

Date: <b>PATIENT DEMOGRAPHICS</b>				
Patient's Full Name:	Middle Initial:	Maiden Name:	Sex:	Preferred Pharmacy:
Preferred Name:	Date of Birth:	Age:	Social Security #:	Marital Status:
Patient Address:		City:	State:	Zip Code:
Patient Primary Phone #:	Patient Home Phone #:		Patient Cell Phone #:	Email:
Race/Ethnicity: White/Not Hispanic or Latino:				
Employer:	Employer Phone #:		Emergency Contact:	
Spouse's Name:	Spouse's Cell Phone #:		Spouse's Social Security #:	Spouse's Date of Birth:

<b>RESPONSIBLE PARTY INFORMATION</b>			
<b>**PERSON SIGNING THIS CONSENT (IF PATIENT IS A MINOR)**</b>			
Responsible Party's Name:	Relationship to Patient:	Sex:	Date of Birth:
Address (if different from patient's):	City:	State:	Zip Code:
Primary Phone #:	Cell Phone #:	E-mail:	
Social Security #:	Employer's Name and Address:	Employer Phone #:	
<b>Signature of Patient Authorizing Medical Services:</b>			

<b>INSURANCE INFORMATION</b>			
Primary Insurance:	Insurance Effective Date:	Contract ID:	Group:
Insurance Address:	City:	State:	Zip Code:
Subscriber Name:	Sex:	Date of Birth:	Relation to Patient:
Subscriber Address (if different from patient's):	City:	State:	Zip Code:

**PROBLEM LIST/PAST MEDICAL HISTORY:**

Have you been diagnosed with any of the following (currently or in the past):

<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Congestive Heart Failure	<input type="checkbox"/>	COPD	<input type="checkbox"/>	Bleeding Disorder
<input type="checkbox"/>	Coronary Artery Disease	<input type="checkbox"/>	Crohn's Disease	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	Esophageal Reflux/GERD	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	HIV
<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	IBS
<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	Type 1 Diabetes	<input type="checkbox"/>	Type 2 Diabetes	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Other:					<input type="checkbox"/>	Congenital Heart Failure

# NEW PATIENT FORM

## WILLOW VALLEY MEDICAL CLINIC

### ALLERGY HISTORY:

- |  |   |                                     |  |
|--|---|-------------------------------------|--|
| <input type="checkbox"/> None          | <input type="checkbox"/> NKDA (No Known Drug Allergies) | <input type="checkbox"/> Latex      | <input type="checkbox"/> Aspirin       |
| <input type="checkbox"/> Acetaminophen | <input type="checkbox"/> Epinephrine                    | <input type="checkbox"/> Sulfur     | <input type="checkbox"/> Others: _____ |
| <input type="checkbox"/> Erythromycin  | <input type="checkbox"/> Lidocaine                      | <input type="checkbox"/> Penicillin |  |

### MEDICATION HISTORY:

I am not currently taking any medications

List any medications, vitamins, minerals, and herbals that you are currently taking:

Name of Medication	Dosage	How Often

### FAMILY HISTORY:

Has any member of your family been diagnosed with any of the following conditions (include deceased family members)? Place an "X" under the correct family member with the condition, and indicate if the family member passed away due to that condition.

Condition	Mother	Father	Sister	Brother
Arthritis				
Asthma				
Cancer				
Congestive Heart Failure				
COPD				
Coronary Artery Disease				
Crohn's Disease				
Depression				
Diabetes Type 1				
Diabetes Type 2				
High Cholesterol				
Hypertension				
Kidney Disease				
Osteoporosis				
Parkinson's Disease				
Thyroid Disease				

Others: \_\_\_\_\_

# NEW PATIENT FORM

## WILLOW VALLEY MEDICAL CLINIC

### PAST SURGICAL HISTORY:

- |   |           |  |           |  |           |
|---|-----------|--|-----------|--|-----------|
| <input type="checkbox"/> None                   | Year: ___ | <input type="checkbox"/> CABG (heart bypass) | Year: ___ | <input type="checkbox"/> Hip Replacement | Year: ___ |
| <input type="checkbox"/> Angioplasty (stent)    | Year: ___ | <input type="checkbox"/> Cesarean Delivery   | Year: ___ | <input type="checkbox"/> Hysterectomy    | Year: ___ |
| <input type="checkbox"/> Appendectomy           | Year: ___ | <input type="checkbox"/> Cholecystectomy     | Year: ___ | <input type="checkbox"/> Neck Surgery    | Year: ___ |
| <input type="checkbox"/> Back Surgery           | Year: ___ | <input type="checkbox"/> Ear Tubes           | Year: ___ | <input type="checkbox"/> Sinus Surgery   | Year: ___ |
| <input type="checkbox"/> Breast Cancer          | Year: ___ | <input type="checkbox"/> Hernia Repair       | Year: ___ | <input type="checkbox"/> Thyroidectomy   | Year: ___ |
| <input type="checkbox"/> Carotid Endarterectomy | Year: ___ | <input type="checkbox"/> Hemorrhoidectomy    | Year: ___ | <input type="checkbox"/> Tonsillectomy   | Year: ___ |

Others: \_\_\_\_\_

### SOCIAL HISTORY:

Have you ever been exposed to hazardous chemicals?  Yes  No

If yes, when: \_\_\_\_\_ what: \_\_\_\_\_

Living Situation:  Lives alone  Lives in home healthcare environment  
 Lives with significant other  Lives in assisted living facility

Assistive Devices :  Oxygen  Shower Chair  Wheeled Walker  Nebulizer  
 Wheelchair  CPAP  Bedside Commode  Cane

Please describe your current tobacco use :

Smoker, current status unknown  Heavy tobacco smoker  Former smoker  Unknown if ever smoked  
 Light tobacco smoker  Current every day smoker  Never smoker

Do you drink alcoholic beverages?  Yes  No

If yes, please indicate what type of beverage and how many servings per day: \_\_\_\_\_

Do you drink caffeinated beverages?  Yes  No

If yes, please indicate what type of beverage and how many servings per day: \_\_\_\_\_

Have you ever used an illicit drugs?  Yes  No

If yes, please indicate what type of drug and how often: \_\_\_\_\_

### INSURANCE:

If you have insurance, please present your card to the receptionist. We **CANNOT** bill your insurance without a copy of the front and back of your insurance card.

If you do **NOT** have insurance, please request a "Sliding Fee Scale Form" from the receptionist in order to set-up a payment plan. **Payment is due at the time of service.**