WILLOW VALLEY MEDICAL CLINIC

NEW PATIENT FORM

Date:	PATIENT DEMOGRAPHICS			
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:

RESPONSIBLE PARTY INFORMATION			
PERSON SIGNING THIS CONSENT **(IF PATIENT IS A MINOR)**			
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 #:	
Signature of Patient Authorizing Medical Services:			

INSURANCE INFORMATION				
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):

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

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ALLERGY HISTORY:

- ☐ None
- ☐ NKDA (No Known Drug Allergies
- ☐ Latex
- ☐ Aspirin
- ☐ Acetaminophen
- ☐ Epinephrine
- ☐ Sulfur
- ☐ Others: ______________
- ☐ Erythromycin
- ☐ Lidocaine
- ☐ 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: ____

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PAST SURGICAL HISTORY:

☐	None	Year: ____	☐	CABG (heart bypass)	Year: ____	☐	Hip Replacement	Year: ____
☐	Angioplasty (stent)	Year: ____	☐	Cesarean Delivery	Year: ____	☐	Hysterectomy	Year: ____
☐	Appendectomy	Year: ____	☐	Cholecystectomy	Year: ____	☐	Neck Surgery	Year: ____
☐	Back Surgery	Year: ____	☐	Ear Tubes	Year: ____	☐	Sinus Surgery	Year: ____
☐	Breast Cancer	Year: ____	☐	Hernia Repair	Year: ____	☐	Throidectomy	Year: ____
☐	Carotid Endarterectomy	Year: ____	☐	Hemorrhoidectomy	Year: ____	☐	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.**