Iredell
Family Care Center

Patient Information: Date: _____

Patient Name: _____ Age: _____ Date of Birth: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ ☐ (home) ☐ (cell) Secondary Phone: _____ ☐ (home) ☐ (cell)

E-mail Address: _____ Employer: _____

How did you hear about us? _____

Pharmacy Local: _____ Mail Order: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

Responsible Party:

Name: _____ Relationship: _____ Date of Birth: _____ SS# _____

Mailing Address: _____

Insurance Information:

Primary Insurance: _____ Subscriber's name: _____

Subscriber's DOB: _____ Insurance ID#:_____ Group#: _____

Secondary Insurance: _____ Subscriber's name:_____

Subscriber's DOB: _____ Insurance ID#:_____ Group#: _____

Financial Responsibility and Assignment of Insurance Benefits:

I guarantee payment to Iredell Family Medicine and its affiliates of all charges for services provided to the patient. I understand I am personally responsible for all charges not covered by insurance. I authorize payment of surgical and medical benefits, which would otherwise be payable to me, to Iredell Family Medicine for services rendered. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Titles V, XVIII, and/or XIC of the Social Security Act is correct.

Appointment Policy: I understand that I have a responsibility to keep the appointments that are scheduled for me. If for any reason I cannot make the appointment, I understand that I need to call in advance to cancel and reschedule. I understand that if I NO SHOW for 3 appointments, I may be discharged from this practice.

Signature of Patient or Authorized Person: _____ Date/Time: _____

Financial Guarantor (if different from above): _____ Date/Time: _____

If limited English proficient or visually impaired, we will offer an interpreter at no additional cost.

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Name:_____ DOB:_____ Age:_____

Phone:_____ Occupation:_____

Reason for today's Visit:_____

Current Medical Problems:_____

Please list the following:

Medication Allergies:_____**Reaction**:_____

_____ _____

_____ _____

Other Allergies:_____

Pertinent Family Medical History:

Mother:_____

Father:_____

Other:_____

Social History:

Do you use tobacco products? ☐ YES ☐ NO Packs per day?_____ Years:_____

Do you drink alcohol? ☐ YES ☐ NO If yes, how much per week?_____

Do you drink Caffeine? ☐ YES ☐ NO If yes, how much per day?_____

Do you use illegal drugs? ☐ YES ☐ NO If yes, frequency and type?_____

Travel:

Have you traveled outside of the USA in the last 6 months? ☐YES☐NO If yes, where?_____

Please list all the medication you are currently taking. Prescription and Over the counter:

_____

_____

_____

_____

_____

How many times have you been pregnant?_____ How many children do you have?_____

Please list all your previous hospitalizations and surgeries:

_____ _____

_____ _____

_____ _____

Health Maintenance:

Please give the last known date of:

Your last Physical:_____ Lab Work:_____

Mammogram:_____ Bone Density Scan:_____

Colonoscopy:_____ Pap Smear:_____

PSA:_____ Stool exam for blood:_____

Lipid Screening:_____ Eye Exam:_____

Urinary Incontinence screening:_____

Immunization:

Please give your last known date of:

Tetanus: _____ Pneumovax: _____ Prevnar 13: _____ Flu: _____ COVID:_____

Menactra/Meningitis: _____ Gardasil: _____ Hepatitis B: _____ Zostavax/Shingles: _____

DIAGNOSTIC TESTING: (MRI, CT scan, ultrasound, etc. and date) _____

_____

Do you consent to allow Iredell Family Medicine to release your medical information to anyone? ☐ YES ☐ NO

If yes, please list the name of individual(s):

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Please list your local Pharmacy:_____ **Mail in Pharmacy**:_____

Please list anything else you would like us to know about your medical situation:_____

_____

_____

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Family Medical History

☐ No significant Family history known

Check all that apply	Mother	Father	Brother	Sister	Child	MGM	MGF	PGM	PGF	Other
Alcohol/Drug Abuse										
Asthma										
Cancer Type:_____										
Emphysema (COPD)										
Depression/Anxiety										
Bipolar/Suicidal										
Diabetes										
Early Death										
Heart Disease										
High Cholesterol										
High Blood Pressure										
Kidney Disease										
Stroke										
Thyroid Disease										
Migraines										
Other _____										
Other _____										

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Medication Log

Please include Prescription Medication, Over the Counter and Herbal Supplements

Name: _____

Date of Birth:_____

Doctor:_____

	Medication	Dose	Frequency	