NEW PATIENT PAPERWORK

PATIENT INFORMATION

Last Name:____________________ First Name: ____________________ DOB: __________________

Preferred Name: ____________________ SSN: __________________ Email: ____________________

Sex: ______ Mailing Address: _____________________________City/State/Zip: __________________

Home #: ____________________ Cell #: __________________ Work #: ______________________

Marital Status: ☐ Single ☐ Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Race/Ethnicity: ☐ American Indian or Alaska Native ☐ Caucasian/White ☐ Asian ☐ Hispanic

☐ African American/Black ☐ Other Race

Employment Status: ☐ Full-Time ☐ Self-Employed ☐ Part-Time ☐ Unemployed ☐ Retired ☐ Student

Emergency Contact: this person will be contacted by **Stankus Family Care** in the event you experience an emergency, and we may speak to this person regarding your medical care.

Last Name:________________ First Name:___________________ Relationship:___________________

Address:_________________________ City:__________________ State/Zip:_____________________

Home #:_____________________ Cell #:_____________________ Work #:______________________

INSURANCES

Primary Insurance: _______________________ Policy Number: _______________________________

Group #: __________________Policy Holder Name (if not patient): _____________________________

DOB: __________________ Relationship to Patient: ____

Secondary Insurance: ________________Policy Number: ________________ Group #: ___________

PHARMACY INFORMATION

Local Pharmacy Name: ____

Local Pharmacy Address/Phone # (if known): ____

Mail Order Pharmacy: ____

ADDITIONAL INFORMATION

Patient Mailing Address (if different than physical address):

Mailing Address: ____

City: ___________________________ State: _________________ Zip: _______________________________

Additional Contacts: **Stankus Family Care** may speak to this contact regarding your medical care.

Last Name: ____________________ First Name: ______________________ Phone #: _________________

Relationship: _______________________ Address: ____

City: _______________________________ State: _______________________ Zip: ____________________

CURRENT AND/OR PREVIOUS PHYSICIANS

NAME	SPECIALTY	PHONE NUMBER	CURRENT PHYSICIAN
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO

IMMUNIZATIONS

IMMUNIZATION	DATE	IMMUNIZATION	DATE
Influenza (Flu Vaccine)		TD Tetanus Diphtheria	
Prevnar-13		Tdap Tetanus (Pertussis)	
Pneumovax-23		Zostavax (Shingles)	

CHIEF COMPLAINTS:

What concerns would you like to discuss during your visit today?

____

____

____

____

CURRENT MEDICATIONS

List all medications you use regularly and how often you take them. ***Please include all non-prescription medications, such as laxatives, cold tablets, vitamins, herbals, and dietary supplements.*** Please attach a separate medication list, as necessary.

PLEASE BRING ALL MEDICATIONS WITH YOU TO EACH VISIT

MEDICATION NAME DOSE HOW YOU TAKE IT HOW LONG HAVE YOU BEEN ON IT

____

____

____

____

____

____

MEDICAL HISTORY

X	CONDITION	DATE	X	CONDITION	DATE	X	CONDITION	DATE
	Anemia			Diverticulosis			HIV/AIDs	
	Anxiety			Drug Addiction			Kidney Trouble	
	Appetite Changes			Emphysema			Liver Disease	
	Arthritis			Epilepsy			Lung Disease	
	Asthma			Gallstones			Oxygen Therapy	
	Cancer			Gonorrhea			Phlebitis/Blood Clots	
	Chest Pain			Gout			Syphilis	
	Colitis			Heart Trouble			Thyroid Disease	
	Depression			Hepatitis			Tuberculosis	
	Diabetes			High Blood Pressure			Yellow Jaundice	

PROCEDURES

X	PROCEDURE	DATE	X	PROCEDURE	DATE
	X-Ray			Bone Density Scan	
	MRI			Flexible Sigmoidoscopy	
	Mammogram			Colonoscopy	
	Echocardiogram			Prostate Exam	
	EKG			Ct-Scan	

If marked **X**, please specify: ____

____

ALLERGIES

List your medication allergies and the type of reaction you had when you took the medication. Please include nonmedication allergies including **food, Iodine, radiology IV dyes and contrast, and latex products.**

Medication/Food/Misc. Agent/Substance Reaction

____
____
____

SURGICAL HISTORY/HOSPITALIZATION

YEAR	OPERATION OR ILLNESS	HOSPITAL NAME	CITY/STATE

FAMILY HISTORY

RELATION	Age, if living	Age, at death	Cause of death	Medical History
Father				
Mother				
Paternal GF				
Paternal GM				
Maternal GF				
Maternal GM				
Brother(s)				
Sister(s)				
Son(s)				
Daughter(s)				

SOCIAL HISTORY

Occupation/Type of Work: ______________________________ Date Last Worked: _____________________

Have you ever used illicit drugs? ☐ YES ☐ NO

Tobacco/Alcohol Use: ☐ Non-Smoker ☐ Current Smoker ☐ Former Smoker

How often do you drink alcohol? ☐ Never ☐ Monthly or less ☐ 2-3 times a week ☐ 4> a week

CONSENT TO TREAT

By signing this consent form you are allowing **Stankus Family Care** to provide you medical treatment, file your insurance and send your medical records to your insurance company, on your behalf. Furthermore, you are responsible for paying for your share of the costs, and if the insurance company does not pay or you do not have insurance coverage on the date of service, you must pay for the cost of these services. You also understand that you have the right to refuse any medical procedure or treatment and you have the right to discuss all medical treatments with your clinician.

X ____

Patient/ Representative Signature Date