PATIENT DEMOGRAPHICS

First Name_______________________MI ____Last Name______________________

Sex: M or F SS#______________________ Date of Birth ________________

Email Address: ____

Street Address ____

City___________________________ State_______ Zip Code_________-______

Home Phone___________________________Work Phone_______________________

Cell Phone__________________________ Primary Doctor____________________

Date Last Seen_______________________ Primary Language __________________

Race ____________ EmergencyContact_____________________________________

Phone #______________________ Marital Status: S M W SEP D

Referred by: _____________________ Pharmacy: ___________________________

PATIENT EMPLOYER INFORMATION

Employer Name_____________________________________Work #______________

Employer Address____

Occupation____

INSURED PERSON (IF OTHER THAN PATIENT)

Name__________________________DOB__________Home Ph#_________________

Address_________________________________City_____________State___Zip____

Employer Name__________________________________Office Phone_____________

GUARANTOR (RESPONSIBLE PARTY)

Name_____________________________________Home Phone___________________

Address________________________________City______________State___Zip____
Relationship to Patient____

GENERAL MEDICAL INFORMATION

Reason for today's visit:____
____

History of present illness:
***Location: Where is the problem?**____
***Quality: How does it feel?**____
*** Severity: How severe is the pain?**____
*** Duration: How long have you had this pain/problem?**__________________________
____
*** Timing: Does this pain/problem occur at a specific time?**______________________
____
***Context: Where were you at the onset of the pain/problem?**____________________
***Associated symptoms:**____
*** Modifying Factors: What makes the problem better or worse?** ________________
____
____

PATIENT MEDICAL HISTORY

Please indicate by check mark in the columns below, if you have had any of these conditions presently or in the past:

	PAST	NOW		PAST	NOW
AIDS/HIV			HEPATITIS		
ALCOHOLISM			MEASLES		
ALLERGIES			MUMPS		
ATHEROSCLEROSIS			MULTIPLE SCLEROSIS		
ARTHRITIS			PACEMAKER		
ASTHMA/COPD/ EMPHYSEMA			PLEURISY		
BIRTH TRAUMA			PNEUMONIA		
CANCER			POLIO		
CHICKEN POX			REFLEX/GERD		
DIABETES			RENAL FAILURE/DISEASE		
EPILEPSY			SWEATS/FEVER		
GOUT			THYROID DISORDERS		
HEART ATTACK/ STROKE			TB/LUNG DISORDERS		
HEART MURMUR			VENEREAL DISEASE		
HIGH BLOOD PRESSURE			WHOOPING COUGH		

*PATIENT MEDICAL HISTORY:

Please list any prior and current medical problems:

____

____

____

Present Medications: ____

____

____

Allergies: (history of skin reaction or other adverse reaction to):

____

List any prior surgeries or hospitalizations: __________________________________

____

*FAMILY MEDICAL HISTORY

	AGE	DISEASE	IF DECEASED, CAUSE OF DEATH
FATHER			
MOTHER			
SIBLINGS			

*PATIENT SOCIAL HISTORY:

Do you smoke? YES/NO Number of years? _______ How much per day? _______
Do you regularly drink alcohol? YES/NO How many ounces/beers per day? _______
Have you in the past or are you currently using recreational drugs? YES/NO

PATIENT'S AUTHORIZATION

I authorize LYLE T. MODLIN, D.P.M., P.A. to apply for benefits on my behalf. My signature authorizes payment of all medical benefits to which I am entitled from my insurance carrier to LYLE T. MODLIN, D.P.M., P.A. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of all medical and/ or insurance claim information necessary to secure the payment(s). I recognize my financial obligation of any insurance copays, deductibles, and non-covered services that may be required.

If my insurance requires a referral or authorization, I understand that it is my responsibility to make sure that I have a valid referral on file for the date that services are rendered. If I do not have a referral or if my referral is not valid, I understand that I will be fully responsible for payment.

This agreement will remain in effect until revoked by me in writing. A copy of this document is considered as valid as an original.

______________________________	______________________________
Patient's Name (please print)	**Patient's Signature** **(Legal Guardian if Patient is a Minor)**

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Witness

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that a copy of the HIPAA Notice of Privacy Practices has been made available to me, and that I have read (or have had the opportunity to read if I so choose) and understand these Privacy Practices.

______________________________	______________________________
Patient Name (please print)	**Today's Date**

____

Parent or Authorized Representative
(If applicable)

____

Patient's Signature

As a new patient, or a patient who has not been seen in the last three years, we ask that you arrive 15 minutes early for your scheduled appointment in order to complete all paperwork.

Late arrivals may be asked to reschedule.

We ask that you provide at least 48 hours notice if you need to pick up any records or x-rays. All information will be released with a signed notification.