HEALTH HISTORY

Name:_____ D.O.B:_____ Age:_____

Reason for visit (please list symptoms):_____

Date symptoms started:_____

Symptoms: Check (✓) symptoms you currently have or have had in the past 6 months.

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

Muscle/Joint/Bone

Pain, weakness, numbness in:
- ❑Arms ❑Hip
- ❑Back ❑Legs
- ❑Feet ❑Neck
- ❑Hands ❑Shoulders

Genito-Urinary
- ❑Blood in urine
- ❑Painful urination
- ❑Lack of bladder control
- ❑Frequent urination

Skin
- ❑Hives
- ❑Bruise easily
- ❑Change in moles
- ❑Itching
- ❑Rash
- ❑Scars
- ❑Sore that won't heal

Cardiovascular
- ❑Chest pain
- ❑High blood pressure
- ❑Irregular heart beat
- ❑Low blood pressure
- ❑Poor circulation
- ❑Rapid heart beat
- ❑Swelling of ankles
- ❑Varicose veins

Gastrointestinal
- ❑Bloating
- ❑Bowel changes
- ❑Constipation
- ❑Diarrhea
- ❑Gas
- ❑Excessive hunger/thirst

Gastrointestinal (cont'd)
- ❑Hemorrhoids
- ❑Indigestion
- ❑Nausea
- ❑Rectal bleeding
- ❑Stomach pain
- ❑Vomiting
- ❑Vomiting blood

Eye, Ear, Nose, & Throat
- ❑Bleeding gums
- ❑Blurred vision
- ❑Difficulty swallowing
- ❑Double vision
- ❑Earache
- ❑Ear discharge
- ❑Sore throat
- ❑Hoarseness
- ❑Loss of hearing
- ❑Nosebleeds
- ❑Persistent cough
- ❑Ringing in ears
- ❑Sinus congestion
- ❑Post nasal drip
- ❑Vision-Halos/Flashes

Conditions: Check (✓) conditions you have or have had in the past.
- ❑AIDS
- ❑Alcoholism
- ❑Anemia
- ❑Anorexia
- ❑Appendicitis
- ❑Arthritis
- ❑Asthma
- ❑Bleeding disorder
- ❑Breast lump
- ❑Bronchitis
- ❑Bulimia
- ❑Cancer
- ❑Cataracts
- ❑Chemical dependency
- ❑Chicken pox
- ❑Diabetes
- ❑Emphysema
- ❑Epilepsy
- ❑Glaucoma
- ❑Goiter
- ❑Gonorrhea
- ❑Gout
- ❑Heart disease
- ❑Hepatitis
- ❑Hernia
- ❑Herpes
- ❑High Cholesterol
- ❑HIV Positive
- ❑Kidney disease
- ❑Liver disease
- ❑Measles
- ❑Migraines
- ❑Miscarriage
- ❑Mononucleosis
- ❑Multiple Sclerosis
- ❑Mumps
- ❑Pacemaker
- ❑Pneumonia
- ❑Polio
- ❑Prostate problem
- ❑Psychiatric care
- ❑Rheumatic fever
- ❑Scarlet fever
- ❑Stroke
- ❑Suicide attempt
- ❑Thyroid problems
- ❑Tonsillitis
- ❑Tuberculosis
- ❑Typhoid fever
- ❑Ulcers
- ❑Vaginal infections
- ❑Venereal disease
- ❑Other: _____

Tobacco Use:

Smoke cigarettes: ❑Never ❑No ❑Yes
Quit Date:_____ How many years did you smoke?_____
Approx. how many cigarettes did you smoke per day?_____
Current smoker: Cigarettes/day:_____ # of years:_____
Other tobacco: ❑Pipe ❑Cigar ❑Snuff ❑Chew

Alcohol Use:

Do you drink alcohol? ❑Yes ❑No
# of drinks week:_____ ❑Beer ❑Wine ❑Liquor

(Over ->)

HEALTH HISTORY
(Cont'd)

Drug Use:
Have you ever used needles to inject drugs? ❑Y ❑N Do you use marijuana/recreational drugs? ❑Y❑N

Medications: Please list medications you are currently taking.

_____

_____

Allergies: To medications or substances.

_____

_____

Emergency Contact Information:

If we were to call you for any reason, what is the best phone number to reach you?

1ST:_____

2ND:_____

If there is no answer can we leave a message on the voicemail? ❑Yes ❑No

Can we leave a message with anyone? ❑Yes ❑No

Name of person(s) allowed to discuss medical information/ or take phone messages:

Name & #_____

Relationship:_____

Name & #_____

Relationship:_____

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 made in the completions of this form.

Signature:_____ **Date:**_____

The Doctors Treatment Center
Urgent Care and Occupational Medicine

Please fill out this form in its entirety. This form will be scanned into our computer system for quick reference. We appreciate your cooperation. Thank you.

Patient Demographics:

Patient Name: (Last, First, M.I.)		Sex: M F	Date of Birth:	Social Security #:	Marital Status: M S D W
Home Address:		City:		State:	Zip Code:
Home Phone:	Cell Phone:	Employer:		Occupation:	Business Phone:
Insurance Company: (Primary)		Policy/I.D. #:		Group/Account #:	
Name of Insured: (If this policy is under your name, write "SELF")		Insured's Employer:		Insured's DOB:	Insured's SS #:
Insurance Company: (Secondary)		Policy/I.D. #:		Group/Account #:	
Name of Insured: (If this policy is under your name, write "SELF")		Insured's Employer:		Insured's DOB:	Insured's SS#:

Additional Information:

Drug Allergies:	Primary Care Physician:	PCP Telephone #:
Pharmacy Name:	Pharmacy Telephone #:	
Emergency Contact:	Relationship:	Phone #:

Insurance Authorization and Assignment

I request that payment of authorized Medicare/Other insurance company benefits made either to me or on my behalf to physician for any services furnished to me by that party who accepts assignment/physician regulations pertaining to Medicare assignment of benefits apply. I authorize any hold of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other insurance company and information needed for this or a related Medicare/Other insurance company claim. I understand that my signature requests that payment be made and authorizes release of medical information to the insurer or agency shown. In Medicare/Other insurance company assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare/other insurance company as the full charge, and the patient is responsible for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare/Other insurance company.

Patient Signature:_____ **Date:**_____

For Minors Only:
I authorize **The Doctors Treatment Center** to provide treatment to my child, _____.

Guardian /Parent Signature:_____

Relationship to Child:_____ Date:_____

THE DOCTORS TREATMENT CENTER

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

I understand that that The Doctors Treatment Center will file claims for services rendered to my Insurance Carrier.

I however acknowledge that I am responsible for any balances that may be due to The Doctors Treatment Center because of:

- Coinsurance or copay amounts
- Yearly deductible amounts
- Non-covered services
- Out-of-network charges
- Terminated coverage
- Failure to provide correct insurance coverage at time of service
- Denied workers compensation claim
- No insurance coverage
- Failure to respond to coordination of benefits inquiry
- Failure to respond to Insurance Carrier correspondence

I understand that I will receive a statement for any balance due after my carrier has processed the claim. I understand and am agreeable that the balance of my statement will be paid in full to The Doctors Treatment Center within 30 days.

If I am unable to pay the entire amount I am responsible to immediately, upon receipt of a statement, call The Doctors Treatment Center to arrange a monthly payment plan.

I understand that failure to pay the balance or arrange payments and follow that payment plan may result in collection agency action.

_____ _____

Signature of patient/responsible party Date