

POINTE MEDICAL SERVICES
 1996 Kingsley Avenue • Orange Park, FL 32073
 (904) 276-5700

<p>PATIENT INFORMATION</p> <p>Date _____</p> <p>Patient _____</p> <p>Address _____</p> <p>_____</p> <p>Sex: <input type="checkbox"/> M <input type="checkbox"/> F Age ____ Birthdate _____</p> <p><input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced</p> <p>Patient SS# _____</p> <p>Occupation _____</p> <p>Employer _____</p> <p>Employer Address _____</p> <p>Employer Phone _____</p> <p>Spouse's Name _____</p> <p>Birthdate _____ SS# _____</p> <p>Occupation _____</p> <p>Spouse's Employer _____</p> <p>Whom may we thank for referring you? _____</p>	<p>INSURANCE</p> <p>Who is responsible for this account? _____</p> <p>Relationship to Patient _____</p> <p>Birthdate _____ SS# _____</p> <p>Insurance Co. _____</p> <p>Group# _____</p> <p>Is patient covered by additional insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Subscriber Name _____</p> <p>Birthdate _____ SS# _____</p> <p>Relationship to Patient _____</p> <p>Insurance Co. _____</p> <p>Group# _____</p> <p>ASSIGNMENT AND RELEASE</p> <p>I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.</p> <p>_____</p> <p>Responsible Party Signature _____</p> <p>Relationship _____ Date _____</p> <p>MEDICARE AUTHORIZATION</p> <p>I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.</p> <p>_____</p> <p>Beneficiary Signature _____ Date _____</p>
<p>CONTACT INFORMATION</p> <p>Cell _____ Home _____ Work _____ Ext _____</p> <p>Email _____</p> <p>Preferred method of contact _____</p> <p>IN CASE OF EMERGENCY, CONTACT</p> <p>Name _____ Relationship _____</p> <p>Home Phone _____ Work Phone _____</p>	

FAMILY HISTORY

Date of last physical examination _____

What is your reason for visit? _____

	FATHER	Present health or cause of death	MOTHER	Present health or cause of death	SPOUSE	Present health or cause of death
ALIVE	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
DECEASED	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
BROTHERS	NO. ALIVE	HEALTH		NO. DECEASED	CAUSE OF DEATH	
SISTERS	NO. ALIVE	HEALTH		NO. DECEASED	CAUSE OF DEATH	
CHILDREN	NO. ALIVE	AGES & HEALTH		NO. DECEASED	AGES & CAUSE OF DEATH	

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES Diabetes Cancer Bleeding tendency Kidney disease Tuberculosis

Heart disease Stroke High blood pressure Nervous illness Allergy Other _____

MEDICAL HISTORY

All information is strictly confidential.

Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- Chills
- Depression/Nervousness
- Dizziness/Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Numbness
- Sweats

GASTROINTESTINAL

- Appetite poor
- Bloating
- Bowel Changes
- Constipation
- Diarrhea
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

EYE, EAR, NOSE, THROAT

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache/Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision - Flashes/Halos

MEN only

- Erection difficulties
- Lump in testicles
- Penis discharge
- Sore on penis
- Other

WOMEN only

- Abnormal Pap Smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge
- Other

Date of last menstrual period _____
Date of last Pap Smear _____
Have you had a mammogram? _____
Are you pregnant? _____
Number of children _____

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- Arms Hips
- Back Legs
- Feet Neck
- Hands Shoulders

CARDIOVASCULAR

- Chest pain
- High/Low blood pressure
- Irregular/Rapid heartbeat
- Poor circulation
- Swelling of ankles
- Varicose veins

SKIN

- Bruise easily
- Hives
- Itching/Rash
- Change of moles
- Scars
- Sore that won't heal

GENITO-URINARY

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

Check (✓) conditions you have or have had in the past.

- | | | | |
|----------------------------------------------|-------------------------------------------|---------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Prostrate Problem |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Venereal Disease |

Describe serious illnesses or operations _____

MEDICATIONS / ALLERGIES

List medications you are currently taking _____

Pharmacy Name _____ Phone _____

List allergies to medications or substances _____

HEALTH HABITS

HEALTH HABITS Check (✓) which Substances you use and describe How much you use.

- Caffeine _____
- Drugs _____
- Tobacco _____
- Other _____

Your occupation _____

OCCUPATIONAL Check (✓) if your work exposes you to the following:

- Stress
- Heavy Lifting
- Hazardous Substances
- Other _____

SIGNATURES

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____

Reviewed By _____ Date _____

NEW PATIENT QUESTIONNAIRE

Name: _____ Today's Date: _____

Address: _____

Date of Birth: _____

Phone: _____

CHIEF COMPLAINT

1. Please mark symptoms that you have had in the last 6 months and/or currently experiencing:
(Please include: onset, severity, duration, possible causes, and remedies tried.)

Decreased Energy _____

Fatigue _____

Weight Gain/Loss _____

Insomnia/Snoring _____

Decreased Libido _____

Hair Loss/Skin Changes _____

Muscle Weakness _____

Joint Pain/Back Pain _____

Hot Flashes _____

Night Sweats _____

PMS/PMDD/Irregular Menses _____

Other _____

MEDICAL HISTORY

2. Please choose any medical conditions that you are currently being treated for or have been treated for in the past five years, and include dates. (Initial here if none ___)

Hormone Replacement _____ (If yes, Bio-Identical or Synthetic?) Hypothyroidism _____

Hyper/Hypotension _____ Cardiovascular Diseases (Please be specific) _____

Asthma _____ Arthritis _____ Diabetes _____ High Cholesterol _____

Anxiety _____ Depression _____ Myalgias _____ Shiftworker Disorder _____

Sleep Apnea _____ (If yes, are you compliant w/ CPAP? Yes No) Insomnia _____

Cancer _____ (If yes, what type and what is your current status?) _____

Other _____

3. Are you being treated for any infectious diseases? If so please include details.

(Initial here if none ___)

SURGICAL HISTORY

4. Please list below any past surgeries and dates. (Initial here if none ___)

FAMILY HISTORY

5. Please list below any family member's health problems - primarily mother/father and life status. (Initial here if none ___)

SOCIAL HISTORY

6. Do you use or have you used tobacco products? If so, what type, how much, and for how long? (Initial here if none ___)

Cigarettes _____ Cigars _____ Smokeless _____

7. Do you drink alcoholic beverages? Yes No If so, how often? (Initial here if none ___)

ALLERGIES

8. Have you had any allergic reactions to the following:

Medications? Yes No If so, what type of reaction? (Initial here if none ___)

Any type of food? Yes No If so, what type of reaction? (Initial here if none ___)

Any environmental allergies? (Initial here if none ___)

Pollen Yes No **Dust** Yes No **Pet Dander** Yes No **Mold** Yes No

Rag Weed Yes No **Latex** Yes No **Surgical Tape** Yes No

Bee/Wasp Stings Yes No **Other** _____

MEDICATIONS

9. Please list below any medications and/or vitamin supplements you are currently being prescribed. Please be sure to include strength and dosages. (Initial here if none ___)

10. What prior medications and/or treatments have you tried in the past?
(Initial here if none __)

FEMALES ONLY

11. How many pregnancies have you had? ___ What type of deliveries?
(Initial here if none ___)

12. Have you had a partial or total hysterectomy? (Initial here if none ___)
If total, were both ovaries removed? Yes No

13. Please list dates of the following: (Please Specify--Normal or Abnormal)

Last Menstrual Cycle _____ Normal or Abnormal

Last Papsmear _____ Normal or Abnormal

Last Mammogram _____ Normal or Abnormal

Female patients over 40 years of age—Have you had any of the following?

14. Colonoscopy Yes No When? _____ Normal or Abnormal

15. Bone Density Yes No When? _____

MALES ONLY

16. Have you had a vasectomy? Yes No When? _____

17. Please list date of last prostate exam: _____

Male patients over 40 years of age—Have you had any of the following?

18. Colonoscopy Yes No When? _____ Normal or Abnormal

19. Bone Density Yes No When? _____

Any other concerns or questions—please list below:
