

Patient Information:			Date:			
Patient Name:			Age:	_ Date of B	irth:	
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 O	rder:			
Emergency Contact:						
Name:	F	Relationship:		Phone: _		
Responsible Party:						
Name:	Relationship: _		_ Date of Birth:		SS# _	
Mailing Address:						
Insurance Information:						
Primary Insurance:		Subs	criber's name: _			
Subscriber's DOB:	Insurance ID#:			Group#:		
Secondary Insurance:		Sı	ubscriber's name	e:		
Subscriber's DOB:	Insurance ID#:			Group#:		
Financial Responsibility and	Assignment of Insurance	Benefits:				
I guarantee payment to Iredell Fam responsible for all charges not cove me, to Iredell Family Medicine for s for payment under Titles V, XVIII, ar	red by insurance. I authorize pa ervices rendered. If covered by	ayment of surgical a Medicare or Medic	and medical benefit	s, which would	otherwise	be payable to
Appointment Policy: I understand make the appointment, I understan appointments, I may be discharged	nd that I need to call in advance				-	
Signature of Patient or Autho	rized Person:			_ Date/Time	:	
Financial Guarantor (if differe	ent from above):			Date/Time	e:	

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



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 Histo	ory:			
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 U	JSA in th	e last 6 n	nonths? YES NO If yes, where?	
Please list all the medication y	ou are o	currently	taking. Prescription and Over the counter:	



low many times have you been pregnant?			How many ch	How many children do you have?					
Please list all your previ	ous hospitaliza	tions and sui	rgeries:						
Health Maintenance:									
Please give the last know	wn date of:								
Your last Physical:	our last Physical: Lab Work:								
Mammogram:			sity Scan:						
Colonoscopy:	lonoscopy: Pap Smear:_								
PSA:		_ Stool exam	n for blood:	blood:					
Lipid Screening:		_ Eye Exam:			_				
Urinary Incontinence sc	reening:								
Immunization:									
Please give your last kno	own date of:								
Tetanus:	Pneumovax: _		Prevnar 13:	Flu:	COVID:				
Menactra/Meningitis: _	(Gardasil:	Hepatitis B:	Zos	tavax/Shingles:				
DIAGNOSTIC TESTING: (MRI, CT scan,	ultrasound, e	etc. and date)						
Do you consent to allow	Iredell Family	Medicine to	release your medical in	formation to an	yone? YES NO				
If yes, please list the nar	me of individua	al(s):							
Name:			Relationship:						
Name:			Relationship:						
Name:			Relationship:						
Name:									
				harmacy:					



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										