PRIMECARE
MEDICAL GROUP

New Patient Information **Date:** ________________

Patient Name ________________________________ Date of Birth _______________

Gender: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race:_________________________ Preferred Language _________________________

Ethnicity: Hispanic_____________ Non- Hispanic_____________ Other_______________

Street Address _______________________________City _______________________

State _____________ZIP ______________Referred by:__________________________

Home Phone ____________ Cell phone ________________ Work phone _____________

Email Address ____

Drivers License # _________________State________ Social Sec # __________________

Employer____

Work Address ____

City ______________________ State _____________ ZIP ______________________

Pharmacy Name ________________________________ Phone # __________________

IF PATIENT IS A MINOR – PLEASE COMPLETE THIS SECTION

Parent Name _____________________________ Daytime Phone #__________________

Street Address ______________________City __________ State ______ ZIP__________

POLICYHOLDER'S INFORMATION (COMPLETE ONLY IF DIFFERENT FROM PATIENT

Policyholder Name _____________________________ Date of Birth _________________

Relationship to Policyholder_______________________ Social Sec # __________________

Street Address __________________________ City__________State_______ ZIP _______

Home Phone # __________________________Work Phone #________________________

Employer Name ____________________________Occupation _____________________

Street Address __________________________City ____________ State _______ ZIP _____

Patient Name: ________________________________ Date: ____________________

Describe your main problem

____

____

How severe is your problem? __________________________

How long have you had this problem? ___________________

What other things happen with this problem? _____________

List previous hospitalizations/Surgeries/Serious Injuries **Date**

____/_________

____/_________

____/_________

____/_________

____/_________

Have you ever had the following?

Diabetes	yes	no
Hypertension	yes	no
Cancer	yes	no
Stroke	yes	no
Heart trouble	yes	no
Arthritis/gout	yes	no
Convulsions	yes	no
Bleeding tendency	yes	no
Acute infections	yes	no
Venereal disease	yes	no
Hereditary defects	yes	no

List the Medications you are taking.

1. ________________________
2. ________________________
3. ________________________
4. ________________________
5. ________________________
6. ________________________
7. ________________________
8. ________________________
9. ________________________
10. ________________________

Patient Social History

Marital status: ☐ Single ☐Married ☐Separated ☐Divorced ☐Widowed

Use of Alcohol: ☐ Never ☐ Rarely ☐Moderate ☐ Daily ____________

Use of Tobacco: ☐ Never ☐ Previously, but quit ☐ Current- ppd_______

Use of Drugs: ☐ Never ☐ Type/Frequency ______________________

Family Medical History

	Age	**Diseases**	**If Deceased, Cause of Death**
Father	_____	________________________	________________________
Mother	_____	________________________	________________________
Siblings	_____	________________________	________________________
	_____	________________________	________________________
Spouse	_____	________________________	________________________