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 _____

PRIMECARE MEDICAL GROUP

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	_____	_____	_____

PRIMECARE MEDICAL GROUP

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

Do We Have Permission To:

Leave test results or appointment confirmations on your		
Answering machine at home?	YES	NO
Leave a message at your place of employment	YES	NO
Leave a message, test results, or appointment confirmations	YES	NO
On your cell phone voice mail?		
Fax copies of your results to another physician if necessary?	YES	NO
Have Televox call or text you with a reminder of your appointment?	YES	NO

I hereby authorize all medical service sources and health care providers to use and/or disclose my protected health information (PHI)
I hereby authorize the release of my PHI as follows (check one):

_____My complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse.

_____My complete health record (with the exception of the following information):

_____ Mental Health Records
_____ Communicable diseases (including HIV and AIDS)
_____ Alcohol/drug abuse treatment
_____ Other (please specify)

In addition to the authorization of my personal health information, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

NAME:_____Relationship_____

NAME:_____Relationship_____

NAME:_____Relationship_____

I allow PrimeCare Medical Group to view my prescription history from an external source

_____Initial here

Self Paid (non-insured) Patients Only

I certify that I do not have insurance benefits and that I will not be filing to an insurance company for reimbursement of these charges.

_____Initial here

Insured Patients Only

I authorize payment of medical benefits to Prime Care Medical Group. I understand that I may be responsible for any amount not paid by my insurance company if they are deemed non-covered items.

_____Initial here

_____ _____

Signature of Patient **Date**

_____ _____

Print Name **Relationship to Patient**

revised 3-2015