past)***

Allergies	Arrhythmia	Asthma	Breast Cancer	Benign Prostate Hypertrophy
Carotid Artery Stenosis	Cerebrovascular Accident (Stroke)	Cholelithiasis (Gallstones)	Colon Cancer	Congestive Heart Failure
COPD	Coronary Artery Disease	Diabetes	Fracture	GERD
Headaches	Hyperlipidemia (High Cholesterol)	Hypertension (Blood Pressure)	Hypothyroidism	Iron Deficiency Anemia
Lung Cancer	Myocardial Infarction (Heart Attack)	Obesity	Osteoarthritis	Osteoporosis
Peptic Ulcer Disease	Prostate Cancer	Skin Cancer	Testicular Cancer	Recurrent Urinary Infections

OTHER: -

_____

SURGERIES: ***(Please circle any surgeries that you've had and the year or age that they occurred)***

Appendectomy	Arthroscopy	Biopsy	CABG (Heart Bypass)	Cataract Removal
Cholecystectomy (Gallbladder)	Circumcision	Coronary Artery Stent Placement	C-section	Dilation & Curettage (D&C)
Fracture Repair	Hernia Repair	Hysterectomy	Joint Replacement	Tubes in Ears
Prostatectomy	PTCA (Coronary Angioplasty)	Sinus Surgery	Tonsil/Adenoidectomy	Tubal Ligation
TURP	Vasectomy			

OTHER: _____

FAMILY HISTORY: ***(Please complete the following information on your relatives)***

	Age If Alive now	Age at time of death	Health Problems and/or Cause of Death
Father			
Mother			
Brothers (#_____)			
Sisters (#_____)			
Spouse			
Children (#_____)			
Grandparents			

NAME: _____ **DOB:** _____

SOCIAL/ PERSONAL HISTORY: ***(Please complete the following information about yourself.)***

Current Occupation:				
Education Completed:	□ Grade School	□ High School	□ College (degree):	□ Post Graduate (degree):
Marital Status:	□ Single	□ Married (Date):	□ Divorced (Date):	□ Widowed (Date):
Hobbies/ Recreation:				
Exercise:	Type:		Frequency/ Week:	
Do you identify with a specific religion?			□ YES	□ NO
If yes, which one?				
Do you attend church or another place of worship?			□ YES	□ NO
Current Tobacco Use:	Type:		Amount/Day:	
Former Smoker:	Amount/day:	Years:		Quit Date:
Exposed to Second-hand Smoke:		□ YES		□ NO
Alcohol Use:	Type:		Amount/Day:	
Recreational Drugs:	Type:		Amount/ Day:	
Caffeine Use: (soda, coffee, chocolate)	Type:		Amount/ Day:	

If there is anything else you'd like us to know about your health history, please tell us in the space below.

_____

_____

_____

_____

_____

_____