TCFPA Medical Centers New Patient Information (Please bring with you to your 1st office visit)

Physician: ☐ Cornwell ☐ Dant ☐ Denman ☐ Greene ☐ Kowalski ☐ Ireland ☐ Phillips ☐ Smith

Date / /2010 Referred By

Do you have a living Will? Yes ☐ No ☐

Patient: First Name Middle Name Last Name

Street Address Apt No. or POBox

City State Zip code

Date of Birth: ☐☐/☐☐/☐☐☐☐ Sex M☐ F☐ Marital Status S☐M☐D☐W☐

Social Security No. ☐☐☐-☐☐-☐☐☐☐

Phone Number (☐☐☐) ☐☐☐-☐☐☐☐ extension☐☐☐☐

Guarantor(If patient is a minor, please complete this section for billing purposes)

Patient: First Name Middle initial Last Name

Street Address Apt No. or POBox

City State Zip code

Date of Birth: ☐☐/☐☐/☐☐☐☐ Sex M☐ F☐ Social Security #☐☐☐-☐☐-☐☐☐☐

Phone Number (☐☐☐) ☐☐☐-☐☐☐☐ extension☐☐☐☐

Patient or Guarantor (if not employed then check one of the following Retired ☐ Student☐ other☐)

Employer

Street Address

City State Zip code

Spouses Name Date of Birth: ☐☐/☐☐/☐☐☐☐

Social Security No. ☐☐☐-☐☐-☐☐☐☐

Phone Number (☐☐☐) ☐☐☐-☐☐☐☐ extension☐☐☐☐

Emergency Contact Person(other than Home number)

Relationship Phone Number (☐☐☐) ☐☐☐-☐☐☐☐

Medical Insurance Information (**We Need A Copy of your Insurance Card**)

I, the undersigned, give my permission to treat and assign directly to Memorial Health Partners, if any, otherwise payable to me for services rendered. I the undersigned understand that I am financially responsible for all charges not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits and authorize the use of this signature on all insurance submissions.

Signature _____ Date _____

TCFPA Medical Center
Medical History Form

Patient Name_____ Birthdate ☐☐/☐☐/☐☐☐☐
Date of Last Physical Exam_____ Your Occupation_____
Place of Employment_____ SpousesOccupation_____
Education Level ☐High School ☐College ☐Masters ☐Ph.D. ☐Other_____
Religious Preference _____ Hobbies_____
Smoking History. Packs Per day_____ For how many years_____
Drinking History Ounces Per day_____ For how many years_____
List the individuals that live in your home_____
How much exercise do you get. Minutes each day___ Hours per week____
What additional information should the doctor have about you?_____
_____
List the reasons that you want to see the doctor. (List in order of importance to you)
1._____
2._____
3._____
List other physicians seen in the past 2 years._____

Past Medical History:

1. Operations (list all and give year)

a._____ d._____
b._____ e._____
c._____ f._____

2. Accidents (list broken bones, injuries, etc.)

a._____ d._____
b._____ e._____
c._____ f._____

3. Illnesses (list problem and year)

a._____ d._____
b._____ e._____
c._____ f._____

4. Hospitalizations (list all and give year)

a._____ d._____
b._____ e._____
c._____ f._____

5. Are you allergic to

	Yes	No		Yes	No
a. Penicillin	☐	☐	e. Demerol	☐	☐
b. Sulfa drugs	☐	☐	f. Barbituates	☐	☐
c. Codeine	☐	☐	g. Anesthetics	☐	☐
d. Aspirin	☐	☐	f. Other(list)_____		

6. Pregnancies_____ Miscarriages_____ Weight of largest Child_____

7. Medications(list all you are taking and have taken in the past Month

a._____ g._____ m._____
b._____ h._____ n._____
c._____ i._____ o._____
d._____ j._____ p._____
e._____ k._____ q._____
f._____ l._____ r._____

Family History	Age	Medical Problems	Cause of death	Age
Father				
Mother				
Brothers - - -				
Sisters - - -				
Spouse				
Children Check one M☐ F☐ M☐ F☐ M☐ F☐ M☐ F☐ M☐ F☐				

Review of Systems(Review the list below and check any that describe a problem you are currently having or circle any problem have had in the past.)

☐Headache
☐Seizures or fits
☐Fainting or blackout spells
☐Black loose bowel movements
☐Strokes
☐Ringing in ears
☐Difficulty with Vision
☐Nose Bleeds
☐Change in Voice
☐Shortness of Breath
☐Swelling in ankles or feet
☐Heart Palpitations
☐Chest Pain or Chest tightness
☐Heart Attacks
☐High Cholesterol
☐Coughing up blood
☐Wheezing during Breathing
☐Sugar Diabetes
☐High Blood Pressure
☐Night Sweats
☐Fever for more than 5 days
☐Trouble Swallowing
☐Chronic Diarhea

☐Constipation
☐Vomit Blood
☐Blood with bowel movements
☐difficulty maintaining balance
☐Jaundice
☐Stomach Ulcers
☐Hemmorhoids
☐Weight Loss
☐Weight Gain in past year
☐Frequent urination(passing water)
☐Pain on urination
☐Pus or milky color of urine
☐Blood in urine
☐Pass a stone in urine
☐Reduction in force of urine
☐Difficulty starting urine stream
☐Leakage of Urine
☐Difficulty with Erection
☐Discharge from Penis
☐Onset of Menstruation(age)___
☐Painful Periods
☐Irregular Periods
☐Last Menstrual Period_____

☐Vaginal Discharge
☐Back Pain
☐Pain in legs when walking
☐Joint Swelling
☐Joint Pain
☐Chronic Weakness
☐Skin Rash
☐Dry Skin
☐Hair Loss
☐Hives
☐Breast Discharge
☐Lumps in Breast
☐Painful Breast
☐Easy Bruising
☐Excessive bleeding after cutting
☐Crying Spells
☐Insomnia
☐Mood Swings
☐Nervousness
☐Difficulty with Memory
☐Chronic Fatigue
☐Depression
☐ Pain in hands or feet with cold Weather exposure

Weight ate age 20____ Weight 1 year ago_____ Weight Now_____

Date Reviewed _____ Physician Signature_____