# Patient Information

Care Plus FAMILY CLINIC

Name (First, Middle, Last)

Address

City State Zip

Date of Birth Age

Sex: ☐ M ☐ F

Social Security Number

Cell Phone Home Phone

Email

Employer or Parent Occupation Work Phone

Responsible Party or Parents Name (if minor)

Marital Status: ☐ S ☐ M ☐ D ☐ W

spouse information

Name

Employer

D.O.B.

Cell Phone Work Phone

Email

## Race

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

## Ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Preferred Language

Pharmacy Preference _____ How Did You Hear About Us? ( ) Google ( ) Friend ( ) Magazine ( ) Other _____

## In case of emergency who should we contact?

Name Relationship

Address City State Zip Code

Phone (Home) Phone (Work) Cell / Mobile Email Address

Referring Provider/source: _____

Information concerning your care provided by this center will be forwarded to your referring doctor/source unless otherwise specified

# Insurance

Care Plus FAMILY CLINIC

Please present your insurance card to the receptionist.

## Primary Insurance Carrier

Insurance Company Name

Address

City State Zip

Phone Policy Number

Group Number / Name

Insured Name & DOB

Patient's relationship to insured:

☐ Self ☐ Spouse ☐ Dependent

## Secondary insurance carrier

Insurance Company Name

Address

City State Zip

Phone Policy Number

Group Number / Name

Insured Name & DOB

Patient's relationship to insured:

☐ Self ☐ Spouse ☐ Dependent

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the Provider and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGE FOR OFFICE VISITS BE PAID BY THE CONCLUSION OF EACH VISIT.

I authorize the release of any medical information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance and other agency reimbursements to this center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature Date

# Patient History

Care Plus FAMILY CLINIC

Is this a workers comp claim: ☐ Yes ☐ No

Worker's Comp Billing Address

Allergies: _____

Medicine Other

Please make an (x) by any of these conditions you may have or have had in the past:

- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Lung disease
- ☐ Diabetes
- ☐ Hypoglycemia (low Glucose)
- ☐ Thyroid disease
- ☐ Stomach disease
- ☐ Kidney, bladder or prostate disease
- ☐ Joint replacement
- ☐ Liver disease
- ☐ Bowel disease
- ☐ Cancer (past or present)
- ☐ Anemia or other blood disease
- ☐ Blood clots
- ☐ Bleeding tendency
- ☐ Stroke
- ☐ Seizures
- ☐ Nerve impairment
- ☐ Cervical spine disorder
- ☐ Lumbar spine disorder
- ☐ Severe headaches
- ☐ Tuberculosis/TB
- ☐ Muscle disease
- ☐ Mental health problems
- ☐ Depression
- ☐ Chronic skin disease
- ☐ Sleep apnea
- ☐ Other _____

Past medical conditions

Approx. Date Condition _____ Approx. Date Condition _____

Approx. Date Condition _____ Approx. Date Condition _____

Current medications (Includes non-prescription products)

1. _____ 3. _____ 5. _____ 7. _____

2. _____ 4. _____ 6. _____ 8. _____

Preferred Pharmacy _____

## Personal Habits

Do you drink caffeinated beverages (coffee, tea, soda)?. . ☐ Yes ☐ No If yes, daily intake? _____

Do you drink alcoholic beverages . . . . . ☐ Yes ☐ No If yes, _____ drinks per ☐ Day ☐ Week ☐ Month

Do you smoke or chew tobacco? . . . . . ☐ Yes ☐ No If yes, _____ per day, _____ years of use

If no, any prior nicotine use? _____ years of use

Orthopedic or Other Major Surgeries

Approx. Date Surgery _____ Approx. Date Surgery _____

Approx. Date Surgery _____ Approx. Date Surgery _____

# Visit Information

Care Plus FAMILY CLINIC

Name (First, Middle, Last) Birthday Date

## Special Considerations

- ☐ Legally blind
- ☐ Hearing impaired
- ☐ Pregnant
- ☐ Attempting Pregnancy
- ☐ Need handicap facilities
- ☐ Smoker_____Packs per day
- ☐ Substance abuse, describe: _____
- ☐ Alcohol abuse, describe: _____
- ☐ None of the above.

## What would you like your Provider/team to accomplish today? (Mark all that apply)

- ☐ Accurate diagnosis
- ☐ Nutritional plan
- ☐ Medication/Injection
- ☐ Physical therapy
- ☐ Surgery plan if necessary
- ☐ Disability information
- ☐ Healthy exercise plan
- ☐ Alternative therapy plan (May include acupuncture, massage, manipulation)
- ☐ Other _____

## Reason for Visit

## Review of Symptoms

| | Do you have | | If Yes, Explain |
|---|---|---|---|
| skin | Rashes, bumps, lumps, open sores, or wounds | ☐ Yes ☐ No | |
| head \| eyes \| ears nose \| throat | Failing eyesight, falls, seizures, vertigo, blackouts, hoarseness, or nasal congestion | ☐ Yes ☐ No | |
| lungs | Unexpected breathlessness, wheezing (day or night), blood in sputum, or chronic cough | ☐ Yes ☐ No | |
| heart | Chest pain, irregular heart beat, or pacemaker | ☐ Yes ☐ No | |
| bowels | Blood in stool, change in bowel habits, worrisome indigestion, or abdominal pain | ☐ Yes ☐ No | |
| bladder \| kidney | Trouble urinating, infections, or blood in urine | ☐ Yes ☐ No | |
| emotional | Any mental health problems, depression, or suicidal tendency | ☐ Yes ☐ No | |
| musculoskeletal | Arthritis, fractures injuries,muscle weakness, or cramping | ☐ Yes ☐ No | |