**Legal Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_ **SSN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

For Office Use Only:

MRN#: \_\_\_\_\_\_\_\_\_\_\_

**Sex:** M / F **Primary Care Provider:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Referred by:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address City ST Zip Code

**Home Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Mobile Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E-mail address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_ **Insurance Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer Name/Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party if Different:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for Visit:**

1. What body part is affected? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Have you had any x-rays taken?\_\_\_\_\_\_\_\_\_ If YES where were they taken\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Is the problem mild, moderate, or severe? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Does anything make the problem worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Does anything make the problem better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. When did the problem start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Was there an injury? **Yes / No** If **YES** where did it occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please briefly describe the problem, and how it started:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History/Illness: (Check all that apply)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| \_\_ Asthma / COPD | \_\_ Blood Clots | \_\_ Heart Attack | \_\_ Gout | \_\_ Blood/Bleeding Problems |
| \_\_ High Blood Pressure | \_\_ Kidney Disease | \_\_ Stroke | \_\_ Heart Failure | \_\_ High Cholesterol |
| \_\_ Liver Disease (Hepatitis) | \_\_ Vascular Disease | \_\_ Seizures | \_\_ HIV/AIDS | \_\_Stomach Ulcers |
| \_\_ Rheumatoid Arthritis | \_\_ Thyroid Disorder | \_\_ Diabetes | \_\_ Cancer, Type/Stage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Past Surgery: (Check all that apply)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| \_\_ Heart Bypass | \_\_ Tubal Ligation | \_\_ Hernia | \_\_ Bowel Surgery | \_\_ Appendectomy |
| \_\_ Prostate | \_\_ Joint Replacement | \_\_ Fractures | \_\_ Gallbladder Removal | \_\_ Hysterectomy |
| \_\_ Tendon/Ligament Repair | \_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

**Social History: (Circle Y or N)**

Do you smoke? **Y / N** How much: \_\_\_\_\_\_\_\_ Have you ever smoked? **Y / N** How much: \_\_\_\_\_\_\_\_

Do you consume alcohol? **Y / N** How much: \_\_\_\_\_\_\_\_ Employment Status: **working**, **retired**, **disabled** Job: \_\_\_\_\_\_\_\_

Relationship Status: **single**, **married**, **divorced**, **widowed** Have Kids: **Y / N**

**Circle Below:**

Mother: Deceased (Yes or No) Age of death \_\_\_\_\_\_\_\_ Cause of death \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father: Deceased (Yes or No) Age of death \_\_\_\_\_\_\_\_\_ Cause of death \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History: Who in your family has the following? (Please write M for Mother, F for Father)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| \_\_\_\_ Asthma | \_\_\_\_ Diabetes | \_\_\_\_ Heart Attack | \_\_\_\_ High Cholesterol | \_\_\_\_ Glaucoma |
| \_\_\_\_ COPD  | \_\_\_\_ Kidney Failure | \_\_\_\_ Stroke | \_\_\_\_ High Blood Pressure | \_\_\_\_ Vascular Disease |

**What pharmacy do you use?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list your medications and doses below: (Include any nonprescription medications)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you allergic to any medications?** Yes or No **Are you in Pain Management/Contact?** Yes or No

**Please list medication allergies and your reaction: Nausea / itching / hives / difficulty breathing / other**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Any allergy to:** Iodine **Y / N** Metal **Y / N**  Latex **Y / N**

**Review of Systems: (Please check all that apply)**

**☐ All below systems have been reviewed and all are negative except for chief complaint**

**Constitutional:** ☐fever, ☐chills, ☐sudden weight loss;

**Ear, Nose, Throat:** ☐deafness, ☐sinusitis, ☐hoarseness, ☐vertigo, ☐tinnitus;

**Cardiovascular:** ☐chest pain, ☐palpitation, ☐irregular heartbeat, ☐murmur;

**Respiratory:** ☐shortness of breath, ☐chronic cough;

**Digestive:** ☐diarrhea, ☐bleeding, ☐change in bowel habits, ☐reflux/heartburn;

**Urologic:** ☐bleeding, ☐incontinence;

**Skin:** ☐rash, ☐lesions that do not heal, ☐change in moles;

**Neurological:** ☐loss of balance/coordination, ☐paralysis;

**Blood and Lymphatic System:** ☐anemia, ☐bleeding tendencies;

**Musculoskeletal:** ☐stiffness, ☐joint pain, ☐muscle pain;

**Authorization, Assignment of Benefits, and Referral Medical Release:**

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution. I authorize payment directly o Columbus Regional Health Network for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. A photocopy of this authorization shall be considered as effective and as valid as the original.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Request for Treatment:**

The Group maintains personnel and facilities to assist my physicians in providing my medical care, and I authorize the Group personnel to perform the care ordered by my physicians. I understand that I have the right to be informed by the physicians of the nature and purpose of an proposed procedure and any available alternative methods of treatment, together with an explanation of the risk associated with each procedure. This form is not a substitute for such explanations, which are the responsibility of my physicians to provide according to recognized standards of medical practice, and I acknowledge that the Group and its personnel are responsible for providing this information.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you!