ALBERTVILLE PRIMARY CARE

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New Patient Paperwork

Patient Name: _____ **Date of Birth** ____ / ____ / _____

□ **Male** □ **Female** **Race:** □ Non-Hispanic □ Hispanic **Language:** _____

Address: _____ **City:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Patient Employer: _____ **Patient Occupation:** _____

Email Address: _____

Pharmacy: _____ **City:** _____

Responsible Party *(if someone other than patient)*

Name: _____ **Relation to Patient:** _____

Address: _____ **City:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Emergency Contact *(Must have phone number different than patient)*

Name: _____ **Relationship:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Referred by: _____ **Previous Primary Care Physician:** _____

Reason for today's visit?

Allergies: *(check all that apply)*

___ Bactrim / Septra / Sulfa
___ Cephalosporin *(i.e. Ceftin, Cefzil, Keflex)*
___ Codienes *(i.e. Prescription Cough Syrup)*
___ Codones *(i.e. Norco, Lortab, Percocet)*
___ Insulin
___ Iodine / Shellfish
___ Latex
___ Penicillin
___ Tape/Adhesive
___ Pollens/Dust/Molds
___ Other *(please list below)*

Past Medical History: *(check all that apply)*

	Condition	*Did you see a specialist?* Y/N	Physician / Office
	Abnormal Menses		
	Anemia		
	Anxiety		
	Arthritis (unspecified)		
	Asthma		
	Breast Cancer		
	Cervical Cancer		
	Chronic Acid Reflux (GERD)		
	Colon Cancer		
	COPD		
	Coronary Artery Disease		
	Deep Vein Thrombosis		
	Depression		
	Diabetes Type 1		
	Diabetes Type 2		
	Emphysema		
	Endometriosis		

	Condition	*Did you see a specialist?* Y/N	Physician / Office
	Fibromyalgia		
	Hepatitis (A, B or C)		
	High Blood Pressure		
	High Cholesterol/Trig		
	Hyperthyroidism		
	Hypothyroidism		
	Kidney Disease		
	Kidney Stones		
	Liver Disease		
	Lung Cancer		
	Polyps (Colon)		
	Prostate Cancer		
	Rheumatoid Arthritis		
	Seasonal Allergies		
	Stroke		
	Autoimmune Disease		

Other (please list below)

Please list any medical issues not listed that you want us to be aware of:

Family History:

If known, please list age of diagnosis in relation to breast cancer, colon cancer, and coronary artery disease diagnoses.

	Mother's Side			Father's Side			Siblings / Other		
	Mother	Grandmother	Grandfather	Father	Grandmother	Grandfather	Brother	Sister	Other
Breast Cancer	_____	_____	_____	_____	_____	_____	_____	_____	_____
Colon Cancer	_____	_____	_____	_____	_____	_____	_____	_____	_____
Coronary Artery Disease	_____	_____	_____	_____	_____	_____	_____	_____	_____
Cystic Fibrosis	_____	_____	_____	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____	_____	_____	_____
Gout	_____	_____	_____	_____	_____	_____	_____	_____	_____
High Cholesterol	_____	_____	_____	_____	_____	_____	_____	_____	_____
Hunting's Disease	_____	_____	_____	_____	_____	_____	_____	_____	_____
Hypertension	_____	_____	_____	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____	_____	_____	_____
Liver Disease	_____	_____	_____	_____	_____	_____	_____	_____	_____
Lung Cancer	_____	_____	_____	_____	_____	_____	_____	_____	_____
Muscular Dystrophy	_____	_____	_____	_____	_____	_____	_____	_____	_____
Osteoarthritis	_____	_____	_____	_____	_____	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____	_____	_____	_____	_____	_____
Prostate Cancer	_____	_____	_____	_____	_____	_____	_____	_____	_____
Rheumatoid Arthritis	_____	_____	_____	_____	_____	_____	_____	_____	_____
Sickle Cell Anemia	_____	_____	_____	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____	_____	_____	_____	_____

Surgical History:

Surgery / Procedure	Approximate Date	Physician / Facility

Female Obstetric / Gynecological History:

Do you have a Gynecologist? (Y / N) _____ Who? _____

When was your last pap smear? _____ Results: (Normal / Abnormal)

When was your last mammogram? _____ Results: (Normal / Abnormal)

Have you ever been pregnant? (Y / N) _____ How many times? _____

How many children have you given birth to? _____

Have you ever had a miscarriage? (Y/N) _____

Diagnostic Imaging:

Have you ever had any of the following diagnostic procedures?

Procedure	Y / N	Date Performed	Results	Provider / Office
Colonoscopy	_____	_____	_____	_____
Bone Density Study	_____	_____	_____	_____
Echocardiogram	_____	_____	_____	_____
MRI	_____	_____	_____	_____
CT	_____	_____	_____	_____
Ultrasound	_____	_____	_____	_____
Stress Test	_____	_____	_____	_____

If you are diabetic, when was your last…	**Provider / Office**
Foot Exam _____	_____
Eye Exam _____	_____

Immunizations:

Children / Adults unders 24, are you current on all "school" vaccinations? _____

If no, what vaccines are outstanding? _____

Are you interested in the HPV Vaccine (Gardisil)? _____

Have you received a COVID vaccine, if so, please give manufacturer and number of doses/boosters:

_____

Adults over 24, when was your last:

_____ TDaP (Tetanus, Diptheria and Pertussis)

_____ Pneumonia Vaccine

_____ Flu Vaccine

_____ Shingles Vaccine

Immunizations:

Have you ever smoked or used tobacco products (Y / N) _____

Do you currently smoke or use tobacco products (Y / N) _____

What kind? _____

When was the last time you smoked or used tobacco products? _____

Do you drink alcohol (Y / N) _____

How often? Occasionally _____ Several drinks per week _____ 1-2 drinks/day _____ >2 drinks/day _____

Current Medications:

Please list ALL medications you are currently taking. Please include all prescription and over the counter medications.

___ **CHECK HERE IF YOU TAKE NO PRESCRIPTION OR OVER THE COUNTER MEDICATIONS**

Medication Name	Strength	How Often?	Reason for Taking

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Albertville Primary Care's Notice of Privacy Practices or have had the opportunity to receive the Notice of Privacy Practices.

_____
Patient Name (Printed)

Signature: _____ Date: _____

RELEASE OF INFORMATION AUTHORIZATION:

Due to federal privacy guidelines (HIPAA), Albertville Primary Care is not allowed to divulge information to anyone other than the patient (or guardian of the patient) unless explicit written authorization is given to discuss personal medical information with someone other than you.

I, _____, give Albertville Primary Care permission to release / discuss personal medical information to include the pickup of prescriptions and / or financial information to:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

GUARANTEE OF ACCOUNT: <u>MUST BE 19 YEARS OF AGE TO SIGN</u>

I, the undersigned, directly assign to Albertville Primary Care all surgical and / or medical benefits, if any, otherwise payable to me for services rendered.

In consideration of services rendered or to be rendered, the undersigned agrees to pay all costs of collection and / or reasonable attorney fees, should the account be turned over to enforce collections of said charges. The undersigned hereby waivers all claims or rights of exemption allowed by the constitution of the state of Alabama or any other state of the United States.

I hereby authorize Albertville Primary Care to release any information necessary to secure payment of benefits to my account.

Signature: _____ Date: _____

May we leave voicemails on the numbers you've provided? ___ Yes ___No

Comments: _____