StarCare Family and Preventive Medicine

Patient Information

Name: (Last)_____ (First)_____ (M)_____

Address:_____(Apt)_____

City:_____ State:_____ Zip Code: _____

DOB: _____ Marital Status: **S M D W** Gender: **M F Other**

Cell Phone:_____ Home Phone:_____

E-Mail:_____ SS #:_____

Emergency Contact: _____ Phone #: _____

Employer Information

Name: _____

Address: _____ City: _____ State:_____

Zip Code: _____ Phone #: _____

Person Who Carries Insurance or Responsible Party

____ Check here if patient above is the holder of the insurance

Name: _____ Relation to you:_____

Address: _____Apt#: _____

City:_____ State:_____ Zip Code: _____

DOB: _____ Gender: **M F Other** Phone#: _____ SS #: _____

Initial and sign below to acknowledge that you understand the below statements.

_____We will attempt to send you to the correct laboratory (as per current lists). However, you are ultimately responsible to be sure that your insurance is contracted with the lab. Please check with your insurance company or refer to your policy. We will not assume any responsibility for this issue.

_____ Please note, we do not accept **MEDICARE** or **MEDICAID**. All Medicare patients will need to sign a Medicare waiver before being seen. We do not accept **WORKER'S COMPENSATION**. If you are being seen for a work-related injury, you will be responsible for all charges and may lose any Worker's Compensation benefits you may have. Please be advised that part of your care may be delegated to a Physician Assistant. 24hr notice is required when canceling or rescheduling an appointment.

I assign medical and surgical benefits to StarCare Family and Preventive Medicine PA. I understand that I am responsible for all charges incurred as a result of services provided including charges from outside labs, etc.

_____ _____

Signature Date

StarCare Family and Preventive Medicine

HIPAA Release

Patient Name: _____

Who to contact:

I hereby give permission to StarCare Family and preventive Medicine to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s), and/or personal friend(s).

Name: _____ **Relationship:** _____

Phone Number: _____

Name: _____ **Relationship:** _____

Phone Number: _____

Name: _____ **Relationship:** _____

Phone Number: _____

[ ] I do not give permission to discuss/disclose any information to anyone.

I wish to be contacted in the following manner:

Home Telephone:

[ ] OK to leave message with general information
[ ] Leave message with call back number only

Work Telephone:

[ ] OK to leave message with general information
[ ] Leave message with call back number only

This duration of the authorization is indefinite unless otherwise revoked in writing. I understand the requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

_____ _____

Signature of patient/legal representative Date

Medical History

Name: _____ **Age:** _____ **Marital Status**: **S M W D Date:**_____

Occupation: _____

FAMILY HISTORY: If any blood relative has suffered from any of the following, please indicate which relatives.

Alcoholism _____	Cancer _____	Glaucoma _____	Mental Illness _____
Allergies _____	Diabetes _____	Gout _____	Migraine _____
Anemia _____	Emphysema _____	Heart Disease _____	Osteoporosis _____
Arthritis _____	Epilepsy _____	Hypertension _____	Stroke _____
Asthma _____	Gastrointestinal _____	Kidney Disease _____	Thyroid _____

HOSPITAL ADMISSIONS:

YEAR	ILLNESS OR OPERATION	MEDICATIONS TAKEN REGULARLY

APPROXIMATE YEAR OF LAST IMMUNIZATION			DRUG ALLERGIES	OTHER ALLERGIES
Pneumonia _____	Hepatitis _____	Rubella _____	_____	_____
Diptheria _____	Measles _____	Pertussis _____	_____	_____
Mumps _____	Tetanus _____	Polio _____	_____	_____

PERSONAL HISTORY – MARK "C" FOR CURRENT PROBLEMS. ✓ BOX AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING DISEASES OR SYMPTOMS:

- ☐ Abdominal pain, chronic
- ☐ Anemia
- ☐ Arthritis/Rheumatism
- ☐ Back pain, recurrent
- ☐ Blood in urine
- ☐ Bloody stools
- ☐ Bone fracture, joint injury
- ☐ Cancer
- ☐ Change in bowel habits
- ☐ Chest pains
- ☐ Chicken pox
- ☐ Chronic cough/bronchitis
- ☐ Chronic fatigue/weakness
- ☐ Cold numb feet
- ☐ Congestion – chronic
- ☐ Constipation
- ☐ Convulsions/seizures
- ☐ Decrease in force urine
- ☐ Decreased hearing
- ☐ Depression
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Diverticulosis
- ☐ Double or blurred vision
- ☐ Ear infections, frequent
- ☐ Eczema
- ☐ Eye infections – frequent
- ☐ Eye pain
- ☐ Failing vision
- ☐ Fainting spells
- ☐ Fall asleep during the day
- ☐ Foot pain
- ☐ Gallbladder trouble
- ☐ German measles
- ☐ Gout
- ☐ Hayfever/Allergies
- ☐ Headaches, frequent
- ☐ Heart murmur
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ High blood pressure
- ☐ Hives
- ☐ Hoarseness – prolonged
- ☐ Indigestion/heartburn
- ☐ Jaundice/hepatitis
- ☐ Kidney stones
- ☐ Leg pain while walking
- ☐ Loss of appetite - recurrent
- ☐ Measles
- ☐ Memory loss
- ☐ Mental illness
- ☐ Moodiness, excessive
- ☐ Mumps
- ☐ Muscle weakness
- ☐ Nausea/vomiting – persistent
- ☐ Nervousness
- ☐ Nose bleeds - recurrent
- ☐ Numbness/tingling sensation
- ☐ Overnight frequent urination
- ☐ Painful urination
- ☐ Palpitations
- ☐ Peptic ulcers
- ☐ Phobias
- ☐ Pneumonia
- ☐ Polio
- ☐ Psoriasis
- ☐ Rashes
- ☐ Rheumatic fever
- ☐ Ringing in ears
- ☐ Scarlet fever
- ☐ Shortness of breath
  - ☐ At rest ☐ Normal activity
  - ☐ On exertion
- ☐ Sinus trouble – recurrent
- ☐ Sleeping difficulty
- ☐ Snoring
- ☐ Sore throat – recurrent
- ☐ Stroke
- ☐ Swollen ankles/feet
- ☐ Thyroid disease
- ☐ Tremor/handshaking
- ☐ Tuberculosis
- ☐ Urethral discharge
- ☐ Urinary infections – frequent
- ☐ Varicose veins/phlebitis
- ☐ Venereal disease
- ☐ Wheezing asthma
- ☐ Weigh gain, recent _____lbs in past year
- ☐ Weight loss, recent _____lbs in past year
- ☐ Substance abuse
- ☐ Smoking: _____pks/day _____ years smoked _____ years quit
- ☐ Alcohol: _____ozs/week
- ☐ Coffee/Tea: _____cups/day

FEMALES ONLY

Birth control method: _____
Onset of periods, age: _____
_____regular _____irregular
Flow: ___heavy ___moderate ____ light ____#days of flow
- ☐ Pain/cramps with periods
- ☐ Pain/bleeding after sex

Date of last period _____
Date of last pap smear _____
Date of last mammogram _____
Pregnancies _____
Live births _____

I CERTIFY THAT THE ABOVE IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

_____ **Patient Signature**

_____ **Physician/PA Signature**