GIRARD Medical Center Clinics

_____ Clinic

Patient Information: **Today's Date:**

Patient Name: _____ **Date of Birth:** _____

Address: _____
(City) (State) (Zip Code)

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

Email Address: _____ **Patient Portal Access:** ☐ **YES** ☐ **NO**

Patient SS#:_____ **Sex:** ☐ **M** ☐ **F** Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐

Patient's Occupation: _____ **Employer Name:** _____

Employer Address: _____ **Employer Phone:** _____

Spouse's Information:

Spouse's Name: _____ **Date of Birth:** _____

Spouse SS#: _____ **Phone:** _____ **Cell:** _____

Occupation: _____ **Employer Name:** _____

Responsibility:

Who is responsible for this account? _____

Relationship to patient: _____ **Birth date:** _____ **SS#** _____

Insurance Information: (Please provide copies of your insurance cards)

Insurance Company: _____ **ID#:** _____

Group Name: _____ **Group#:** _____

Subscriber Name: _____ **Birth date:** _____ **SS#** _____

Relationship to Patient: _____

Medicare *Retirement Date:_____ ***Spouse retirement date:**_____
Is patient covered by additional insurance? YES ☐ **NO** ☐ **(If Yes - Please provide the same above information for the additional insurance policy):**

_____

****Payment is expected at the time of service unless prior arrangements have been made****

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Patient Name: _____ DOB: _____ Today's Date: _____

Parental Information: (For patients under age 18)

Mother: _____ **Father:** _____

Address: _____ **Address:** _____

Phone: _____ **Phone:** _____

Who has legal custody of child? _____

List medications you are currently taking: (Include over the counter medications)

_____

_____

_____

_____

List allergies to medications, substances, or food:

_____

_____

_____

Current Pharmacy:

Name/City: _____ Phone: _____

Previous Physician: _____

Contact Information:

Emergency Contact: _____ Phone: _____

Relationship: _____

Advance Directive Information:

DO YOU HAVE ADVANCE DIRECTIVES? ☐ **YES** ☐ **NO**

If you would like information concerning advanced directives, please let us know.

Whom may we thank for referring you: _____

GIRARD Medical Center Clinics

Patient Name: _____ DOB: _____ Today's Date: _____

Past Medical History: (Please check all that apply)

☐ Diabetes	☐ Irregular heartbeat	☐ COPD	☐ Arthritis
☐ Kidney Disorder	☐ Heart disease	☐ Tuberculosis	☐ Gout
☐ High blood pressure	☐ Heart failure	☐ Hepatitis	☐ Rheumatic fever
☐ High cholesterol	☐ Anemia	☐ Peptic ulcer	☐ Polio
☐ Cancer	☐ Stroke	☐ Reflux (heartburn)	☐ Skin ulcers
☐ Poor circulation	☐ Seizures/ Epilepsy	☐ Urinary problems	☐ Hay Fever/allergies
☐ Heart attack	☐ Pneumonia	☐ Kidney stones	☐ Depression
☐ Vein problems	☐ Asthma	☐ Syphilis/V.D.	☐ Anxiety
☐ Blood clots			

Other (please specify): _____

****Immunizations/Testing: Please provide a copy of your immunization records****

Past Surgical History: (Please list all previous surgeries and dates)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Family History

Father: Alive☐ Deceased☐ Present health or cause of death:_____

Mother: Alive☐ Deceased☐ Present health or cause of death:_____

Siblings: #Alive☐ #Deceased☐ Present health or cause of death:_____

Children: #Alive☐ Ages and Health_____

#Deceased☐ Age and Cause of Death_____

Indicate any illnesses that have occurred in any of your **blood relatives**: **(M-maternal, P- paternal, S-Sibling)**

☐ Diabetes ☐ Cancer ☐ Bleeding Tendency ☐ Allergy

☐ Kidney Disease ☐ Tuberculosis ☐ Depression ☐ Anxiety

☐ Heart Disease ☐ Heart Attack ☐ High Blood Pressure ☐ High Cholesterol

☐ Stroke ☐ Other: _____

Health Habits

Do you/have you smoked? _____ How many packs per day? _____ For how long? _____

Do you/have you used chewing tobacco? _____ How much? _____ For how long? _____

Do you drink alcohol? _____ How much? _____

Do you use any illicit drugs? _____ What? _____ How much?_____

Do you exercise on a regular basis? _____ What do you do? _____

Do you follow any specific diet? _____ What is the diet? _____

Have you traveled out of the country in the last three months? ☐ **Yes** ☐ **No**

If yes please list country/countries: _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature_____ **Date:** _____