

PRIMARY CARE PHYSICIAN CENTER, PC

Please present your insurance card, driver's license, and copayment at the time of check-in.
Patients having no health insurance coverage must pay in full for all anticipated services at check-in.
We accept **NO CASH** payments. We accept VISA and MC only, debit cards and money orders.
Personal checks must list two (2) phone numbers (home and business – no cell) and a current physical street home address (no PO Box).

DATE _____

PATIENT NAME _____
Last First MI

HOME ADDRESS (No PO boxes) _____
Street # Street Name Apt #
_____ City State Zip

PHONE _____
Home Business Cell

EMPLOYER NAME _____

ADDRESS _____
Street # Street Name (Apt. #)
_____ City State Zip

SEX M F MARITAL STATUS S M D SEP STUDENT Y N LEVEL ES HS COL

Do you have a living will? Y N If not, do you want to complete one now? Y N

EMERGENCY CONTACT _____
Name Phone

RELATIONSHIP _____

Do you have medical insurance? Y N Carrier Name _____

Who does the plan belong to? Self Spouse Parent (Mother Father) Other _____

I authorize Primary Care Physician Center PC to (1) release information in my medical record, including information on HIV, drug/alcohol use or psychological conditions to my insurance carrier(s) or specialist (s) to whom I am being referred, if requested (2) accept the assignment of benefits for services rendered to me, and (3) release information to agencies that may be required for collection services for delinquent payments.

I understand that I will be responsible for (1) payment of deductibles, copayments and/or full payment for services prior to receiving medical service if uninsured, (2) payment for medical services not covered or deemed medically necessary by my insurance policy, (3) a \$35.00 fee for returned checks, (4) a \$25.00 direct charge for failure to provide a 24 hour cancellation notice for scheduled appointments and (5) payment for collection proceedings for non-payment of services for which I am responsible.

PATIENT SIGNATURE (or guardian if minor) DATE

PATIENT MEDICAL HISTORY

PATIENT NAME _____ DATE _____

AGE _____ DOB _____ DATE OF LAST PHYSICAL _____

MEDICATION ALLERGIES _____

Patient Signature _____

Please circle those diagnose(s) that you have had in the past or present. Please indicate if any immediate family member has had the same problem by writing **F** for father, **M** for mother, **B** for brother or **S** for sister.

AIDS	Glaucoma	Mumps	HOSPITALIZATIONS	YEAR
Alcoholism	Gonorrhea	Pacemaker	1	_____
Anemia	Gout	Pneumonia	2	_____
Anorexia	Heart Disease	Polio	3	_____
Appendicitis	Hepatitis	Prostate Problem	PREGNANCY HISTORY	YEAR
Arthritis	Hernia	Psychiatric Care	Number	_____
Asthma	Herpes	Rheumatic Fever	Complications	_____
Bleeding	High Blood Pressure	Scarlet Fever	Miscarriages	_____
Breast Lump	High Cholesterol	Stroke	Abortions	_____
Bronchitis	HIV Positive	Suicide Attempt	Infertility	_____
Bulemia	Kidney Disease	Thyroid Problems	SURGERIES	YEAR
Cancer	Liver Disease	Tonsillitis	1	_____
Cataracts	Measles	Tuberculosis	2	_____
Chicken Pox	Migraine	Typhoid Fever	3	_____
Diabetes	Miscarriage	Ulcers	ACCIDENTS	YEAR
Emphysema	Mononucleosis	Vaginal Infections	1	_____
Epilepsy	Multiple Sclerosis	Venereal Disease	2	_____

OTHER NOT LISTED: _____

Children 18 and younger: Prenatal Care Y N Type of Delivery _____

Death of Immediate Family Members and Cause:

SHOTS: DT DTP MMR POLIO CHICKEN POX PNEUMOVAX FLU HEPATITIS A B TET (yr____)

SUBSTANCE USE: Caffeine _____ Alcohol _____ Tobacco _____ Other _____

OCCUPATIONAL CONCERNS: Stress Heavy Lifting Other _____

CHEMICAL DEPENDENCY: Y N SEXUALLY ACTIVE: Y N FAMILY ISSUES: Y N

