SoutheastHEALTH

PATIENT INFORMATION FORM

Patient Name: _____

Date of Birth: (M/D/Y) _____ **Birth Sex:** [ ] Male [ ] Female **SSN:** (patient) _____

Previous and/or Maiden Name: _____

Parent/Legal Guardian Name: (if patient is a minor) _____ **SSN :**(Parent/guardian) _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Email: _____ **Marital Status:** [ ] Single [ ] Married

Language: [ ] English [ ] Spanish [ ] Other: _____

Race: [ ] Caucasian/White [ ] Black/African American [ ] American Indian [ ] Asian [ ] Hispanic/ Latino [ ] Other: _____

EMPLOYMENT AND INSURANCE

Patient or Parent's Employer: _____ **Occupation:** _____

Primary Insurance Company: _____
Policy Holder's Name: _____**Date of Birth:** _____
Policy Holder's Employer: _____**Occupation:**_____
Relationship to Patient: _____**SSN:**_____

Secondary Insurance Company: _____
Policy Holder's Name: _____**Date of Birth:** _____
Policy Holder's Employer: _____**Occupation:**_____
Relationship to Patient: _____**SSN:**_____

EMERGENCY CONTACT

Name: _____**Relationship:** _____
Phone Number: _____ **Date of Birth:** _____

Name: _____**Relationship:** _____
Phone Number: _____ **Date of Birth:** _____

Power of Attorney: _____

Do you have an Advanced Directive? (End of Life Care) [ ] Yes [ ] No

I consent for staff to leave a voice mail pertaining to your health information. [ ] Yes [ ] No

_____ _____

Signature of Patient or Guardian Date

SoutheastHEALTH

NEW PATIENT HISTORY FORM

Patient Name: _____

Date of Birth: _____

Reason for Visit: _____

Primary Care Physician: _____

Referring Physician: _____

Any religious, cultural or spiritual beliefs that may affect your treatment? ☐ Yes ☐ No

If yes, please explain: _____

PAST MEDICAL HISTORY (Please check all that apply)**:**

- ☐ Allergies
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Arial Fibrillation
- ☐ Benign Prostatic Hypertrophy
- ☐ Blood Clots
- ☐ Cancer (type)
- ☐ CVA (stroke)
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Gallbladder Disease
- ☐ GERD
- ☐ Hepatitis C
- ☐ HIV
- ☐ Hypertension
- ☐ Irritable Bowel Disease
- ☐ Liver Disease
- ☐ Migraine Headaches
- ☐ Myocardial Infarction
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Peptic Ulcer Disease
- ☐ Renal Disease
- ☐ Seizure Disorder
- ☐ Thyroid Disease
- ☐ Valve Disease
- ☐ Other: _____

PAST SURGICAL HISTORY (Please check all that apply)**:**

- ☐ Angioplasty
- ☐ Angioplasty with Stent
- ☐ Appendectomy
- ☐ Arthroscopy Knee
- ☐ Back Surgery
- ☐ CABG (Heart Bypass
- ☐ Carpal Tunnel Release
- ☐ Cataract Extraction
- ☐ Cholecystectomy (Gall Bladder)
- ☐ Colectomy
- ☐ Colostomy
- ☐ Ear Tubes
- ☐ Gastric Bypass
- ☐ Hernia Repair
- ☐ Hip Replacement
- ☐ Knee Replacement
- ☐ Lasik
- ☐ Liver Biopsy
- ☐ Open Reduction Internal Fixation
- ☐ Pacemaker
- ☐ Small Bowel Resection
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ Other: _____

SoutheastHEALTH

NEW PATIENT HISTORY FORM

Patient Name: _____

Date of Birth: _____

SOCIAL HISTORY

Been exposed to Hazardous Materials (examples: asbestos, radiation, TB, etc.): [ ] Yes [ ] No

Special Diet Restrictions: _____

Frequency of Exercise: [ ] None/Occasionally [ ] 1-2 times/week [ ] 3-5 times/week [ ] Every day

Type of Exercise (ex: aerobic, walking, martial arts, etc.)**:** _____

Drug Usage: [ ] Never [ ] Occasionally [ ] Regularly [ ] Used in the past – Year Quit: _____

Type of Drug(s) (ex: acid, cocaine, marijuana, etc.): _____

Route of Drug(s) (ex: inhale, in muscle, oral, etc.)**:** _____

Alcohol Usage: [ ] Never [ ] Occasionally [ ] Regularly [ ] Used in the past – Year Quit: _____

Alcohol Type: _____ Drinks Per Week: _____ Years Used:_____

Tobacco Usage: [ ] Never [ ] Occasionally [ ] Regularly [ ] Used in the past – Year Quit: _____

Type: _____ Packs/Cans Per Day: _____ Years Used:_____

Exposed to second hand smoke: [ ] Yes [ ] No

SoutheastHEALTH

NEW PATIENT HISTORY FORM

Patient Name: _____
Date of Birth: _____

FAMILY HISTORY (Please check all that apply):

___	ADD/ADHD	___	Mother	___	Father	___	Brother	___	Sister	___	Other	_____
___	Alcoholism	___	Mother	___	Father	___	Brother	___	Sister	___	Other	_____
___	Allergies	___	Mother	___	Father	___	Brother	___	Sister	___	Other	_____
___	Alzheimer's Disease	___	Mother	___	Father	___	Brother	___	Sister	___	Other	_____
___	Asthma	___	Mother	___	Father	___	Brother	___	Sister	___	Other	_____
___	Blood Disease	___	Mother	___	Father	___	Brother	___	Sister	___	Other	_____
___	Breast Cancer	___	Mother	___	Father	___	Brother	___	Sister	___	Other	_____
___	Colon Cancer	___	Mother	___	Father	___	Brother	___	Sister	___	Other	_____
___	CVA (stroke)	___	Mother	___	Father	___	Brother	___	Sister	___	Other	_____
___	Depression	___	Mother	___	Father	___	Brother	___	Sister	___	Other	_____
___	Developmental Delay	___	Mother	___	Father	___	Brother	___	Sister	___	Other	_____
___	Diabetes	___	Mother	___	Father	___	Brother	___	Sister	___	Other	_____
___	Eczema	___	Mother	___	Father	___	Brother	___	Sister	___	Other	_____
___	Hearing Deficiency	___	Mother	___	Father	___	Brother	___	Sister	___	Other	_____
___	Heart Disease	___	Mother	___	Father	___	Brother	___	Sister	___	Other	_____
___	High Blood Pressure	___	Mother	___	Father	___	Brother	___	Sister	___	Other	_____
___	Hyperlipidemia	___	Mother	___	Father	___	Brother	___	Sister	___	Other	_____
___	Irritable Bowel Disease	___	Mother	___	Father	___	Brother	___	Sister	___	Other	_____
___	Learning Disability	___	Mother	___	Father	___	Brother	___	Sister	___	Other	_____
___	Lung Cancer	___	Mother	___	Father	___	Brother	___	Sister	___	Other	_____
___	Mental Illness	___	Mother	___	Father	___	Brother	___	Sister	___	Other	_____
___	Migraines	___	Mother	___	Father	___	Brother	___	Sister	___	Other	_____
___	Obesity	___	Mother	___	Father	___	Brother	___	Sister	___	Other	_____
___	Osteoarthritis	___	Mother	___	Father	___	Brother	___	Sister	___	Other	_____
___	Prostate Cancer	___	Mother	___	Father	___	Brother	___	Sister	___	Other	_____
___	PVD (Blood flow problems: arms, legs, neck)	___	Mother	___	Father	___	Brother	___	Sister	___	Other	_____
___	Renal Disease	___	Mother	___	Father	___	Brother	___	Sister	___	Other	_____
___	Seizure Disorder	___	Mother	___	Father	___	Brother	___	Sister	___	Other	_____
___	Thyroid Disease	___	Mother	___	Father	___	Brother	___	Sister	___	Other	_____

Other: _____

MEDICATION & ALLERGIES FORM

Patient Name: _____
Date of Birth: _____

PHARMACY INFORMATION

Pharmacy Name: _____

Location: _____

ALLERGIES [ ] None [ ] Penicillin [ ] Sulfa Drugs [ ] IVP Dye

[ ] Food: _____

[ ] Other: _____

MEDICATIONS

NAME	DOSAGE	HOW OFTEN?

Southeast HEALTH

PATIENT AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

Patient Printed Name	Date of Birth	Med. Record Number

To our valued patients:

While coordinating care during your treatment at Southeast Health, our healthcare professionals may be asked to discuss your health information with a family member or friend involved in your care (i.e., to make arrangements for physician appointments, discuss diet, care, or medication instructions, discuss information related to any of your medical/health−related conditions, answer financial/billing questions, etc.).

You may also find it neccessary to have a family member or friend pick up your prescription that can't be called in or e−prescribed.

We ask that provide the names and relationships of family member(s) and friend(s) who you authorize to have access to your health information and/or pick up prescriptions during your treatment at Southeast Health.

Permission to Discuss PHI and Release Prescriptions:

Name	Relationship to Patient	Please check box if permitted to pick up your prescriptions:
Name	Relationship to Patient	☐
Name	Relationship to Patient	☐
Name	Relationship to Patient	☐
Name	Relationship to Patient	☐
Name	Relationship to Patient	☐

Southeast HEALTH

PATIENT AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION CONT.

Patient Printed Name	Date of Birth	Med. Record Number

Additional Disclosure Permissions:

If this patient has a legal representative or Durable Power of Attorney for Healthcare, please note here and provide a copy of the legal documentation for filing with the patient's electronic medical record:

Name of Rep or DPOA	Type of Representative	Phone Number

I further understand that this authorization will remain in effect until and/or may be revoked at any time by myself, my legal representative, or my Durable Power of Attorney for Healthcare.

Patient Signature	Date	Time

Witness Printed Name	Relationship or Title

Witness Signature	Date	Time

Thank you. Southeast Health respects your right to privacy.