Diana Holte, APRN

Kellie Chacanaca, APRN

PATIENT INFORMATION – Please Print

Date:______________

Name ____

Gender: __ M __ F Date of Birth ____________________SSN _____-_______-________________________

Address:____Apt#___________________

City:_________________________________ State:_________ Zip_______________________________________

Home Phone:_________________________ Cell ____

Preferred Contact: *(circle one)* **Home** **Work** **Cell** **Email** ____________________________

Employer: ___________________________ Work Phone: ____

Martial Status: *(circle one)* **Single** **Married** **Widowed** **Divorced** **Partner**

Race: *(circle one)* **White** **African American** **Asian** **Native Hawaiian/Pacific Islander**
Native American Indian/Alaskan **Other Race:** __________ **Preferred Language** ____________

Preferred Pharmacy:____

Appointment Reminder: Please select how you would like to be notified of your appointment. You may select more than one option. *(circle one)*: **Email** **Text** **Phone Call**

*Messages and data rates may apply for text messages. To change your preferences at anytime, you may fill out an Appointment Reminder form at the receptionist desk.

SPOUSE or PARENT (if minor) INFORMATION

Name: ________________________ Date of Birth ________________ Social Security ______________________

Employer ______________________________Address ______________________Phone _____________________

EMERGENCY CONTACT INFORMATION

Relative or Friend not in the home

Emergency Contact ____Relationship ______________________

Phone________________Address____________________________City______________State____Zip _________

PATIENT NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have read and acknowledged the Patient Notice of Privacy Practices from Advanced Health and Wellness.

Do you wish for a copy of the Patient Notice of Privacy Practices? Yes No

SIGNATURE ____DATE ______________________________

In the event this Acknowledgment form is being executed by a personal representative, guardian or parent, please print your name, date of birth, social security number, and relationship to the patient here.

My self/My Spouse (skip to the next section) OR:(list Father, Mother, Guardian or other)

PERSON RESPONSIBLE PARTY FOR PAYMENT

Name:____ DOB: ______________________

Address:____

City:___________________________ State:__________ Zip:____________

HEALTH INSURANCE INFORMATION

Please provide a copy of your insurance card to the receptionist

Medicare Medicare No. ______-________-________-________ Effective Date ___________

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Advanced Health and Wellness for any services furnished to me by the provider. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid and its agents any information needed to determine these benefits payable for related services.

PRIMARY INSURANCE____

ID #_____________________________ GP# _______________________ Phone# _____________________

Policy Holder's Name________________________ DOB____________ SS#_________________________

Relationship to Policy Holder: *(Circle one)* **Self** **Spouse** **Child** **Step-Child** **Other:**______________

SECONDARY INSURANCE____

ID#___________________________ GP#______________________ Phone# _________________________

Policy Holder's Name________________________ DOB____________ SS#_________________________

Relationship to Policy Holder: *(Circle one)* **Self** **Spouse** **Child** **Step-Child** **Other:**______________

INSURANCE AUTHORIZATION & FINANCIAL AGREEMENT

I hereby authorize Advanced Health and Wellness to give my insurance company or companies all information they may require concerning my case, and I hereby assign to the physician(s) all payments for medical services rendered. I understand that I am responsible for any amount not covered by my insurance. I agree to pay any co-pay and amount due at the time of service. Further, I agree to be responsible for any and all cost of collection to include court costs and a reasonable attorney fee.

Signed ____Date __________

HOW DID YOU HEAR ABOUT US?

- Recommended by a friend or family member
- Clinic web site, www.dicksonstclinic.com
- E-mail, Facebook or Twitter
- Signs or location
- My employer

Other: *Please specify* _________________________

Thank you for choosing Advanced Health and Wellness.

Please complete the information below to help your doctor evaluate your health.

Name ______________________________ Date______________ Date of Birth_____________

What brought you today? ____

Do you feel that you are basically healthy? *(circle one)* **Yes** **No**

Mark any diseases known to have occurred in the family with the appropriate initial: **M** (Mother), **F** (Father), M**GM** (maternal grandmother), PGM (paternal grandmother), M**GF** (maternal grandfather), PGF(paternal grandfather) , **A** (aunt), **U** (uncle), **C** (cousin), **B** (brother), **S** (sister).							
Alzheimer		Cancer		Hearing Prob.		Obesity	
Asthma		Stroke		Cholesterol		Blood Clots	
Alcoholism		Depression		High Blood Pressure		Kidney Prob	
Blood Disease		Developmental Problems		Mental Disease		Seizures	
Coronary Artery Dis		Diabetes		Migraines		Sickle Cell	

About You:
Education:*(circle one)* **Elementary** **High School** **GED** **College** **Graduate School** **Tech School**

Occupation__________________________ *(circle one)* **Single** **Married** **Widowed** **Divorced**

Tobacco Use: Type: *(circle one)* **Cigarettes** **Smokeless Tobacco**

Current -Everyday, how many ppd? _________ Current -occasional, how much?___________________

Former, how many ppd? __________ Year started________ Year Quit_________ Never ______

Alcohol Use: *(circle one)* **Yes** **No** Formerly How much and often? ______________________

Illicit drug use:*(circle one)* **Yes** **No** Formerly Please list_____________________________

Allergies: Medicines _______________________________Other _______________________

Medications: *Please list medications you take regularly.*
Over the Counter (Include vitamins and supplements) :___________________________________

____

Prescription: ____

____

____

____

Medical Conditions: ____

____

____

Operations *(Please include where and when)*

_____________________ _________________________ ______________________

_____________________ _________________________ ______________________

_____________________ _________________________ ______________________

Please mark "yes" to anything you have experienced recently or frequently:

	Y	N	When		Y	N	When
General:				***Gastrointestinal:***			
Feel anxious, depressed, or irritable							
Nervous breakdown				diarrhea			
Fever, Chills, Night Sweats				Frequent indigestion or gas			
Skin:				***Genitourinary:***			
Skin Rashes				Blood in urine			
Eyes, Ears, Nose, Throat:				Burning when you pass urine			
Severe or frequent headaches				Sexually transmitted disease			
Hearing trouble				***Musculoskeletal:***			
Goiter or thyroid trouble				Arthritis			
Vision trouble				**Health Changes:**			
Respiratory:				Has your weight changed in the past year?			
Shortness of breath				Approximate weight 1 year ago____________			
Asthma				***Other:***			
Cough				Excessive thirst			
Cardiovascular:				Swollen glands			
Heart trouble Pain in chest				Hay fever or allergies			

For Women

Are you currently pregnant? *(circle one)* **Yes** **No** Pregnancies(#):_____ Miscarriages:_____

Living children: _____ Age when menstrual periods began ____________

Patient Signature____**Date**_____________________