HISTORY FORM

NAME: _____ AGE: _____ SEX: _____ MARITAL STATUS: _____

OCCUPATION: _____ REFERRING PHYSICIAN: _____

PRESENT ILLNESS: (Describe briefly the problems you are having and the reason you are here today.)

_____
_____
_____
_____

MEDICATIONS: (List or attach a list of all medication you are now taking, the dosage and how frequently you are taking them.)

_____
_____
_____
_____

ALLERGIES: (List all medication allergies such as penicillan, iodine, etc.)

_____
_____
_____
_____

PAST HISTORY:

MEDICAL: (List all major illnesses you had in the past.) _____
_____
_____
_____

SURGICAL: (List any heart related (Bypass, Stents, Valve surgery, Pacemaker) surgeries you had and the approximate dates they occurred.) _____
_____
_____

SOCIAL HISTORY:

Tobacco Use:

_____ Current Smoker: _____ packs/day
_____ Previous Smoker
_____ Never Smoked

NAME: _____ DATE OF BIRTH: _____

REVIEW OF SYMPTOMS: Please check any current symptoms you have.

Cardiovascular
____ Chest Pain
____ Palpitations/Fluttering
____ Shortness of Breath

Genitourinary
____ Frequent Urination
____ Bloody Urination
____ Nighttime Urination

Constitutional
____ Recent Fever/Sweats
____ Fatigue/Weakness
____ Weight Loss/Gain

Endo
____ Cold/Heat Intolerance

Eyes
____ Change in Vision

Skin
____ Skin Bruising

Gastrointestinal
____ Heartburn/Reflux
____ Nausea/Vomiting

Neurological
____ Headaches
____ Memory Loss
____ Fainting
____ Disorientation
____ Dizziness
____ Lack of Coordination
____ Numbness/Tingling
____ Weakness

Respiratory
____ Cough/Wheezing
____ Coughing up Blood
____ Use Oxygen
____ Use CPAP/BiPap
____ Snoring
____ Do not feel rested in the morning

FAMILY HISTORY: (List major illnesses: Heart Disease, Hypertension, Congestive Heart Failure, Stroke, Heart Surgery (Bypass, Valve), Stents, Other.)

Father: _____

_____

Mother: _____

_____

Brothers/Sisters: _____

_____

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Patient Registration

Patient Demographics

Last Name	First Name	M.	Preferred Name

Mailing Address	City	State	Zip Code

Home Phone	Cell Phone	Work Phone	Birthdate (MM/DD/YYYY)	Gender at Birth
				☐ Male ☐ Female

Communication preference for Appointments, Rx refills, & Test Results: ☐ Phone ☐ Text (SMS) ☐ Both	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Social Security Number

Employer Name	Occupation/Job Title	Status
		☐ Full-time ☐ Part-time

Employer City	Employer State	Identifying Gender
		☐ Male ☐ Female ☐ Other _____

Guarantor Information (skip if same as above)

Last Name	First Name	M.	Relationship to Patient

Address	City	State	Zip Code

Home Phone	Cell Phone	Birthdate (MM/DD/YYYY)	Social Security Number

Emergency Contact

Patient Relationship to Emergency Contact: ☐ Spouse ☐ Parent ☐ Child ☐ Other_____	Last Name	First Name	M.

Address	City	State	Zip Code

Home Phone	Cell Phone	Work Phone

Primary Insurance Information

Primary Insurance Company	Policy ID Number #

Coverage Start Date	Subscriber/Insured Name	Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Parent ☐ Other_____

Group Number #	Group Name	Subscriber Date of Birth	Subscriber Social Security Number

Secondary Insurance Information

Secondary Insurance Company	Policy ID Number #

Coverage Start Date	Subscriber/Insured Name	Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Parent ☐ Other_____

Group Number #	Group Name	Subscriber Date of Birth	Subscriber Social Security Number

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Patient Registration continued

Rx History Consent and Advance Directive

As a SJ/C patient, your physician will have access to view your Rx history from external sources. Indicate if you wish to opt out.

☐ Opt Out (Not recommended)

Advance Directive protects your right to refuse medical treatment that you do not want or to request treatment you do want.

Do you have an Advance Directive? ☐ Yes ☐ No

If NO, would you like more information? ☐ Yes ☐ No

Patient Portal Information

You will have access to the SJ/C a Patient Portal. Indicate if you wish to opt out. ☐ Opt Out

Email Address (Required for Portal Access):

Additional Information

Race

☐ Asian ☐ Black ☐ Hispanic ☐ White

☐ Other_____

Ethnicity

☐ Hispanic or Latino

☐ Non-Hispanic or Non-Latino

Language

☐ English ☐ Spanish

☐ Sign Lng. ☐ Other

Primary Care Physician "PCP":	Last Visit with PCP:	Referred By:	Preferred Hospital: ☐ Candler ☐ St. Joseph's ☐ Other_____

If the preferred facility is not designated by the Patient, all tests will be sent to St. Joseph's/Candler facilities and the Patient will be responsible for payment.

Laboratory

☐ St. Joseph's/Candler (preferred) ☐ LabCorp

☐ Quest Diagnostics ☐ Other _____

Radiology / X-ray

☐ St. Joseph's/Candler (preferred)

☐ Other_____

Pharmacy Information

Pharmacy Name (Primary)	Phone	Fax

Address	City	State	Zip Code

Authorization To Treat & Assignments Of Benefits

I do hereby consent to and Authorize the performance of all treatments, surgeries, and medical services deemed advisable by the health care providers and staff of SJ/C Physician Network to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I request that payment of authorized benefits be made to SJ/C Physician Network and authorize SJ/C Physician Network to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency.

☐ Yes ☐ No Initial _____

I have read and understand the above statements and agree to be bound by its terms and conditions. I understand that I may be selected to participate in a brief survey about my visit and choose to receive communications from SJ/C Physician Network by text or e-mail at the number or address stated above, including but not limited to communications about appointments, treatment, and payment.

_____ _____

Patient Signature Date

_____ _____

Patient's Guardian or Capacity *Date*

_____

Relationship to Patient